MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 219/02/94D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings against **FRANCIS ANTONY FRIZELLE** medical practitioner of Christchurch

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Ms S Cole, Dr G S Douglas, Dr A R G Humphrey, Dr J L Virtue (Members)

Ms K L Davies (Hearing Officer)

Ms N Wetti (Stenographer)

Hearing held at Christchurch on Wednesday 13 November 2002

APPEARANCES: Ms M McDowell, Director of Proceedings

Mr C J Hodson QC for Professor F A Frizelle.

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The Charge

1. Professor Frizelle is a registered medical practitioner. Amongst his duties and responsibilities Professor Frizelle is a colorectal and general surgeon employed by Canterbury District Health Board (formerly Canterbury Health Limited).

2. In an amended notice of charge dated 24 October 2002 the Director of Proceedings charged Professor Frizelle with conduct unbecoming a medical practitioner.[1] The allegations relate to an incident which occurred on 4 September 1999 when Professor Frizelle was caring for the complainant, Ms Henry.

3. The amended notice of charge particularised the allegations against Professor Frizelle in the following way:

> *"1. [He] failed to communicate with [his] patient in a sensible and respectful manner.*
>
> *2. [He] removed a seton from [his] patient without first obtaining her informed consent to that procedure.*
>
> *3. [He] failed to offer [his] patient pain relief when [he] knew or ought to have known she was experiencing significant pain.*
>
> *4. Having removed a seton from [his] patient [he] failed to adequately explain to her:*
>
> > *(a) that [he] had done so; and/or*
> >
> > *(b) the consequences or care following removal".*

Hearing

4. The hearing of the charge took place in Christchurch on 13 November 2002. The evidence was able to be heard expeditiously because of the co-operation of the parties. Counsel for Professor Frizelle and the Director of Proceedings provided the Tribunal with

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[1] See s.109(c) Medical Practitioners Act 1995 which sets out the disciplinary offence of "… conduct unbecoming a medical practitioner, and that [the] conduct reflects adversely on the practitioner's fitness to practise medicine".

an agreed summary of facts. In addition to receiving that memorandum the Tribunal heard evidence from Professor Frizelle.

5. At the conclusion of the hearing of evidence and submissions from both counsel the Tribunal adjourned to consider its decision. Later on 13 November the Tribunal advised the parties it was satisfied the charge against Professor Frizelle had been proven. Submissions were sought on what penalty (if any) should be imposed.

6. The following paragraphs comprise the reasons for the Tribunal's decision announced on 13 November and the Tribunal's decision concerning the penalties it imposes on Professor Frizelle.

Summary of Director of Proceedings Case

7. It is convenient to commence with a very brief summary of the case advanced against Professor Frizelle by the Director of Proceedings.

8. The gravamen of the Director of Proceedings case is that Professor Frizelle treated Ms Henry in an insensitive manner and failed to explain in any satisfactory way the nature and consequences of the procedure he intended to perform on her. As a consequence, the Director of Proceedings alleges Professor Frizelle did not obtain Ms Henry's informed consent for the procedure he carried out. It is also said he failed to offer Ms Henry pain relief in circumstances where pain relief should have been provided.

Summary of Professor Frizelle's case

9. Professor Frizelle has accepted most of the factual evidence upon which the charge is based. However, Professor Frizelle contests the suggestion that his acts and omissions on 4 September 1999 amounted to conduct unbecoming a medical practitioner and that his conduct reflected adversely on his fitness to practise medicine.

Assessment of Evidence and Basis of Tribunal's Findings

10. Notwithstanding the agreement as to facts, the Tribunal has evaluated the evidence on the basis that the onus of proof in relation to all allegations rests with the Director of

Proceedings. The standard of proof is the civil standard with the qualification that the elements of the charge must be proven to a standard commensurate with the gravity of those allegations.[2]

Findings of Fact

Background

11. In 1996 Ms Henry was referred to Professor Frizelle because of a concern she may have suffered colitis. Professor Frizelle performed a colonoscopy and took a biopsy. He diagnosed Crohns disease. After this diagnosis Ms Henry was seen by Professor Frizelle and other doctors on a number of occasions between 1996 and 1999.

12. On 9 March 1999 Professor Frizelle performed a procedure on Ms Henry. That procedure involved excision of a perianal tag and a fistulotomy.[3]

13. On 25 June 1999 Professor Frizelle performed another procedure on Ms Henry under general anaesthetic. On this occasion Professor Frizelle inserted a seton – a drainage tube which is inserted to assist with the treatment of a fistula with sepsis. The seton was sutured into place with a slip knot. The technique employed by Professor Frizelle when inserting the seton required the suture to be slowly tightened over a period of time allowing the seton to slowly cut through the sphincter muscle. The tightening of the seton suture was carried out uneventfully on 19 July and 30 August 1999.

14. On 2 September 1999 Ms Henry telephoned Professor Frizelle's registrar (Dr Connor) and advised she was in significant discomfort as a result of the tightening of the suture on 30 August. Ms Henry contacted Dr Connor again on 3 September. Her pain was such she could hardly walk. It was arranged Ms Henry would attend Christchurch Hospital the following morning (Saturday 4 September) to see Dr Connor.

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[2] *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139, *Brake v PPC* (unreported, HC Auckland 169/95, 8 August 1996)

[3] Operation of an anal fistula.

Events of 4 September 1999

15. Ms Henry and her husband went to Christchurch at the appointed time on 4 September. Ms Henry explained to Dr Connor that the seton was very painful. She asked him to be gentle. Dr Connor then examined Ms Henry and attempted to cut the suture with a scalpel. This caused Ms Henry considerable pain. She cried out. Dr Connor stopped his efforts to enable Ms Henry to take some codeine. A few minutes later Dr Connor made another attempt to cut the suture. The process was so painful Ms Henry screamed. It was accepted that Ms Henry was in such pain that she "grabbed a cord on the wall, was crying with pain, and felt she was going to vomit". At this stage Dr Connor stopped the procedure and asked a nurse to get some morphine which he proposed to administer intravenously. He also called for nitrous oxide.

16. Soon after the nurse left Professor Frizelle entered the room. He asked if he could examine the suture. Ms Henry asked Professor Frizelle to be gentle with her.

17. When Professor Frizelle examined Ms Henry he pulled on the suture. This caused Ms Henry to scream with pain. Professor Frizelle told Ms Henry to stop screaming. Ms Henry said Professor Frizelle was blunt and unsympathetic.

18. Professor Frizelle then asked Dr Connor to get some scissors. Professor Frizelle said that administering a local anaesthetic would hurt as much as cutting the suture. Professor Frizelle then told Ms Henry to raise her buttocks. He provided no further explanation of what he was going to do, or what options were available. Nor did Professor Frizelle offer Ms Henry any pain relief.

19. Professor Frizelle then proceeded to remove the seton. Ms Henry had assumed the suture was going to be loosened. She did not appreciate the seton had been removed until the following day when she took a shower.

20. The process of removing the seton caused Ms Henry considerable pain and anguish. She felt like vomiting. She cried and shook all day. Ms Henry had stomach cramps and disturbed sleep with nightmares that evening.

21. Subsequently Ms Henry requested a transfer of her care to another surgeon. On 13 October 1999 Ms Henry had another seton inserted. That seton fell out and was not replaced.

22. On 6 September 1999 Ms Henry complained to the Health and Disability Commissioner. She also lodged a complaint with Canterbury Health Limited on the same day.

23. Professor Frizelle explained that when he saw Ms Henry on 4 September she was screaming at the top of her voice. He said Ms Henry was distressed and that rapid action was necessary. Professor Frizelle believed the seton was the cause of Ms Henry's pain and accordingly he thought it appropriate to remove the seton as quickly as possible.

24. Professor Frizelle accepted he did not explain matters in any detail and that he may have been brisk and firm with Ms Henry. Professor Frizelle thought he had made it clear he intended to remove the seton. He also accepted he had been annoyed with Dr Connor for seeing Ms Henry without him knowing and that his displeasure with Dr Connor may have been conveyed to Ms Henry.

25. Professor Frizelle accepted he had acted inappropriately. He wrote a letter of apology on 3 May 2000 and again apologised to Ms Henry at the hearing before the Tribunal on 13 November 2002.

Professor Frizelle's Professional Duties and Obligations

Duty to Treat Ms Henry With Respect

26. Particular 1 of the amended notice of charge focuses on Professor Frizelle's failure to communicate in a sensitive and respectful manner with Ms Henry.

27. The Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996 ("the Code") greatly assists in determining Professor Frizelle's professional duties and obligations to Ms Henry when focusing on the first particular of the amended notice of charge.

28. Right 1(1) of the Code provides:

> *"Every consumer has the right to be treated with respect".*

Closely related is Right 3 which provides:

> *"Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual"* (emphasis added)

29. A doctor's duty to treat patients with respect and dignity enshrined in Rights 1(1) and 3 of the Code mirror medical ethical obligations. For example, the International Code of Medical Ethics[4] stresses the duty of a doctor to practise *"... with compassion and respect for human dignity"*. The same obligation can be found in the 1994 Code of Ethics of the New Zealand Medical Association, in place at the time of this incident [5]. In his book "Medical Practice in New Zealand : A Guide to Doctors Entering Practice"[6] Professor D Cole reminds New Zealand doctors that their "*Patients have the right to be treated with kindness, care and dignity throughout the management of their ill health or other medical management period*".

30. Prior to the Code being promulgated the Office of the Health and Disability Commissioner issued a commentary on the proposed Code.[7] In relation to Right 1 the then Commissioner noted:

> *"Respect for the intrinsic value and uniqueness of each consumer as a person is an essential cornerstone of rights in the Code. Respect gives dignity through recognition of the essence of each individual".*

Duty to Inform and Obtain Informed Consent

31. Particulars 2, 3 and 4 of the amended notice of charge allege Professor Frizelle failed to properly inform Ms Henry of the procedure he was proposing to carry out, the options available, and after the event he failed to explain the consequences of having removed the seton. Particular 2 also alleges Professor Frizelle failed to obtain Ms Henry's informed

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[4] 1949, 1968 and 1983
[5] Refer paragraph 1 – Responsibilities to the Patient
[6] Medical Council of New Zealand 1995 p.10
[7] A proposed Draft Code of Rights for Consumers of Health and Disability Services, July 1995.

consent to the removal of the seton. Particular 3 focuses on Professor Frizelle's failure to offer Ms Henry pain relief in circumstances where he should have done so.

The Code

32. Section 2 of the Health and Disability Commissioner Act 1994 refers to informed consent in the following way:

> *"Informed consent means consent to that [healthcare] procedure where that consent –*
>
> *(a) Is freely given, by the health consumer ... and*
>
> *(b) Is obtained in accordance with such requirements as are prescribed by the Code."*

33. The Code describes in detail the duties of health professionals to inform patients and obtain informed consent to medical procedures where required. The provisions of the Code relevant to the case before the Tribunal are:

- Right 5(2) which provides:

  "Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly and effectively".

- Right 6(1) which provides:

  "Every consumer has the right to information that a reasonable consumer, in that consumer's circumstances, would expect to receive ..."

- Right 6(2) which provides:

  "Before making a choice or giving consent, every consumer has a right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent."

- Right 7(1) which provides:

"Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or common law, or any other provision of this Code provides otherwise".

Medical Ethics

34. Medical Ethical Codes now recognise the rights of patients to be informed and make informed choices about their medical care. For example the 1994 New Zealand Medical Association Code of Ethics recognised:

"… the right of all patients to know … the available treatments together with their likely benefits and risks"[8]

and the duty of doctors to:

"Exchange such information with patients as is necessary for them to make informed choices where alternatives exist" [9]

The current Code of Ethics of the New Zealand Medical Association records:

"Doctors should ensure that patients are involved within the limits of their capacities, in understanding the nature of their problems, the range of possible solutions, as well as the likely benefits, risks, and costs, and shall assist them in making informed choices".[10]

Medical Council Statements

35. The Medical Council of New Zealand has gone to considerable lengths to ensure doctors in this country understand their duty to inform patients and obtain informed consent when required.

36. The first comprehensive statement for the New Zealand medical profession on information for patients and consent was issued in June 1990.[11] That report was issued in response to

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[8] Paragraph 7 1994 NZMA Code of Ethics

[9] Paragraph 11 1994 NZMA Code of Ethics

[10] Paragraph 10 2002 NZMA Code of Ethics

[11] A statement for the Medical Profession on Information and Consent, Medical Council of New Zealand, June 1990.

the *Cartwright Inquiry*.[12] In describing the duty of New Zealand doctors to inform patients, the Medical Council said at page 1 of its 1990 statement:

> *"Information must be conveyed to the patient in such detail and in such manner, using appropriate language, as to ensure that an informed decision can be made by that particular patient. The necessary standard for this requirement (that is the extent, specificity and mode of offering the information) should be that which would reflect the existing knowledge of the actual patient and the practitioner. More generally, it should also reflect what a prudent patient in similar circumstances might expect."*

37. In 1995 the Medical Council published a pamphlet summarising its 1990 guideline on information and consent. In its 1995 pamphlet the Medical Council reiterated the standards expected of New Zealand doctors in relation to informing and obtaining consent set out in paragraph 36 of this decision.

38. The key ingredients of the Medical Council's 1990 and 1995 statements for the medical profession on information and consent can be summarised in the following way:

- Information must be conveyed to the patient in a way which enables the patient to make an informed decision.

- When conveying information to the patient the doctor must have regard to the patient's existing knowledge and understanding of their condition, proposed treatment and the options available.

- The assessment of whether or not a doctor has discharged their responsibility to properly inform a patient is measured from the standpoint of the expectations of a reasonable patient and not from the viewpoint of a reasonable doctor.

39. In both the 1990 and 1995 statements the Medical Council stated:

> *"If it can be shown that a doctor has failed to provide adequate information and thereby failed to ensure that the patient comprehends, so far as is possible,*

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[12] The Report of the Cervical Cancer Inquiry into allegations concerning the treatment of Cervical Cancer at National Women's Hospital and into other related matters, 1988.

the factors required to make decisions about medical procedures, such failure could be considered medical misconduct and could be the subject of disciplinary proceedings."

40. For the sake of completeness the Tribunal records that in April 2002 the Medical Council issued a further statement on "Information and Consent". The updated statement reflects the Code and recent case law. That statement post dates the events under consideration by the Tribunal. Nevertheless, the Tribunal notes that in all respects relevant to its decision the 2002 Medical Council statement is similar to the Medical Council's 1990 and 1995 statements on "Information and Consent".

Common Law

41. The common law also provides some guidance when assessing a doctor's duty to inform a patient and obtain their consent to proposed medical procedures. The authorities referred to below illustrate the main components of the doctrine of informed consent and also demonstrate there are divergent approaches to this topic within common law jurisdictions.

- A convenient starting point is *Canterbury v Spence*[13], a decision of the US Court of Appeals, District of Columbia. The following key points can be extracted from the judgement:

    1. To determine what should be done with his or her body, a patient is entitled to make an informed choice which entails knowing the options and risks attendant upon the proposed treatment.

    2. The scope of the doctor's duty to communicate with the patient is measured by the patient's need for information that is material in enabling the patient to make a decision about consenting to proposed treatment.

    3. A risk is material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk in deciding whether or not to forego the proposed therapy.

- In *Sidaway v Board of Governors of the Bethlem Royal Hospital*[14] the House of Lords rejected the doctrine of "informed consent" as it had developed in North

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[13] (1972) 464 F(2d) 772
[14] [1985] AC 871

American jurisdictions. In that case the House of Lords held that whether or not a particular risk should be explained to a patient depended on whether a reasonable body of the medical profession would have disclosed the information in question.[15]

- In *Rogers v Whittaker*[16] the High Court of Australia endorsed the patient orientated North American approach when it determined a doctor had failed to discharge his professional obligations by failing to disclose to a patient a rare but known risk of surgery. The High Court of Australia held:

  > *"…that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment: a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, warned of the risk, would be likely to attach significance to it."*

  In their judgments the High Court of Australia did not refer to the New Zealand Medical Council 1990 statement on information and consent. Nevertheless, the approach taken by the High Court of Australia was strikingly similar to the standards which the New Zealand Medical Council had enunciated two years earlier.

- The final case the Tribunal refers to is *B v The Medical Council of New Zealand*[17] an unreported but nevertheless important judgment in New Zealand medical law. That case concerned a charge of conduct unbecoming a medical practitioner brought under the Medical Practitioners Act 1968. The case concerned several allegations including a claim that a doctor failed to properly inform his patient about the risks associated with not excising a lump found in the patient's breast. In *B v The Medical Council of New Zealand* the High Court adopted the reasoning of the High Court of Australia in *Rogers v Whittaker*. The High Court of New Zealand stressed the importance of assessing the adequacy of information conveyed by a

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[15] That is to say, the House of Lords applied the test articulated in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 in determining whether or not the doctors had breached the duty of care to inform their patient of risks associated with surgery.

[16] (1992) CLR 175

[17] Unreported, HC Auckland 11/96, 8 July 1996, Elias J.

doctor to a patient from the viewpoint of the patient, rather than the doctor. Poignantly the learned High Court Judge opined:

> *"In my view, the provision of inadequate information in a situation where the patient needs that information for his or her decisions affecting treatment or investigation, will almost always be professional misconduct or conduct unbecoming".*

42. In the Tribunal's view:

- ➢ Rights 5(2), 6(1), 6(2), and 7(1) of the Code; and
- ➢ The ethical obligations set out in paragraph 34 of this decision; and
- ➢ The statements on information and consent issued by the Medical Council; and
- ➢ The judgment of Elias J. (as she then was) in *B v The Medical Council of New Zealand* can be distilled to the following elementary propositions:

- Ms Henry had the right to be properly informed about:
  - ♦ her medical condition, and
  - ♦ any treatment/procedure Professor Frizelle proposed to carry out, and
  - ♦ any options for treatment which were available; and
  - ♦ the consequences of carrying out the proposed treatment/procedure.
- When informing Ms Henry about these matters Professor Frizelle needed to have regard to Ms Henry's circumstances, her existing knowledge and her understanding of the matters referred to above.
- An assessment of whether or not Professor Frizelle discharged his duty to properly inform Ms Henry is to be measured from the standpoint of the expectations of a reasonable patient in Ms Henry's circumstances.

Right to Services of an Appropriate Standard

43. The third particular in the amended notice of charge involves an allegation that Professor Frizelle failed to properly inform Ms Henry of the option of pain relief when he knew or ought to have known she was experiencing significant pain. Another element implicit in particular three is that Professor Frizelle failed to provide services of an appropriate standard by not providing Ms Henry with pain relief.

44. Right 4(3) of the Code records the right of consumers of health services to "have services provided in a manner consistent with his or her needs".

Right 4(4) is also relevant in that it recognises a consumers right to "have services provided in a manner that minimises the potential harm to …that consumer".

45. Having explained Professor Frizelle's professional duties and obligations in this case the Tribunal now deals with the elements required to prove "conduct unbecoming".

Disciplinary Threshold

46. The common perception is that "conduct unbecoming a medical practitioner" is the least serious of a trilogy of disciplinary offences contained in s.109(1)(a) and (c) Medical Practitioners Act 1995. The conventional view is that the most serious charge a doctor can face is "disgraceful conduct in a professional respect" and that "professional misconduct" reflects the "middle category"[18] of disciplinary offences. This leaves "conduct unbecoming a medical practitioner" as the least serious category of the disciplinary offences found in s.109(1)(a), (b) and (c) of the Act. The origins of the view that conduct unbecoming is less serious than professional misconduct can be traced back to comments made in Parliament when the Medical Practitioners Act 1968 was amended in 1979 to provide for the new disciplinary offence of conduct unbecoming a medical practitioner. The then Minister of Health the Hon. E S F Holland said:

[18] To quote Jeffries J in *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369

> *The new clause 15B introduces a charge of conduct unbecoming a medical practitioner, representing a complaint or charge of lesser seriousness than that of professional misconduct.*[19]

47. The view that "conduct unbecoming" is a less serious charge than professional misconduct also has its origins in the fact that when the Medical Practitioners Act 1968 was amended in 1979, Divisional Disciplinary Committees were empowered to hear charges of conduct unbecoming a medical practitioner. The penalties which Divisional Disciplinary Committees could impose were confined to censure and costs. However, under the 1968 Act the Medical Practitioners Disciplinary Committee could also hear charges of conduct unbecoming a medical practitioner as well as charges of professional misconduct. As McGechan J pointed out in *Cullen v The Preliminary Proceedings Committee*[20] when the Medical Practitioners Disciplinary Committee heard a charge of conduct unbecoming a medical practitioner:

> *"The penalties for conduct unbecoming a practitioner and professional misconduct are exactly the same … [and that] Parliament by the terms of the statute it passed envisaged the possibility of cases of 'conduct unbecoming a practitioner' so grave that penalty imposed could equal the most serious available for professional misconduct.*

48. *Cullen v the Preliminary Proceedings Committee* involved a charge brought under the Medical Practitioners Act 1968. However the observations of McGechan J in *Cullen* are equally relevant to the current statutory regime. Section 110 Medical Practitioners Act 1995 confers on the Tribunal exactly the same powers to penalise a doctor found guilty of professional misconduct as one who is found guilty of conduct unbecoming a medical practitioner.

49. It is axiomatic that there must be a distinction between professional misconduct and conduct unbecoming a medical practitioner. If there were no distinction s.109(1)(c) Medical Practitioners Act 1995 would be otiose. There is a distinction between professional misconduct and conduct unbecoming a medical practitioner but as McGechan J also noted in *Cullen*, the difference "becomes a fine one".

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[19] New Zealand Parliamentary Debates Vol 426 p. 3524

[20] Unreported High Court Wellington AP 225/92, 15 August 1994

50. The legislative regime now in place suggests conduct unbecoming a medical practitioner is a disciplinary offence which may in some instances parallel professional misconduct. The language employed to describe the offence of "conduct unbecoming a medical practitioner" suggests that offence may encompass conduct by a doctor which falls outside the scope of a doctor's "professional" conduct. This interpretation is reinforced when account is taken of the way Parliament has now framed the charge of "conduct unbecoming a medical practitioner" to include the requirement the conduct must also reflect adversely on the practitioner's fitness to practise medicine.

51. Parliament has drawn a distinction between professional misconduct and "conduct unbecoming a medical practitioner". That distinction can be maintained by recognising that charges of "conduct unbecoming a medical practitioner" can encompass allegations that extend beyond a doctor's "professional conduct".

52. In *B v Medical Council* Elias J. observed:

> *"There is little authority on what comprises "conduct unbecoming". The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission of [counsel for the appellant] that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional [mis]conduct or conduct unbecoming; <u>Doughty</u> v <u>General Dental Council</u> [1988] 1 AC 164; <u>Pillai</u> v <u>Messiter</u> (No.2) (1989) 16 NSWLR 197; <u>Ongley</u> v <u>Medical Council of New Zealand</u> (1984) 4 NZAR 369. The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standard applied by competent, ethical and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only*

> *practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards".*

53. In *Lake v The Medical Council*[21] Smellie J endorsed the analysis of "conduct unbecoming" undertaken by Elias J in *B v Medical Council*. The essential ingredients which can be distilled from the judgments of the High Court in *B v Medical Council* and *Lake v Medical Council* are:

- The conduct in question must depart from acceptable professional standards.
- The conduct in question must be significant enough to attract sanction for the purposes of protecting the public.[22]
- The question to focus on is not whether an error was made but whether the practitioner's conduct was an acceptable discharge of their professional obligations.
- The threshold for meeting the test of conduct unbecoming is inevitably one of degree.

54. *B v Medical Council* and *Lake v Medical Council* concerned "conduct unbecoming" under the Medical Practitioners Act 1968. Section 109(1)(c) Medical Practitioners Act 1995 clearly shows that in addition to proving "conduct unbecoming", those who bring a charge under this section against a doctor must also establish the acts or omissions "reflect adversely on the practitioner's fitness to practise medicine".

55. The words "reflect adversely on the practitioner's fitness to practise medicine" have been commented upon in two District Court decisions:

- In *Complaints Assessment Committee v Mantell*[23] the Court said:

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[21] Unreported High Court Auckland MC123/96, 23 January 1998

[22] The Tribunal adds that in addition to protecting the public, a disciplinary finding may be made to uphold professional standards and/or punish the doctor.

[23] District Court Auckland, NP 4533/98, 7 May 1999

"The text of the rider in my view makes it clear that all that the prosecution need to establish in a charge of conduct unbecoming is that the conduct reflects adversely on the practitioner's fitness to practise medicine. It does not require the prosecution to establish that the conduct establishes that the practitioner is unfit to practise medicine. The focus of the enquiry is whether the conduct is of such a kind that it puts in issue whether or not the practitioner whose conduct it is, is a fit person to practise medicine... The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree".

- In *W v Complaints Assessment Committee* [24] the Court said:

"It is to be borne in mind that what the Tribunal is to assess is whether the circumstances of the offence "reflect adversely" on fitness to practise. That is a phrase permitting of a scale of seriousness. At one end the reflection may be so adverse as to lead to a view that the practitioner should not practise at all. At the other end a relatively minor indiscretion may call for no more than an expression of disapproval by censure or by an order for costs".

56. The Tribunal notes the penalties set out in s.110 Medical Practitioners Act 1995 do not permit removal of a doctor's name from the register if they are guilty of conduct unbecoming a medical practitioner. Thus, in making an assessment as to whether or not established acts or omissions "reflect adversely" on a doctor's fitness to practise the Tribunal cannot contemplate striking the doctor's name from the register. The conduct in question might at one extreme, be so adverse as to lead to the view that the practitioner be suspended. At the other extreme the acts or omissions may call for nothing more than a censure and/or order for costs.

57. In his helpful submissions Mr Hodson QC said that if Professor Frizelle's acts and omissions amounted to "conduct unbecoming" then his conduct would also "reflect adversely on the practitioner's fitness to practise medicine". The rationale for this submission was expressed in the following way by Mr Hodson:

[24] District Court Wellington, CMA 182/98, 5 May 1999

> *"It seems tolerably clear that if the conduct is so unbecoming ... that guilt must be found then it does reflect adversely on the practitioner's fitness to practise medicine".*

58. It is very tempting to accept Mr Hodson's proposition. However the Tribunal believes that in assessing whether or not a doctor is guilty of conduct unbecoming it is essential to ascertain whether or not the alleged acts/omissions constitute "conduct unbecoming" and then consider whether or not the established "unbecoming conduct" reflects adversely on the practitioner's fitness to practise medicine. Unless this two step approach is taken the Tribunal would not be paying proper regard to Parliament's requirement that conduct "reflect adversely on the practitioner's fitness to practise medicine" before making a finding against that practitioner under s.109(c) of the Medical Practitioners Act 1995.

59. In determining whether or not a doctor is guilty of conduct unbecoming a medical practitioner, and that conduct reflects adversely on the practitioner's fitness to practise medicine, the Tribunal has adopted the two stage analysis referred to in the previous paragraph. The Tribunal has first determined whether the acts or omissions in question amount to conduct unbecoming a medical practitioner and then whether that conduct reflects adversely on the practitioner's fitness to practise medicine.

60. In relation to the first step in the process referred to in paragraph 59 the Tribunal has answered the following questions which are based upon the principles found in the judgments of the High Court in *B v Medical Council of New Zealand* and *Lake v Medical Council of New Zealand*:

- ➢ Do the acts or omissions constitute a departure from acceptable professional standards? If so:

- ➢ Is the departure of sufficient degree to attract a disciplinary sanction for:

  - ♦ The purpose of protecting the public: and/or

  - ♦ Protecting the standards of the medical profession: and/or

  - ♦ Punishing the practitioner

In answering these questions the Tribunal has applied an objective test which reflects the expectations of representatives of the medical profession and the community.

61. The reference to representatives of the community is necessary because those who sit in judgment of doctors today comprise three members of the medical profession, a lay representative and a chairperson who must be a lawyer. The composition of the Tribunal requires the Tribunal to assess a doctor's conduct objectively against the expectations of the profession and society. Sight must not be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession. [25]

62. In addressing the second step in the process referred to in paragraph 59 the Tribunal has assessed whether or not the circumstances of the unbecoming conduct reflect adversely on the practitioner's fitness to practise medicine. In making this assessment the Tribunal has recognised it need not determine whether the practitioner is fit to practise medicine. The test applied by the Tribunal involves an assessment of the degree to which the practitioner has failed to comply with professional standards and the extent to which that departure reflects adversely on the doctor's fitness to practise medicine.

Decision in Relation to Each Particular of the Charge

First Particularised Allegation

63. Professor Frizelle accepts he failed to communicate with Ms Henry in a sensitive and respectful manner. In the summary of facts presented to the Tribunal by both parties it is recorded during the course of the consultation on 4 September 1999 Professor Frizelle:

> *"… told Ms Henry to 'stop screaming', its hurting my ears … control it".*

64. In the same summary it is said Ms Henry thought Professor Frizelle used a

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[25] *B v Medical Practitioners Disciplinary Tribunal; Lake v The Medical Council of New Zealand* in which it was said: "If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in *B* goes beyond usual practice to take into account patient interests and community expectations."

"*rough tone towards her …that [Professor] Frizelle was annoyed and angry with her, and that [she perceived Professor Frizelle] thought she was screaming for nothing".*

Ms Henry was frightened and shaken by the encounter. The summary also records Ms Henry thought Professor Frizelle's manner was "forceful and dominating".

65. In his letter of apology to Ms Henry dated 3 May 2000 Professor Frizelle "… *apologise[d] unreservedly for appearing to be rude and abrupt".* In his brief of evidence Professor Frizelle recorded that he:

"*… accepts the summary of facts [presented to the Tribunal] as an accurate account of what occurred in [his] presence on 4 September 1999".*

66. Professor Frizelle's explanation for failing to communicate in an appropriate and sensitive manner with Ms Henry is that he wanted to move with "haste" to address Ms Henry's situation. The Tribunal accepts Professor Frizelle's motives were genuine but also records the situation which Professor Frizelle encountered was not an emergency. Ms Henry was clearly in considerable pain. The situation required a calm and sensitive appreciation of Ms Henry's circumstances.

67. The crucial issue is whether Professor Frizelle's acknowledged shortcomings constitute conduct unbecoming a medical practitioner and reflect adversely on his fitness to practise.

68. The Tribunal is unanimously of the view that Professor Frizelle's lack of sensitivity and respect for Ms Henry on this occasion do meet the threshold of conduct unbecoming a medical practitioner and that his conduct reflects adversely on his fitness to practise medicine.

69. The Tribunal assesses the events of 4 September 1999 as constituting:

- A departure from the standards expected of a doctor in Professor Frizelle's position; and that

- The breach of standards was sufficiently serious to justify a disciplinary finding against Professor Frizelle in order to ensure appropriate professional medical standards are upheld.

70. In reaching this conclusion the Tribunal accepts that not every breach of professional standards by a practitioner will constitute conduct unbecoming or professional misconduct. In assessing the seriousness of Professor Frizelle's conduct on this occasion the Tribunal believes his attitude and demeanour to Ms Henry was totally unacceptable and justifies a disciplinary sanction.

71. The Tribunal has also assessed Professor Frizelle's behaviour as being sufficiently serious as to reflect adversely on his fitness to practise medicine. The Tribunal bears in mind that when assessing whether or not a practitioner's shortcomings reflect adversely on their fitness to practise the Tribunal must recognise not all departures from accepted standards will automatically reflect adversely on the doctor's fitness to practise. In this instance however, Professor Frizelle's lack of respect and compassion for his patient crossed the threshold of reflecting adversely on his fitness to practise medicine.

Second Particularised Allegation

72. The Tribunal is satisfied to the requisite standard Professor Frizelle elected to remove the seton without providing Ms Henry with an explanation as to:

- What he was proposing to do;
- What options were available; and
- What the likely consequences of his treatment were.

73. The Tribunal is in no doubt that an ordinary patient, in Ms Henry's circumstances would expect to be told that it was the doctor's intention to remove the seton, as opposed to cut or release pressure on the suture holding the seton in place. An ordinary patient would expect to be told the options available and what the consequences were of removing the seton.

74. In addition to failing to inform Ms Henry in accordance with the standard expected of a reasonable patient, Professor Frizelle failed to take account of Ms Henry's personal circumstances and desire to understand what was happening. The fact Ms Henry was unaware the seton had been removed until the following day highlights the inadequacy of Professor Frizelle's explanations to Ms Henry.

75. In assessing Professor Frizelle's failure to properly explain his treatment plan, its consequences, and the options available the Tribunal pays particular regard to the fact Ms Henry was at the time distraught and in very considerable pain.

76. Professor Frizelle accepted he may have been brusque, used a firm tone, and was quick with his explanation. He thought he had made it clear the seton would be removed but he also acknowledged that he did not explain the risks or options available and that following removal of the seton he did not explain what further procedure, management or treatment would be required.

77. The Tribunal is unanimously of the view Professor Frizelle failed to:

- Properly inform Ms Henry of his proposed method of treatment, the consequences of that treatment and the options available; and

- Obtain Ms Henry's consent to the removal of the seton.

78. Professor Frizelle's failures as set out in paragraph 77 of this decision constitute conduct unbecoming a medical practitioner and reflect adversely on his fitness to practise medicine because they were:

- A serious departure from accepted professional standards; and
- Require a disciplinary sanction in order to:
    - Uphold professional standards;
    - Protect the public;
    - Punish the practitioner.

79. The Tribunal is also satisfied Professor Frizelle's conduct passes the threshold of reflecting adversely on his fitness to practise medicine. Failing to properly inform his patient, and obtaining her informed consent in the circumstances of this case was a breach of Professor Frizelle's fundamental professional obligations. Properly informing patients and obtaining their consent in situations where informed consent is required is a basic right of the patient to determine what happens to themselves regardless of the views and wishes of their doctor. In *Rogers v Whittaker* the High Court of Australia reasoned that the Courts and not the medical profession should determine the standard of care in disclosure cases:

> "*After giving weight to 'the paramount consideration a person is entitled to make his own decisions about his life'*" [26]

This right to "self determination" in relation to medical treatment is reflected in s.11 New Zealand Bill of Rights Act 1990.[27]

80. The Tribunal stresses that a doctor's duty to inform and obtain informed consent from a patient when required is as fundamental as the doctor's duty to provide treatment in accordance with appropriate professional standards. The Tribunal finds it necessary to emphasise the importance it places on ensuring patients are properly informed and give consent when required because of an editorial written by Professor Frizelle in the New Zealand Medical Journal[28] six weeks prior to the hearing of the charge against him.

81. In his editorial Professor Frizelle said:

> *"The increasing legalisation of medical practice has led to concerns by medical practitioners about their ability to deal with these unrealistic expectations. One can always add something more to a consultation. Doctors have to be careful to ensure that they are realistic about the information that should be given in regard to a procedure. One can almost always in retrospect add something, or clarify something. With the aid of retrospective analysis, when a patient does have an unexpected complication or problem, one will always wish that the possibility had been discussed. Even if it had, however,*

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[26] Quoting *F v R* (1983) 33 SASR 189 at 193

[27] Right to refuse to undergo medical treatment – everyone has the right to refuse to undergo any medical treatment.

[28] The New Zealand Medical Journal Vol 115 No. 1162

there is increasing evidence to show that there is a good chance that the patient or their family member would not remember it anyway.

…

The aim of the increased legalisation is to protect the patient, and there have undoubtedly been times when it is apparent that it is required. We must be careful, though, not to lose touch with the real world; we are real people and the world we live in is not perfect. The legalisation of what should be a medical act has increased to such an extent that it is almost impossible to fulfil the requirements of informed consent (or it is almost always possible to pick holes in it)."

82. It would be unfortunate if the idea were to gain currency that a doctor should comply with their obligations to obtain informed consent simply to protect the doctor from potential disciplinary action. The doctor should comply with their duty to inform and obtain informed consent because of their respect for the dignity and independence of the patient, not because they feel bound to protect themselves.

Third Particularised Allegation

83. Professor Frizelle knew Ms Henry was in considerable pain. At the time he removed the seton Professor Frizelle did not know his Registrar had called for morphine which he intended to administer intravenously. Dr Connor had also called for nitrous oxide.

84. The circumstances Professor Frizelle faced necessitated he not remove the seton without providing Ms Henry with the option of sedation or strong analgesia.

85. The parties made available to the Tribunal in their agreed summary of facts an opinion from an independent expert, Dr Ian Stewart who is a general surgeon. In Dr Stewart's opinion Professor Frizelle should not have removed the seton in this case without some form of sedation or strong analgesia, for example, intravenous medication. Professor Frizelle accepts the validity of Dr Stewart's opinion. The Tribunal is also firmly of the view Professor Frizelle should not have removed the seton without providing appropriate sedation/analgesia.

86. The Tribunal is unanimously of the view Professor Frizelle's acknowledged shortcomings set out in the third particular of the amended notice of charge constitute conduct unbecoming a medical practitioner. The Tribunal has reached the conclusion that:

- Dr Frizelle's conduct as set out in the third particular of amended notice of charge constituted a significant breach of professional standards; and

- Requires a disciplinary sanction for the purposes of upholding professional standards and protecting the public.

87. The Tribunal also believes Professor Frizelle's failure to offer Ms Henry pain relief in the circumstances of this case crossed the threshold of reflecting adversely on his fitness to practise medicine. The Tribunal has reached this view because of the seriousness of Professor Frizelle's omissions in this instance.

Fourth Particularised Allegation

88. The fourth particularised allegation focuses on Professor Frizelle's failure to explain to Ms Henry what he had done after he had removed the seton and the consequences which would follow from his removal of the seton.

89. Professor Frizelle accepted that he did not explain matters in "much detail" after he had removed the seton. The Tribunal was left in no doubt Professor Frizelle failed to communicate to Ms Henry he had removed the seton and the consequences of his having removed the seton.

90. The Tribunal is unanimously of the view that Professor Frizelle's conduct as alleged in the fourth particular of the amended notice of charge constitutes conduct unbecoming a medical practitioner. The Tribunal is of the view that:

- Professor Frizelle's conduct as set out in the fourth particular of the amended notice of charge constitutes a significant breach of professional standards; and

- Requires a disciplinary sanction for the purposes of upholding professional standards and protecting the public.

91. The Tribunal also believes Professor Frizelle's failure to properly inform Ms Henry of the fact he had removed the seton and the consequences of removing the seton crossed the threshold of reflecting adversely on his fitness to practise medicine. The Tribunal has reached this conclusion because of the seriousness of Professor Frizelle's failure to inform Ms Henry that he had removed the seton or the consequences which would follow from removing the seton.

Summary of Findings

92. The Tribunal concludes Professor Frizelle's acts and omissions as set out in all four particularised allegations of the amended notice of charge individually and cumulatively amount to conduct unbecoming a medical practitioner and reflect adversely on his fitness to practise medicine. For the sake of clarity the Tribunal emphasises that it is making an omnibus finding that Professor Frizelle is guilty of conduct unbecoming a medical practitioner and that the conduct reflects adversely on his fitness to practise medicine.

Penalty

93. The Director of Proceedings has not sought any orders under s.110(1)(b) or (c) of the Medical Practitioners Act 1995. Similarly the Tribunal does not believe that the acts and omissions detailed in this decision justify suspension or the placing of any conditions on Professor Frizelle's ability to practise medicine.

Censure

94. It is normal for the Tribunal to censure a doctor found guilty of conduct unbecoming a medical practitioner. The Tribunal sees no reason for departing from the usual consequences of an adverse finding of this nature against a doctor. The Tribunal therefore orders Professor Frizelle be censured.

Fine

95. A doctor found guilty of conduct unbecoming in circumstances where they have failed to honour their duty to properly inform a patient about medical procedures and obtain informed consent could expect the Tribunal to impose a substantial fine. The maximum fine that can be imposed is $20,000. The Tribunal records that under normal circumstances Professor Frizelle could expect a fine in the vicinity of $7,000 to $10,000 in relation to the findings made against him.

96. In this instance the Tribunal proposes to discount the fine it would normally impose because of its concern that the events in question occurred more than three years ago, because Professor Frizelle has on two occasions proffered a full apology to the complainant and because of Professor Frizelle's co-operative approach of the hearing of the charge against him.

97. The Tribunal is very concerned that the matters complained of occurred on 4 September 1999. A chronology setting out the steps taken when investigating Ms Henry's complaint was made available to the Tribunal. Ms Henry's complaint was sent to the Health & Disability Commissioner on 6 September 1999. Contemporaneously, Ms Henry lodged a complaint with Canterbury Health Limited. Canterbury Health Limited's inquiries were concluded in May 2000. The Health & Disability Commissioner's final opinion was sent to the parties on 19 April 2002. The file was also referred to the Director of Proceedings on 19 April 2002. It is clear the majority of the delays occurred during the Health & Disability Commissioner's investigation of the allegations made by Ms Henry. The delay in having this matter brought before the Tribunal was in itself a punishment for Professor Frizelle. The Tribunal proposes to reflect its concern about delay by reducing the fine it would normally impose to $4,000.

Costs

98. The costs incurred in relation to this case comprise:

- The costs of the Health and Disability Commissioner in relation to the subject matter of the charge; $9,376.82

- The prosecution of the charge by the Director of Proceedings; $4,000.00
- The hearing by the Tribunal. $15,359.94

TOTAL **$28,736.76**

99. It is usual in cases of this kind for the practitioner to be ordered to pay between 30% to 40% of the total costs incurred.

100. The Tribunal sees no reason to depart from the usual awards of costs made in cases of this kind and directs Professor Frizelle pay 33% of the costs identified in paragraph 98. That is to say Professor Frizelle is to pay $9,483.13 by way of costs.

Publication

101. The hearing was held in public and no request has been made to prohibit publication of this decision. The Tribunal also orders publication of its orders in the New Zealand Medical Journal pursuant to s.138 of the Medical Practitioners Act 1995.

Summary

102. The Tribunal finds Professor Frizelle's acts and omissions constitute conduct unbecoming a medical practitioner and reflect adversely on his fitness to practise medicine. He is:

(a) Censured;

(b) Fined $4,000;

(c) Ordered to pay costs of $9,483.13;

(d) The Tribunal orders publication of the above orders in the New Zealand Medical Journal pursuant to s.138 of the Act.

DATED at Wellington this 3rd day of December 2002

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal