MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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NB: PUBLICATION OF THE NAME OF THE PATIENT AND RESPONDENT AND ANY DETAILS THAT MIGHT IDENTIFY THEM IS PROHIBITED

DECISION NO: 198/01/87D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **DR XX** registered medical practitioner

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Ms S Cole, Dr L Ding, Dr F McGrath, Dr J L Virtue (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Wellington on Tuesday 19 March 2002

APPEARANCES: Ms M McDowell for the Director of Proceedings

Mr C J Hodson QC for Dr xx.

The Charge

1. The Director of Proceedings ("the Director") charged that between 14 January 2000 and 31 March 2000 Dr xx acted in such a way that amounted to disgraceful conduct in that he had an intimate and sexual relationship with his patient.

2. The charge was admitted by Dr xx.

3. Section 109 of the Medical Practitioner's Act 1995 (the Act) provides that the Tribunal may make any one or more of the Orders authorised in s110 if the Tribunal, after conducting a hearing, is satisfied that the practitioner has committed one of the acts set out in paragraph (a) to (g) of s109(1). Accordingly the Tribunal, notwithstanding the admissions made by Dr xx, has considered whether it is satisfied that Dr xx is guilty of disgraceful conduct.

The Facts

4. An agreed summary of facts was provided to the Tribunal. It is not necessary, given the sensitive nature of the matter, to set out all of the contents of the summary of facts in this decision.

5. Stated briefly, at all relevant times Dr xx was a specialist registered medical practitioner and, since 1999 was responsible for Ms A's care and treatment. It was agreed that due to the nature and severity of her clinical condition Ms A was a 'particularly vulnerable' patient. In January 2000, immediately prior to a period of leave, the professional relationship between Dr xx and Ms A became sexualised. While he was on leave Dr xx contacted Ms A by telephone and they exchanged letters. Dr xx made arrangements to meet Ms A and sexual intercourse occurred in February and March 2000.

6. On his return from annual leave at the end of March 2000, Dr xx disclosed the situation that had developed to a supervisor. He explained that he had begun to experience intense feelings for Ms A two weeks before he went on leave. Dr xx admitted to his supervisor that a sexual relationship had developed with Ms A. Dr xx explained that it was not until

he had returned to work that the enormity of his actions dawned on him. As a result of those admissions Dr xx was immediately suspended from his employment.

7. Following his suspension, Dr xx returned his Annual Practising Certificate and has not practised at all since March 2000. He also subsequently resigned from all professional positions and responsibilities relating to his medical practice.

8. Dr xx has stated that he has permanently withdrawn from medical practice.

The Hearing

9. Counsel for the Director made written submissions relating to both the issue of non-publication of the names and identifying details of Dr xx and Ms A and as to disciplinary level, penalty and costs. The Tribunal also heard oral submissions on all of these matters from Counsel for Dr xx.

The Law

10. The Tribunal has approached its consideration of the legal issues present in this case by reference to those cases involving sexual misconduct referred to by the Director, and to the Medical Council's Statement entitled "Sexual Abuse In the Doctor/Patient Relationship – Statement For the Profession" which came into effect on 16 June 1994, and which was in effect at the time of the events giving rise to this charge.

11. In particular, the Director referred to *Brake v Preliminary Proceedings Committee* [1997] 1 NZLR 71, a case on appeal from the Medical Council in which the test for disgraceful conduct was considered at length. In that case, the High Court (Tompkins, Cartwright and Williams JJ) held:

"The test for "disgraceful conduct in a professional respect" was said by the Court of Appeal in Allinson v General Council of Medical Education and Registration [1894] 1 QB 750, 763 to be met:

> *"If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably*

> *regarded as disgraceful or dishonourable by his professional brethren of good repute and competency…".*

It is apparent from this test, and from the later cases in which it has been adopted, that it is an objective test to be judged by the standards of the profession at the relevant time.

Mr Vickerman referred to the decision of the Privy Council in Felix v General Dental Council [1960] AC 704. The Council was concerned with a charge of infamous conduct in a professional respect. It said that to constitute infamous conduct there must be some "element of moral turpitude of fraud or dishonesty" in the conduct complained of. Mr Vickerman submitted that the test for "disgraceful conduct" should be the same and that moral turpitude, fraud or dishonesty must be proved.

We do not accept that submission. In Doughty v General Dental Council [1987] 2 ALL ER 843 at p 847, the Privy Council adopted the following passage from the judgment of Scrutton LJ in R v General Council of Medical Education and Registration of the United Kingdom [1930] 1 KB 562 at p 569:

> *"It is a great pity that the word 'infamous' is used to describe the conduct of a medical practitioner who advertises. As in the case of the Bar so in the medical profession advertising is serious misconduct in a professional respect and that is all that is meant by the phrase 'infamous conduct'; it means no more than serious misconduct judged according to the rules written or unwritten governing the profession."*

In our view the same test should be applied in judging disgraceful conduct. In Doughty the Privy Council pointed out that Lord Jenkins' observation in Felix was in the context of a case in which dishonesty was very much the issue.

In considering whether conduct falls within that category, regard should be had to the three levels of misconduct referred to in the Act, namely disgraceful conduct in a professional respect, s58(1)(b); professional misconduct, s43(2); and unbecoming conduct, s42B(2). Obviously, for conduct to be disgraceful, it must be considered significantly more culpable than professional misconduct, that is, conduct that would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct, or as it was put in Pillai v Messiter (No 2) (1989) 16 NSWLR 197, 2000, a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."

12. That passage setting out the test for disgraceful conduct has subsequently been adopted by this Tribunal in *White* (1) Decision number 63/98/24C; *White* (2) Decision number 69/98/36C, and in *Parry* Decision No. 139/00/62D.

13. As stated in *Parry*, and upheld on appeal, the principal purpose of the Act is to protect the health and safety of members of the public. That purpose is entirely consistent with the underlying purpose of the Medical Council's policy on sexual abuse in the context of the professional relationship. As was stated in *Brake*, the medical profession has long recognised that the doctor/patient relationship is a relationship of trust and is intended for the benefit of the patient. The proper conduct of the doctor/patient relationship requires the doctor to ensure that every interaction with a patient is conducted in a sensitive and appropriate manner, with full information provided and appropriate consent obtained. All forms of sexual abuse in the doctor/patient relationship are regarded as disgraceful conduct with severe consequences for the doctor.

14. The Medical Council's statement for the profession is expressed in terms of 'zero tolerance'. It states:

"Sexual behaviour in a professional context is abusive. Sexual behaviour comprises any words or actions designed or intended to arouse or gratify sexual desires…

Council condemns all forms of sexual abuse in the doctor/patient relationship for the following reasons:

- *The ethical doctor/patient relationship depends upon the doctor creating an environment of mutual respect and trust in which the patient can have confidence and safety.*

- *The onus is on the doctor to behave in a professional manner. Total integrity of doctors is the proper expectation of the community and of the profession. The community must be confident that personal boundaries will be maintained and that as patients they will not be at risk. It is not acceptable to blame the patient for the sexual misconduct.*

- *The doctor is in a privileged position which requires physical and emotional proximity to the patient. This may increase the risk of boundaries being broken.*

- *Sexual misconduct by a doctor risks causing psychological damage to the patient.*

- *The doctor/patient relationship is not equal. In seeking assistance, guidance and treatment, the patient is vulnerable. Exploitation of the patient is therefore an abuse of power and patient consent cannot be a defence in disciplinary hearings of sexual abuse.*

- *Sexual involvement with a patient impairs clinical judgement in the medical management of that patient.*

Council will not tolerate sexual activity with a current patient by a doctor.

The guiding principle is that there is no exploitation of the patient or their immediate family members.

The Council rejects the view that changing social standards require a less stringent approach. The professional doctor/patient relationship must be one of absolute confidence and trust. It transcends other social values and only the highest standard is acceptable.

The Medical Council believes the issue of the power differential between patient and doctor means that consent of the patient is not a defence in disciplinary findings of sexual abuse. It may become an issue in consideration of penalty. Each case must be examined in relation to the degree of dependency between patient and doctor and the duration and nature of the professional relationship.

DEFINITIONS

For the purposes of disciplinary action, the Council has defined sexual abuse under three categories:

sexual impropriety

sexual transgression

sexual violation

…

***Sexual violation** means doctor/patient sexual activity, whether or not initiated by the patient. Recent disciplinary cases have included such examples as:*

masturbation or clitoral stimulation

other forms of genital or other sexual connection."

15. These principles have been reaffirmed in a further Medical Council document dated July 2000 entitled "Trust in the Doctor/Patient Relationship".

16. The Director also referred the Tribunal to the statement in *Brake* (at p78) in which the Court stated, in the context of a doctor entering into a sexual relationship with a patient:

"The medical profession has for long recognised that any sexual behaviour between a doctor and a patient while a doctor/patient relationship is in existence is completely unacceptable. In a discussion document the Medical Council issued in 1992 it adopted 'the principle of zero tolerance with respect to a doctor who engages in sexual activity with a current patient'.

Doctor Robin Briant, the former chair of the Medical Council said in 1994 (Newsletter of the Medical Council, (no 9) March 1994):

> *'The doctor-patient interaction is for the patient's benefit and there is no place in it for a sexual liaison. It would do immense harm to the quality of doctor-patient interactions generally if it were even suspected that intimate or sexual relationships may evolve from medical consultations. Only when people feel safe in a professional relationship can they entrust it with their most private, emotional, psychological and physical secrets'.*

She went on to say that 'there is nothing new about medical council policy on sexual abuse in the doctor/patient relationship; Hippocrates said it all long ago (500 BC) and much more succinctly: 'into whatever houses I enter, I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief or corruption; and further, from seduction of females or males or free men or slaves'.

In June 1994 – well after the events to which this appeal relates – the council issued a statement for the profession on sexual abuse in the doctor/patient relationship. The statement confirms that the doctor must ensure that every interaction with a patient is conducted in a sensitive and appropriate manner with full information and consent, and that the council condemns all forms of sexual abuse in the doctor/patient relationship for reasons set out in the statement. It points out that the onus is on the doctor to behave in a professional manner, that total integrity of doctors is the proper expectation of the community and of the profession, that the doctor is in a privileged position which may increase the risk of boundaries being broken, that sexual misconduct by a doctor risks causing psychological damage, and that the doctor/patient relationship is not equal – in seeking assistance, guidance and treatment, the patient is vulnerable.

Although this statement was issued some two years after the events to which this appeal relates, we have no reason to doubt that it fairly states what have long been

the rules of conduct recognised by the profession, any serious breach of which would be regarded as disgraceful conduct.

This is confirmed by a consideration of reports of a number of cases published in the New Zealand Medical Journal where the council has found doctors guilty of sexual intimacies of various kinds. Where the degree has been other than minor, the council has consistently found the doctor's name has been removed from the register or the doctor has been suspended from practice."

Burden and Standard of Proof

17. The burden of proof is on the Director. The standard of proof is the civil standard, i.e. the balance of probabilities. The degree of satisfaction that is called for will vary according to the gravity of the allegation made.

Aggravating features

18. The Tribunal heard submissions from the Director on the aggravating features of this case. The Director submitted that the sexual conduct engaged by Dr xx was at the most serious end of the spectrum for this kind of offending and was, ultimately, abusive in nature.

19. The Director submitted that Ms A was in a position of particular vulnerability given her presenting symptoms and clinical history and her current situation. Additionally, Dr xx was significantly older than Ms A at the time of the offending and he was a very senior and experienced practitioner.

20. The Director submitted that Dr xx would have been well aware of the dynamics of the relationship and the importance of maintaining appropriate sexual boundaries. There was a significant power differential between Dr xx and Ms A which, the Director submitted, highlighted the abusive nature of the relationship. Dr xx specifically and actively made contact with Ms A while on leave, and pursued the relationship.

21. The Director disputed the evidence provided by Dr xx that he was suffering from depression at the time that the relationship took place.

Mitigating features

22. The Director acknowledged that Dr xx had frankly acknowledged his wrongdoing at an early stage and that he appears remorseful. Dr xx admitted to the conduct, resigned from his various professional positions, and handed in his Annual Practising Certificate. He has not sought to practise medicine since this incident came to light. The Director also recognised the early guilty plea made by Dr xx, which spared Ms A the necessity of giving evidence.

23. Mr Hodson submitted that, at the time of the offending, Dr xx was suffering a depressive illness characterised by low mood, sleep disturbance, significant weight loss, a pattern of obsessional thought, loss of normal judgment of the reality of the situation and his future. This was attributed to overwork and exhaustion.

24. Mr Hodson also noted that Dr xx had not previously faced disciplinary action.

Submissions on penalty and costs

25. It was submitted by the Director that, in all but the most minor of cases where a practitioner has been involved in the sexual relationship with a patient, his (or her) name has been removed from the Register by the relevant disciplinary body. She reiterated that in determining penalty the paramount consideration should be the protection of the public in accordance with the Act's principal purpose.

26. The Director submitted that Dr xx's name be removed from the Register and that he be censured and fined at a level relative to the seriousness of his conduct. The Director also submitted that Dr xx should pay costs and undertook to provide the Tribunal a schedule of costs relating to the Health and Disability Commissioner's investigation and the Director's proceedings.

27. Mr Hodson accepted that removal of Dr xx's name from the register is appropriate in this case. Mr Hodson then also outlined Dr xx's history, including his reputation for taking on difficult cases.

28. On the issue of costs, Mr Hodson described Dr xx's current financial circumstances, particularly his inability to pay any fine. He submitted that in the circumstances a fine would be excessive and inappropriate.

29. Mr Hodson also submitted that the Health and Disability Commissioner's delay in bringing this matter before the Tribunal was unreasonable and should result in the Health & Disability Commissioner's office being deprived of all of its costs.

30. The Director submitted that there was no delay so far as the Director of Proceedings' process was concerned, that the Act required that certain procedural steps be completed, and that these all took some time to be completed. However, the Tribunal reiterates concerns that it has expressed on previous occasions about the length of time it takes for the process to be completed and charges brought to the Tribunal. In this case notwithstanding early admissions on the part of the practitioner almost two years elapsed from the date of the events giving rise to the charge and the hearing of it.

Submissions on name suppression of doctor and identifying details of patient

31. On this occasion, it was the Director who sought permanent name suppression for Dr xx on the basis that publishing his name may lead to identification of Ms A. In support of this, the Director submitted that there was concern for the safety of Ms A if Dr xx's name were to be published due, in large part, to her perception that publication of the practitioner's name would inevitably lead to disclosure of her own, with attendant comment in the local community and/or media interest. However, the Director also conceded that it was in the public interest that the decision be published.

32. On behalf of Dr xx, Ms Gibson submitted that, while he had initially also sought name suppression, he had instructed counsel not to appeal the Tribunal's decision declining his application, and he did not now seek name suppression. Indeed he had been advised it was unlikely that any such application would succeed, and he accepted that advice.

33. However, the patient concerned was an unwilling participant in these proceedings and, whilst she accepted that they were inevitable, she did not instigate the charge. Her anxiety

and personal difficulties were heightened as a result of the hearing, to the extent that she was likely to be 'at risk' from self-harm if she was identified – and Ms A believed that was inevitable if Dr xx was publicly identified. Whilst this might be more a matter of perception rather than reality, Ms Gibson advised the Tribunal that, notwithstanding that Dr xx's name was suppressed, he had already been contacted by the news media about this hearing.

34. A further relevant factor to take into consideration was that because Dr xx had ceased practice there was no possibility that suspicion would fall on any other practitioner in the relevant geographic location or area of practice.

The Decision

35. The Tribunal carefully considered all of the evidence presented to it and Counsel's helpful and extensive submissions. The Tribunal is satisfied that Dr xx is guilty of disgraceful conduct in a professional respect in terms of s109(1)(a) of the Act.

Reasons

36. As stated in *Brake,* the applicable test for disgraceful conduct is relatively straight-forward and uncomplicated – Dr xx's conduct must be judged against the standards of the profession at the relevant time. Notwithstanding admissions on his part, the Tribunal must be satisfied that the Director has established, to the requisite degree of proof, that Dr xx's conduct in engaging in a sexual relationship with Ms A while he was her medical practitioner would be reasonably regarded by his professional brethren as disgraceful and dishonourable – that is, serious misconduct according to the rules of the profession.

37. In assessing the degree of Dr xx's culpability, the starting point for the Tribunal was the Medical Council's statement to the profession. As already stated, this statement of the relevant professional standards was circulated to all practitioners in June 1994 and therefore was current at the time of the events giving rise to the charge.

38. The Tribunal agrees that Council's policy on doctor/patient sexual relationships is expressed in unequivocal terms. All sexual behaviour in a professional context is abusive. The onus is on the doctor to behave in a professional manner at all times.

39. In terms of the Medical Council's categorisation of sexual abuse, Dr xx's sexual relationship with Ms A falls into the most serious of the three categories; sexual violation. "*Sexual violation*" being defined in the Statement as "*doctor/patient sexual activity whether or not initiated by the patient*".

40. The reasons for such a policy are fundamental. The ethical doctor/patient relationship depends upon the doctor creating an environment of respect and trust in which the patient can have confidence and safety. In the context of the relevant statutory regime, the primary purpose of which is stated to be to ensure the health and safety of members of the public generally, not just specific patients, it appears to this Tribunal that it must approach its task on the basis that misconduct of the kind alleged in this case constitutes the most serious breach of fundamental professional obligations. On that basis, it may properly be categorised as disgraceful conduct unless there is evidence presented to the Tribunal which would make an adverse finding at that level unfair or unreasonable. The Tribunal is satisfied that no such evidence has been presented in this case.

41. As the Director submitted, in this case, a number of aggravating factors were identified, and these have been referred to earlier in this Decision.

42. In relation to the issue of name suppression, the Tribunal also accepts counsels' submissions that this is an unusual case in that the patient is an unwilling participant in these proceedings and that Ms A's concerns and anxiety largely arise out of the possibility of her being identified as a result of publication of this decision. While it is not normally the case that the Director seeks permanent name suppression of the name of the practitioner involved, the Tribunal accepts that this application is made on the basis of the Director's very real concern for the safety of Ms A, and that her concerns are shared by Dr xx and his counsel.

43. In light of those submissions the Tribunal considers that it is appropriate in this case to permanently suppress Dr xx's identity and also all other details that might identify either Dr xx or Ms A.

Orders

44. The Tribunal is satisfied that Dr xx is guilty of disgraceful conduct and ORDERS as follows:

(a) That Dr xx's name be removed from the Medical Register pursuant to Section 110(a) of the Act.

(b) It is appropriate in the circumstance that Dr xx is censured.

(c) He is to pay a fine of $7,500.00. The Tribunal considers that a fine at this level is appropriate and fairly takes into account the seriousness of the offending, Dr xx's personal circumstances, and like cases.

(d) Dr xx is to pay $11,847.29 being 50% of:

(i) the costs and expenses of and incidental to the investigation made by the Commissioner and the prosecution of the charge by the Director; and

(ii) the costs and expenses of and incidental to the hearing by the Tribunal.

(e) Publication of the names and any identifying details of Dr xx and Ms A, including the location of the offending; the name of any medical clinic or institution involved; Dr xx's specialist area of practice and/or his professional status, and the nature of Ms A's medical condition and treatment, is prohibited.

(f) That a notice under s138(2) of the Act be published in the New Zealand Medical Journal, such notice to omit the names and identifying details of Dr xx and Ms A, in accordance with the non-publication orders made in paragraph 44(e) herein.

DATED at Wellington this 30th day of April 2002

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal