MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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NB: PUBLICATION OF THE NAME OF THE DOCTOR AND ANY DETAILS WHICH MAY IDENTIFY THE DOCTOR AS A FORMER XX PRACTITIONER IS PROHIBITED

DECISION NO.: 225/02/97C

IN THE MATTER of the MEDICAL PRACTITIONERS ACT 1995

AND

IN THE MATTER of a charge laid by a Complaints Assessment Committee against **D** medical practitioner of xx .

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

HEARING The parties agreed that the Tribunal consider the application and determine it on the basis of the parties' written evidence and submissions

PRESENT: Dr D B Collins QC - Chair

Mrs J Courtney, Dr B D King, Dr U Manukulasuriya, Dr J L Virtue (members)

COUNSEL: Ms K P McDonald QC for Complaints Assessment Committee

Mr A H Waalkens for respondent

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Introduction

1. This is one of three interlocutory decisions of the Tribunal in this case. The issues dealt with in this decision can most conveniently be framed as questions:

   1.1 Is the Complaints Assessment Committee (CAC) able to amend the charge from conduct unbecoming a medical practitioner[1] to disgraceful conduct[2] before the case is opened and evidence is heard by the Tribunal?

   1.2 If yes, should the CAC be permitted to amend the charge in this instance?

The Charge

2. The CAC has charged Dr D with conduct unbecoming a medical practitioner. The particulars of the charge state:

   "The Complaints Assessment Committee pursuant to s.93(1)(b) of the Act charges that Dr D, registered medical practitioner of xx over the period 22

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[1] The full description of the charge is "conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine" (refer s.109(1)(c) Medical Practitioners Act 1995 ("the Act")

[2] The full description of a charge laid under s.109(1)(a) of the Act is "disgraceful conduct in a professional respect".

February 1995 and 28 March 1995 in the course of his management and treatment of his patient …:

1. *Asked questions and made comments of an inappropriate and sexual nature; and*
2. *Performed five internal vaginal examinations in the course of six consultations which was (sic) inappropriate and not medically justified; and*
3. *Performed one or more of the internal vaginal examinations in an inappropriate sexual manner; and*
4. *First discussed and then suggested to his patient that he should use on her a 'perineometer' which he had made himself which was inappropriate and for which there was no medical justification; and*
5. *When confronted by his patient on or about 28 March 1995 destroyed or sought to destroy her medical notes; …"*

Events leading to the CAC's application

3. The Tribunal initially set aside 7 and 8 April 2003 to hear the charge. However counsel for the CAC (Ms McDonald QC) has indicated she may not now be available on those dates. To avoid any further difficulties over hearing dates the Tribunal has now set the case down for hearing on 14 and 15 April 2003.

4. On 5 February 2003 counsel for the CAC filed and served a proposed new notice of charge. The proposed new notice of charge alleges Dr D's conduct constitutes disgraceful conduct in a professional respect.

5. An issue arose as to the procedure to be followed in relation to the laying of the proposed new notice of charge. Counsel for Dr D (Mr Waalkens) sought an order from the Tribunal requiring the CAC to apply to the Tribunal to amend the charge. Mr Waalkens also sought an order affording Dr D an opportunity to oppose any application which the CAC may make to amend the charge. In a decision delivered on 10 February the Tribunal ordered:

> *"The CAC file with the Tribunal and serve upon Dr D's counsel an application to amend the charge. That application, and any supporting submissions which the CAC may wish to make shall be filed and served by 20 February 2003;*

Any notice of opposition and submissions in opposition should be filed and served by 27 February 2003.

The Tribunal proposes to deal with the application on the papers. If any party wishes the application to be dealt with by way of oral hearing they are required to give notice of this request, supported by written reasons within 48 hours of the release of these directions".

6. The CAC filed its application to amend the charge on 20 February. Dr D's notice of opposition was received on 24 February 2003. Both counsel filed helpful submissions. Neither party has given notice that they wish to be heard orally. Accordingly, the Tribunal proposes to deal with the application by relying on the written materials it has received.

7. In his submissions Mr Waalkens set out a chronology of the events that have occurred to date in this case. The contents of that chronology have not been challenged. The Tribunal proposes to adopt Mr Waalkens' chronology (with minor modification and additions):

(a)	22.02.95 – 28.03.95	Consultations between Dr D and complainant.
(b)	22.6.00	Complainant writes a letter of complaint to Medical Council of New Zealand (received by Medical Council on 30.6.00).
(c)	31.01.01	Medical Council forwards complaint to Dr D.
(d)	03.12.01	Complaints Assessment Committee writes to Dr D.
(e)	07.12.01	Dr D responds to Complaints Assessment Committee.
(f)	20.12.01	Complaints Assessment Committee advises Dr D that it had conducted its first meeting and appointed a legal assessor.
(g)	18.01.02	Dr D sends transcript of Medical Records to CAC.
(h)	20.02.02	Dr D sends to CAC a detailed response to the allegations.
(i)	22.02.02	CAC meets with complainant.
(j)	12.03.03	Legal assessor for CAC writes to Dr D's counsel seeking further information from Dr D.
(k)	12[04].02	Dr D replies to CAC.
(l)	30.04.02	CAC writes again to Dr D explaining the inquiries it proposed to make.

(m)	28.05.02	CAC convenes in xx.
(n)	19.11.02	CAC notifies the Tribunal of the charge.
(o)	20.11.02	CAC advises Dr D of its decision to bring a charge of conduct unbecoming a medical practitioner.
(p)	25.11.02	Tribunal issues the charge.
(q)	11.12.02	Dr D applies for name suppression.
(r)	16.12.02	Dr D swears affidavit in support of his name suppression application.
(s)	16.12.02	Dr D seeks disclosure of relevant documents from CAC, and particulars of the charge.
(t)	19.12.02	Dr D files application challenging Tribunal's jurisdiction to hear charge.
(u)	27.01.03	CAC files notice of opposition to application challenging Tribunal's jurisdiction to hear charge.
(v)	28.01.03	Directions conference. At this conference the CAC indicates it may wish to amend the charge to disgraceful conduct. Also at this conference further information was sought from Mr Waalkens concerning Dr D's name suppression application.
(w)	30.01.03	Mr Waalkens responds to Tribunal's questions concerning name suppression application.
(x)	04.02.03	Dr D withdraws his application challenging the Tribunal's jurisdiction to hear the charge.
(y)	05.02.03	CAC lodges proposed amended charge.
(z)	09.02.03	Tribunal convenes to consider name suppression application.

(aa)	12.02.03	Tribunal issues minute seeking further information from Dr D concerning name suppression application.
(bb)	10.02.03	Tribunal issues its decision concerning procedure to be followed concerning amendment of charge.
(cc)	20.02.03	CAC files its application to amend charge (with supporting submissions).
(dd)	24.02.03	Dr D files his notice in opposition to application to amend charge (with supporting submissions).
(ee)	24.02.03	Dr D files memorandum in support of his name suppression application.
(ff)	26.02.03	Tribunal receives further information from Dr D concerning name suppression application.
(gg)	04.03.03	Tribunal convenes to consider CAC's application to amend charge and Dr D's name suppression application.

8. The chronology illustrates that there have been extraordinary delays involved with this case. The Tribunal is in no position to apportion blame for the delays. Suffice to say the Tribunal is extremely concerned that this case must be heard and determined promptly. It is not fair or reasonable to subject the complainant and Dr D (and his family) to the stress and strains generated by the delay in resolving this matter. Dr D is xx years old. It is very unfortunate that almost three years have now elapsed since the complaint was laid with the Medical Council. This case should have been able to be heard and determined by the Tribunal during the course of 2001.

9. The Tribunal is concerned that misunderstandings may have arisen in some quarters about the scope of a charge of "conduct unbecoming a medical practitioner". The Tribunal wishes to explain the circumstances when a charge of "conduct unbecoming a medical practitioner" should be brought. As part of this exercise the Tribunal will also briefly traverse the scope and purpose of the other categories of disciplinary charges set out in s.109 (1)(a) and (b) of the Act.

"Conduct unbecoming a medical practitioner" – s.109(1)(c) Medical Practitioners Act 1995.

10. There is a common perception that "conduct unbecoming a medical practitioner" is the least serious of the trilogy of disciplinary offences contained in s.109(1)(a) (b) and (c) of the Act. That perception can be traced to the disciplinary regime in force under the Medical Practitioners Act 1968.

There is no doubt "disgraceful conduct in a professional respect" was the most serious charge a doctor could face under the 1968 Act. The status of a charge of "disgraceful conduct in a professional respect" has not changed under the current Act. "Disgraceful conduct in a professional respect" is still the most serious disciplinary offence a New Zealand doctor can face. This point is re-emphasised in paragraphs 21 to 24 of this decision.

It was once thought that "professional misconduct" (now found in s.109(1)(b) of the Act) was the "middle category"[3] of disciplinary offences. If "disgraceful conduct in a professional respect" was the most serious disciplinary offence, and "professional misconduct" the middle category of disciplinary offence then, it was reasoned, "conduct unbecoming a medical practitioner" must be the least serious category of disciplinary offences found in the equivalent of what is now s.109(1)(a) (b) and (c) of the Act. The origins of the view that "conduct unbecoming" was 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:

> *"The new clause 15B introduces a new charge of conduct unbecoming a medical practitioner, representing a complaint or charge of lesser seriousness than that of professional misconduct".*[4]

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

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

11. The view that "conduct unbecoming" was 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 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*[5] 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 [were] 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 the penalty imposed could equal the most serious available for professional misconduct".*

12. *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 highly relevant to the current statutory regime. Section 110 of the Act 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".

13. The legislative regime now in place portrays "conduct unbecoming a medical practitioner" as a disciplinary offence which parallels "professional misconduct". The language employed to describe the offence of "conduct unbecoming a medical practitioner" suggests that offence encompasses 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

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

medicine"[6].

14. 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". The distinction which does exist between "conduct unbecoming" and "professional misconduct" can be maintained by ensuring charges of "conduct unbecoming a medical practitioner" focus on allegations that extend beyond a doctor's "professional conduct".

15. It will be apparent from the contents of paragraphs 10 to 14 of this decision that if a disciplinary charge involves allegations about the way and doctor has conducted himself/herself in their professional capacity then it would not normally be appropriate to charge the doctor with "conduct unbecoming a medical practitioner".

Professional misconduct – s.109(b) Medical Practitioners Act 1995

16. The charge "professional misconduct" has been part of New Zealand's medical disciplinary regime since 1949.[7] It is not necessary to traverse in detail the test which has evolved for determining whether or not conduct constitutes "professional misconduct". Suffice to say, that since Jeffries J delivered his seminal judgment in *Ongley v Medical Council of New*

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[6] 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* (District Court Auckland, NP 4533/98, 7 May 1999) the Court said: *"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* (District Court Wellington, CMA 182/98, 5 May 1999) 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 practice. 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 practice 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".*

[7] Medical Practitioners Amendment Act 1949

Zealand[8] the test as to what constitutes "professional misconduct" has evolved so that today there are two limbs to the test.

17. The first portion of the test of "professional misconduct" involves answering the following question:

> *"Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?"*

The second portion of the test requires an answer to the following question:

> *"If the established conduct falls below the standard expected of the doctor, is the departure significant enough to attract disciplinary sanction for the purpose of protecting the public?"*

18. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the communities' expectations may require the Tribunal to be critical of the usual standards of the profession.[9]

19. This second limb to the test recognises the observations in *Pillai v Messiter,*[10] *B v Medical Council, Staite v Psychologists Board*[11] and *Tan v ARIC*[12] that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

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8 (1984) 4 NZAR 369 at 375.

9 *B v Medical Practitioners Disciplinary Tribunal*; Unreported, HC Auckland 11/96, 8 July 1996, Elias J; *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) 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".

10 (1989) 16 NSWLR 197

20. For present purposes it is necessary to emphasise that a charge of "professional misconduct" should focus upon allegations that relate to the way a medical practitioner has discharged or failed to discharge their professional responsibilities. In most, but not all cases[13] a charge of "professional misconduct" will arise from a doctor/patient relationship. Allegations which do not relate to the way a doctor has discharged, or failed to discharge their professional responsibilities are more appropriately dealt with as a charge of "conduct unbecoming a medical practitioner".

Disgraceful conduct in a professional respect – s.109(1)(a) Medical Practitioners Act 1995

21. The term "disgraceful conduct in a professional respect" was first used in s.55 Medical Practitioners Act 1968. Prior to then the most serious disciplinary offences which could be brought against a doctor in New Zealand were charges of "grave impropriety or infamous conduct in a professional respect"[14] The change in phraseology aimed to explain the nature of the charge by using modern terminology.

22. It is sufficient for present purposes to emphasise that a charge of "disgraceful conduct in a professional respect" is reserved for the most serious instances of professional disciplinary offending. Doctors found guilty of disgraceful conduct in a professional respect are at risk of having their name removed from the register of medical practitioners. This penalty is the gravest which can be inflicted on a doctor in New Zealand under this country's disciplinary regime. It is a penalty that cannot be imposed on those found guilty of "professional misconduct" or "conduct unbecoming a medical practitioner"[15]

23. In *Duncan v Medical Practitioners Disciplinary Committee*[16] the Court of Appeal said:

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11 (1998) 18 FRNZ 18
12 (1999) NZAR 369
13 See for example, *Tan v ACC*
14 Medical Practitioners Act 1950, s.44; Medical Practitioners Amendment Act 1924,s.6; Medical Practitioners Act 1914, s.22.
15 Section 110(2) Medical Practitioners Act 1995.
16 [1986] 1 NZLR 513

> *"A charge of disgraceful conduct in a professional respect has been described by the Privy Council as alleging conduct deserving of the most serious reprobation"*[17]

This observation succinctly conveys the seriousness of a charge of disgraceful conduct in a professional respect.

24. As with charges of "professional misconduct" charges of "disgraceful conduct in a professional respect" will normally involve an allegation that focuses on the way a doctor has discharged, or failed or discharge their professional responsibilities. The distinction between "professional misconduct" and "disgraceful conduct in a professional respect" is one of degree. The Tribunal would normally expect that extremely serious allegations relating to the way a doctor has discharged or failed to discharge their professional responsibilities would be brought before the Tribunal as a charge of "disgraceful conduct in a professional respect".

Grounds for the CAC's application

25. The grounds advanced by the CAC in Ms McDonald's memorandum can be summarised in the following way:

    25.1 The CAC advises the complainant will testify that on a number of occasions in February and March 1995 Dr D:

    - initiated inappropriate conversations of a sexual nature;
    - performed internal examinations without any clinical justification, and that these had obvious sexual overtones;
    - destroyed part of the complainant's file after she remonstrated with him.

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[17] Citing *Felix v General Dental Council* [1960] AC 704; *McEniff v General Dental Council* [1980] 1 All ER 461.

25.2 The CAC has now revisited its initial decision to characterise Dr D's behaviour as conduct unbecoming a medical practitioner. (That re-assessment has been undertaken since Ms McDonald was instructed to prosecute the charge for the CAC).

25.3 Following its re-assessment the CAC appreciated that it had erred when it classified the charge as one of conduct unbecoming a medical practitioner.

25.4 In *Brake v PPC*[18] a full bench of the High Court observed that where it is established a doctor has engaged in sexual misconduct with a patient the doctor will usually face a charge of disgraceful conduct.

25.5 It is in the public interest that the charge be amended. Two reasons are advanced for this submission:

- The integrity of the disciplinary process requires Dr D be held accountable for the full extent of his wrongdoing;
- That if appropriate, Dr D be prevented from returning to practice.

25.6 The interests of the complainant are said to be a factor which justifies the amendment. The complainant's interests appear to relate to a submission that from the complainant's perspective Dr D engaged in a fundamental breach of trust.

Dr D's grounds of opposition

26. Mr Waalkens submissions contain two general grounds of opposition to the application. First, Mr Waalkens submits there is no jurisdiction to amend the charge at this juncture. Second, Mr Waalkens argues that if there is jurisdiction to amend the charge, the grounds advanced by the CAC do not justify the amendment which is sought.

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[18] [1997] 1 NZLR 71 at 79

Jurisdiction

27. Mr Waalkens advances the following reasons for submitting there is no jurisdiction to amend the charge at this juncture.

27.1 The CAC is a statutory body created by s.88 of the Act;

27.2 The powers of the CAC are, for present purposes set out in s.92(1)(d) of the Act. That subsection enables the CAC to determine whether a complaint should be considered by the Tribunal.

27.3 If a CAC decides a complaint should be determined by the Tribunal the CAC is required by s.93(1)(b)(i) of the Act to take the following steps:

> *"(i) Frame an appropriate charge and lay it before the Tribunal by submitting it in writing to the chairperson of the Tribunal"*

27.4 Once "the charge" is laid with the Tribunal pursuant to s.102 of the Act the chairperson of the Tribunal is required:

> *"…as soon as reasonably practicable after the laying of the charge, [to] convene a hearing of the Tribunal to consider "the charge".*[19]

The chairperson is also required to cause a notice to be sent to the practitioner "specifying the particulars of the charge"[20]

27.5 Mr Waalkens submissions on this topic are summarised in the following way:

> *"… the CAC, having made its determination and having framed the appropriate charge, and that process having culminated in the chairperson issuing the charge with the requisite notice to the doctor – the CAC has no ability to amend the charge.*

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19 s.102(2) of the Act.

20 Section 103(1)(c) of the Act

... Any amendment can only be made by the Tribunal".

27.6 Mr Waalkens advances his client's case by emphasizing that clause 14(1) of the first schedule to the Act authorises the Tribunal to amend a charge *"... at any time during the hearing of any charge ...".* Mr Waalkens emphasises the Tribunal's power to amend the charge is discretionary and the Tribunal's power can only be exercised "*during the hearing*".

27.7 Mr Waalkens summarises this aspect of his submissions by saying:

> *"...the 'hearing' of the charge has not started. The date for the hearing of the charge was provisionally set at the 28th January 2003 directions conference to be the 7th and 8th April. That is when the 'hearing' of the charge would take place."*

<u>Grounds for amendment</u>

28. Mr Waalkens further submits that if there is jurisdiction for the charge to be amended at this juncture then the reasons advanced by the CAC for amending the charge are inadequate. This aspect of Mr Waalkens' submissions are summarised in the following way:

28.1 Nothing has changed since the CAC determined the charge should be framed as an allegation that Dr D's conduct amounted to "conduct unbecoming a medical practitioner".

28.2 Mr Waalkens rejects the CAC's submission that "*its initial decision was reached without a complete understanding of the significance of the allegations and accordingly level of charge that this kind of offending attracts ....*"

Mr Waalkens underscores his submissions by pointing out:

- The CAC is a body with considerable experience of investigating allegations, including allegations of sexual impropriety by doctors;

- The CAC had the benefit of an experienced legal assessor.

Tribunal's decision as to jurisdiction to amend the charge

29. It is common ground that if the interlocutory phase of this case falls within the ambit of the phrase "*any time during the hearing of the charge …*"[21] then the Tribunal would have jurisdiction to amend the charge.

30. In this decision the Tribunal is able to determine the CAC's application without recourse to the powers conferred on the Tribunal by clause 14 of the first schedule to the Act. Thus, as with its interlocutory decision of 10 February, the Tribunal addresses the CAC's application without needing to decide if there has been a commencement of the hearing of the charge against Dr D.

31. The Tribunal is of the view that a fundamental error has occurred in this case. In electing to charge Dr D with "conduct unbecoming a medical practitioner" the CAC failed to "frame an appropriate charge" as it was required to do by s.93(1)(b) of the Act.

32. The reasons why the charge of "conduct unbecoming" is inappropriate are:

32.1 The allegations relate to the way Dr D discharged his professional responsibilities to the complainant and focus on his alleged abuse of the doctor patient relationship. The parties accept the allegations relate to the way Dr D conducted clinical consultations with the complainant and responded to her remonstrations about the way he had behaved. The allegations do not fall within the scope of "conduct unbecoming a medical practitioner".

32.2 Allegations of sexual misconduct by a doctor towards a patient are amongst the most serious complaints that can be leveled against a doctor. A full bench of the High Court of New Zealand stated in *Brake v PPC*[22]

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[21] Clause 14(1) first schedule of the Act

[22] [1997] 1 NZLR 71, 79

"*In June 1994 … the [Medical] 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 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 guilty of disgraceful conduct, with the consequence that the doctor's name has been removed from the register or the doctor has been suspended from practice."

33. It is however not sufficient for the Tribunal to simply conclude the initial charge was inappropriate. The Tribunal must also be satisfied it has jurisdiction to permit the CAC to amend the charge at this juncture.

Jurisdiction to amend the charge

34. The Tribunal does have the power to "*regulate its procedure in such manner as it thinks fit*"[23]. The significant qualification to this broad power is the Tribunal's common law and statutory obligation to observe the rules of natural justice.[24]

35. The Tribunal believes its broad powers to regulate its own procedures encompasses the jurisdiction to authorise the CAC to amend a charge during the interlocutory phase of a case where the following criteria are satisfied:

    35.1 The Tribunal is satisfied a fundamental error has occurred in the framing of the charge by the CAC (i.e. the charge is not an "appropriate charge" as required by s. 93(1)(b)(i) of the Act);

    35.2 The principles of natural justice have been adhered to when considering the application to amend the charge.

    35.3 The interests of the public and complainant outweigh the natural and obvious concerns of the doctor if the charge is amended;

    35.4 The doctor is not prejudiced in the conduct of his defence if the charge is amended.

Should the Charge be amended?

36. The criteria identified in paragraphs 35.1 and 35.2 have already been considered and answered in favour of the CAC's application. It is necessary to say a little more about the criteria referred to in paragraphs 35.3 and 35.4.

37. The Tribunal is satisfied the interests of the public and complainant significantly outweigh the natural and obvious concerns Dr D will have if the charge is amended along the lines proposed by the CAC. The allegations are very serious. It is in the public interest that the hearing of the evidence proceed on the basis that the charge appropriately reflects the gravity of the allegations. The Tribunal acknowledges that it could amend the charge during

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23 Clause 5(1)(a)first schedule of the Act

the "hearing of the charge". According to Mr Waalkens' analysis this could conceivably occur as soon as counsel for the CAC opens the CAC case. However, rather than defer deciding whether or not the Tribunal should exercise its powers under clause 14(1) of the first schedule of the Act, the Tribunal believes that the objectives of the disciplinary process are best served if the nature of the charge is settled upon as soon as it is reasonably practicable. In making these observations the Tribunal stresses two points:

37.1 It has not given any indication what decision it might have made if it were required to exercise its jurisdiction to amend the charge during "the hearing of the charge";

37.2 If the allegations are established, but not at the level of "disgraceful conduct" the Tribunal has the option of substituting the charge of "disgraceful conduct" with "professional misconduct".

38. Mr Waalkens has not suggested Dr D will be prejudiced in the conduct of his defence if the charge is amended at this juncture. This should not be construed as a criticism of Mr Waalkens. It is difficult to conceive of any basis upon which Dr D could be prejudiced in the conduct of his defence. The Tribunal instantly acknowledges Dr D will of course be concerned and distressed if the charge is amended along the lines proposed by the CAC. However Dr D's natural anxieties do not constitute prejudice to the conduct of his defence.

39. Before summarizing its conclusions it is necessary for the Tribunal to address aspects of Mr Waalkens submissions that have not previously been referred to in this decision.

39.1 The Tribunal accepts Mr Waalkens submissions that the CAC's decision to seek to amend this charge is not based on any new factual information. To that extent Mr Waalkens is correct when he says "*nothing has changed*" between the laying of the initial charge and the application to amend. However, as the Tribunal has emphasised, it is satisfied that the CAC laboured under a fundamental

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[24] Clause 5(3) first schedule of the Act

misunderstanding of the scope of the nature of charges of "conduct unbecoming a medical practitioner" when it laid the initial charge in this case.

39.2 The Tribunal also accepts the CAC appointed an experienced legal assessor. However, the Tribunal has no information about what advice, if any, the legal assessor gave the CAC on the appropriateness of the initial charge, or whether in fact the CAC accepted his advice.

Conclusions

40. The Tribunal is satisfied that it has the jurisdiction to authorise the CAC to amend the charge from conduct unbecoming a medical practitioner to disgraceful conduct at this juncture.

41. The Tribunal is also satisfied that the charge should be amended in the way proposed by the CAC for the following reasons:

41.1 The allegations do not fall within the scope and purpose of a charge of "conduct unbecoming a medical practitioner";

41.2 The allegations are very serious and fall within the category of complaints that the Tribunal would normally expect to see prosecuted as charges of "disgraceful conduct";

41.3 The CAC made a fundamental error when it framed the charges "conduct unbecoming a medical practitioner";

41.4 The interests of the public and complainant in permitting the CAC to amend the charge outweigh the natural concerns of Dr D;

41.5 Dr D is not prejudiced in the conduct of his defence if the charge is amended.

42. The CAC is permitted to amend the charge and substitute the claim Dr D's conduct constituted "conduct unbecoming a medical practitioner" with an allegation that his conduct amounted to "disgraceful conduct in a professional respect".

DATED at Wellington this 7th day March 2003

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D B Collins QC
Chair
Medical Practitioners Disciplinary Tribunal