Medical Practitioners Disciplinary Tribunal

PO Box 5249 Wellington Telephone (04) 499-2044 Facsimile (04) 499-2045
All Correspondence should be addressed to The Secretary

DECISION NO: 85/99/42D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **COLIN FREDERICK WAKEFIELD** medical practitioner of Havelock North

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Mr P Budden, Dr R S J Gellatly, Dr J M McKenzie,

Dr D C Williams (Members)

Ms K G Davenport (Legal Assessor)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Napier on Wednesday 30 June 1999 and hearing by teleconference on Friday 16 July 1999

APPEARANCES: Ms T W Davis, Director of Proceedings

Mr C J Hodson QC for Dr C F Wakefield.

1.1 THE CHARGE:

TAKE NOTICE that pursuant to Sections 102 and 104 of the Medical Practitioners Act 1995, the Director of Proceedings charges that on or about 4 March 1997 whilst treating your patient, Mrs A, you being a registered medical practitioner, acted in such a way that amounted to professional misconduct in that you provided services of an inadequate professional standard.

IN PARTICULAR YOU:

1) Failed to properly inform your said patient that you intended to undertake a full medical examination including a breast screening examination.

AND/OR

2) Failed to obtain your said patient's informed consent for a full medical examination including a breast screening examination.

AND/OR

3) Lifted your said patient's underpants and looked at and/or touched her groin and/or her pubic area.

AND/OR

4) Undertook a clinically inadequate breast screening examination of your said patient.

AND/OR

5) Failed to record in your said patient's clinical records that a breast screening examination was undertaken and the findings of the examination.

1.2 **DURING** the course of the hearing the Director of Proceedings withdrew the third particular of the charge.

1.3 **IN** Interim Decision No. 83/99/42D which issued on 22 July 1999 it was explained the majority determination of the Tribunal was that the charge against Dr Wakefield be dismissed in its entirety. Full reasons for that determination follow in this Decision together with the Chair's dissenting minority Decision which would uphold the charge at a level of conduct unbecoming which reflects adversely on fitness to practise medicine.

2. BACKGROUND:

2.1 **SOME** time in 1995 Mrs A injured her shoulder. She had been seeing Dr B for the shoulder injury and had been referred to an acupuncturist. Dr B left his practice and Mrs A chose to go to Dr Wakefield, apparently because his wife was an acquaintance of hers.

2.2 **ON** 4 March 1997 Mrs A saw Dr Wakefield for the first time. The reason for the consultation was for Mrs A to have her shoulder injury assessed for the purpose of her on-going ACC claim.

2.3 **DURING** the consultation, after examining Mrs A' shoulder, Dr Wakefield conducted a general examination which included a breast screening examination.

2.4 **IT** was during this consultation that the omissions or events which are detailed in the particulars of the charge faced by Dr Wakefield are claimed to have occurred.

2.5 **THE** burden of proof is on the Director of Proceedings to establish that Dr Wakefield is guilty of the charge and to produce the evidence that proves the facts upon which the charge is based. Whilst it is well established in professional disciplinary cases that the civil rather than the criminal standard of proof is required the Tribunal has been reminded on many occasions by the legal assessor that the standard required never the less is a high one in keeping with the seriousness of such a charge as professional misconduct which is the charge facing Dr Wakefield. Even the lesser charge of conduct unbecoming a medical practitioner must be regarded by the Tribunal as a serious charge. A charge at either level if proved has a profound effect upon a doctor's life in general and practice in particular.

2.6 **THE** Tribunal will now proceed to a separate consideration of each particular of the charge, although because the thrust of particulars 1 and 2 of the charge are similar, they will be considered together.

3. PARTICULARS 1 AND 2:

3.1 **CONVENIENTLY** these two particulars can be summarised to read, that Dr Wakefield failed to properly inform his patient and obtain her informed consent that he intended to undertake a full medical examination including a breast screening examination.

3.2 **IT** was the evidence of Mrs A, after explaining to Dr Wakefield why she was there, that he asked her to take her top off and while he was standing he asked her to move her arms in

different positions. Mrs A said she was used to this because the acupuncturist and physiotherapist got her to do that too.

3.3 **AFTER** physically examining her shoulder Dr Wakefield then went on to do a full general medical examination. This included measurements of her height and weight and blood pressure. Her heart rate was measured and her throat, abdomen and breasts were examined. At the same time Dr Wakefield also went into her family history and her personal and social history.

3.4 **IN** evidence Dr Wakefield advised the Tribunal that all of these were standard normal medical examinations undertaken because Mrs A was a new patient to his practice and he understood that she had switched from another practitioner to him. The evidence for that was that he was holding the records which had been transferred to him from the other practice and into which he made his notes of that day's consultation.

3.5 **WHILST** Mrs A says that she did not know why he was undertaking a full examination Dr Wakefield believes that he would have informed her of that and further his nurse would have done so at the time of making the appointment as new patients required an extended appointment time. Mrs A says that she does not recall Dr Wakefield's nurse informing her of the extended appointment time.

3.6 **IN** evidence Mrs A said *"I kept asking myself why Dr Wakefield was doing these things"*. When questioned as to why she did not ask Dr Wakefield why he was doing things or indeed complain at the time of him doing them she replied that *"I could have asked but I trust*

doctors. He is a professional and he knows what he is doing". There is no doubt that had she asked Dr Wakefield he would have explained again what he was doing and why and there is also no doubt that Mrs A, as she said in her evidence, would then have accepted willingly what he was doing because in her perception it was not outside the ordinary physical examination normally conducted by a general practitioner.

3.7 **AT** the end of the examination Dr Wakefield signed a form so that Mrs A could have further acupuncture for her shoulder injury.

4. DISCUSSION AND FINDING PERTAINING TO PARTICULARS ONE AND TWO

Particular One:

4.1 **IT** is clear from the evidence that Dr Wakefield believed that he had informed his patient that he was going to undertake a full medical examination. It is similarly clear that Mrs A does not believe that she was adequately made aware of this. There was therefore a lack of communication to the extent that Mrs A believed she was not properly informed of the intended examination. However, the nature of informed consent relies upon the patient's understanding and consenting to the treatment and to that extent is a subjective not an objective test.

4.2 **COMPLIANCE** with the obligation to make sure that a patient is adequately informed is an important part of every doctor's professional obligations and one that the Tribunal takes very seriously. In addition while the Director of Proceedings assured the Tribunal that there was no allegation of sexual impropriety, a breast examination is a sensitive area and one in which

the doctor has to be particularly aware of the needs of his patient. Dr Wakefield clearly made an error in his failure to inform Mrs A that he was about to carry out such an examination and obtain her specific consent to it.

4.3 **HOWEVER**, part of the Tribunals' task is to determine whether the charge is not simply mere error but one which is such a serious dereliction of his duty that a finding of professional misconduct must be made.

4.4 **THE** accepted test to professional misconduct is to ask, *"has the practitioner behaved in a professional capacity in a way that the established acts being scrutinised would be reasonably regarded by the practitioners colleagues as constituting professional misconduct?"*

4.5 **IN** *B v The Medical Council* (High Court, Auckland HC 11/96) Elias J said:

"*There is little authority on what comprises conduct unbecoming. The classification requires assessment of degrees. 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 it's privileges, is available.*

A finding of conduct unbecoming is not required in every case where error is shown. The question is not whether error was made but whether the practitioners conduct was an acceptable discharge of his or her professional obligation. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional misconduct or conduct unbecoming."

4.6 **IN** *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369 the Court said:

"The structure of the disciplinary processes set up by the Act which rely in a large part upon judgement of a practitioners peers, emphasises that the best guide to what is

acceptable professional misconduct is the standards applied by competent, ethical and responsible practitioners."

4.7 **IN** a judgement of Smellie J concerning the problem of professional misconduct he notes:

"As with conduct unbecoming I was referred to a number of older cases in the text books but in my judgement the best treatment is to be found in Cullens and he quotes "a charge of professional misconduct is a severe label. It could well seem disproportionate for the minor end of professional misconduct activity". He goes on to state "that it is misconduct not negligence or error of judgement that is being discussed."

4.8 **GALLEN**, J. addressed the question in *Faris v Medical Practitioners Committee* [1993] 1 NZLR 60 as follows:

"Those standards must be fixed by Members of the Committee themselves but by doing so they must bear in mind they acted in a representative capacity and must endeavour to formulate standards which are themselves seen as representative rather than an expression of their own personal views."

4.9 **FINALLY** there is a strong statement in an Australian case in a decision of a Court of Appeal of New South Wales, *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197 where it records:

"But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession, something more is required; it includes a deliberate departure of accepted standards or such serious negligence as although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."

4.10 **THESE** examples and admonitions from various authorities remind the Tribunal that as representatives of the profession and as lay person to safe guard the public interests they must weight the alleged misdemeanour and find whether it reaches the level of gravity to be considered professional misconduct or conduct unbecoming in a professional respect such as to reflect on the doctor's fitness to practise. The Tribunal has considered this issue carefully and is of the opinion that though both Particular One and two have been proved, the level of gravity falls below that required to reach a finding of professional misconduct or conduct

unbecoming in a professional respect such as to reflect on the practitioner's fitness to practise. We therefore do not find against Dr Wakefield concerning these particulars.

5. PARTICULAR THREE:

5.1 **WHILE** particular three was withdrawn the Tribunal wishes to make a comment in relation to this particular and their overall findings of Mrs A's credibility. Particular three was a serious allegation and one that was properly withdrawn by the Director of Proceedings when Mrs A's evidence did not support the allegation. However generally the Tribunal found that Mrs A's evidence and recollection of events was less than optimal. For example in her brief of evidence Mrs A had said that Dr Wakefield looked in her underwear during this examination, but when questioned she said that he was examining her abdomen and that she was *"just looking straight up"* at the time. The Tribunal was therefore mindful of this in reaching its decision not to make a finding of professional misconduct or conduct unbecoming against Dr Wakefield.

6. PARTICULAR FOUR:

The Tribunal found this particular more difficult. On the evidence which was undisputed, Dr Wakefield clearly did not undertake an adequate breast screening examination. Again, this is a serious matter for any doctor. We have wrestled with the facts and the very serious consequences a finding of professional misconduct has on a doctor. We believe that the particular is very important and that every doctor should place the highest importance on ensuring that he or she has the skills to carry out an adequate breast examination. However, having said that we do not feel that a finding that this particular has been proven should lead to a finding of professional misconduct or conduct unbecoming against Dr Wakefield and accordingly make no finding against him on this particular.

7. PARTICULAR FIVE:

AS with Particular Four there was no record at all concerning the breast examination and it is self evident therefore that the particular is made out "that he failed to record in the patient's clinical records the findings of the breast screening examination". Again we have similar views on this particular to those articulated above. Dr Wakefield should have made adequate notes of the examination. However, his failure to do so cannot lead to a finding of professional misconduct or conduct unbecoming.

8. **IN** summary then, the majority of the Tribunal which is made up of three competent doctors and one lay person find that Dr Wakefield is not guilty of the charge as laid.

9. MINORITY DECISION OF THE CHAIR:

9.1 **BEFORE** proceeding with his minority opinion the Chair will make some comments concerning the findings which have been made by a majority of the Tribunal (the Tribunal).

Particulars 1 and 2:

9.2 **PARAGRAPH** 3.5 implies a preference for the evidence of Dr Wakefield over the evidence of Mrs A.

9.3 **TO** the Chair some measure of ambiguity and/or inconsistency arises out of the findings made in respect of particulars 1 and 2.

9.4 **ON** balance the Tribunal is equivocal as to whether Dr Wakefield informed Mrs A of his intention to undertake a full medical examination and obtain the appropriate consent. On this

aspect the Tribunal seems to have preferred Dr Wakefield's evidence over that which was given by Mrs A. Notwithstanding this the Tribunal is unequivocal in its view that Dr Wakefield failed to inform Mrs A that he was about to carry out a breast examination and to obtain her specific consent to it.

9.5 **THE** Chair wishes it to be clear that for his part he is satisfied that all aspects of particulars 1 and 2 have been established to the required standard for the following reasons:

9.6 **UNDER** cross-examination Mrs A denied emphatically that Dr Wakefield told her at any stage he was going to do a full examination. In response to Mr Hodson's suggestion that she could have asked Dr Wakefield if he was going to do a full examination, Mrs A conceded *"I could have asked but I trust doctors, he's a professional and he knows what he's doing"*.

9.7 **ACKNOWLEDGEMENTS** made by Mrs A when questioned by Dr McKenzie are helpful in gaining an understanding of Mrs A's reaction following the examination conducted by Dr Wakefield. Dr McKenzie put it to Mrs A that if Dr Wakefield had talked about doing a full examination with her, would she have expected the kind of examination which followed. Mrs A replied *"I think so, [provided] he tells me what he was going to do"*. Mrs A further acknowledged that the main problem was that she got on the bed not knowing what was going to happen. She conceded that the actual examination of her breasts and her tummy and the other things done would have been considered reasonable by her had Dr Wakefield discussed them with her beforehand.

9.8 **DR** Wakefield's formal brief of evidence does not cover what he actually told Mrs A, or what form of consent he obtained from her. He deposed only to normal practice at the outset of consultations with new patients. While the Chair can be satisfied that Dr Wakefield did ask a number of questions of Mrs A to fill the gaps in her health history, he has grave doubts that on this occasion Dr Wakefield communicated with Mrs A in such a way as to make clear to her his intention to complete a full history, and to carry out a general examination, including a breast screening check. This omission on Dr Wakefield's part seems clear enough from certain aspects which were clarified during the course of cross examination and questions asked of Dr Wakefield by some of the members.

9.9 **ASKED** by Mr Hodson if he had a recollection of any, or all, or parts of the subject consultation, Dr Wakefield replied that he had an excellent memory of some parts, and no memory of others. Moreover Dr Wakefield could not specifically recall giving any explanation to Mrs A, and could rely only on his usual practice.

9.10 **DURING** cross-examination it was put to Dr Wakefield that Mrs A did not know why she was lying on the bed after the shoulder examination. He accepted that it was possible that he did not explain to her he was going to give her a full physical examination.

9.11 **NOT** surprisingly therefore, Dr Wakefield conceded that he had no recollection of explaining to Mrs A in detail what would be involved in a breast screening examination. Dr Wakefield went on to acknowledge the possibility that he did not explain to Mrs A in detail what would be involved in a breast screening examination.

9.12 **DR** Wakefield further conceded that in retrospect he did not communicate sufficiently clearly to Mrs A, but that he had improved his communication and consent techniques following the complaints made by two patients to the Health & Disability Commissioner.

9.13 **MRS** A confirmed she had a good understanding of English, saying in response to a query *"I am sure of myself"*. Further asked if she believed Dr Wakefield had explained that with new patients he carried out a full medical examination, Mrs A confirmed that had he done so, she would have understood.

9.14 **MR** Hodson submitted that the first particular had not been established because Mrs A, understandably, did not recollect large areas of the subject consultation. Therefore Mr Hodson argued the probability is that the problem is not what was said, but that what was said was not understood or appreciated.

9.15 **THIS** submission invites the reversal of the onus placed on the medical practitioner to communicate effectively. It is tantamount to saying that any difficulties in comprehension are the responsibility of the patient rather than the doctor. The submission made by Mr Hodson does not in any way accord with the right which a consumer is given under Right 5 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (the Code of Rights):

"... to effective communication in a form, language and manner that enables the consumer to understand the information provided" with the rider that where necessary and reasonably practicable, this includes the right to a competent interpreter. The test of effective communication is subjective. It is the responsibility of the doctor/health professional

to take all reasonable steps to ensure that the patient understands the information being communicated.

9.16 **IT** was accepted by Ms Davis that the clinical records of the consultation by Dr Wakefield on Mrs A were generally thorough, although they did not contain a record of both the breast and an abdominal examination. But just because Mrs A was unable to give a full account of what was probably a much fuller examination than she recollects, as evidenced by the doctor's notes, should not reflect adversely on her contention, and credibility, that she was not made to understand she was about to undergo a full medical, including a breast examination. As was acknowledged by Mr Hodson, Mrs A had it in her mind only to get an ACC form signed, and that she was running short of time in her lunch hour. In these circumstances it was incumbent on Dr Wakefield to communicate effectively with his patient, Mrs A. Quite clearly in the Chair's view this did not happen.

9.17 **FOR** these reasons it is the Chair's finding that all aspects of particular 1 of the charge have been established to the required standard.

9.18 **MR** Hodson acknowledges that particular 2 has much more substance, and should therefore be of greater concern than particular 1. Mr Hodson further acknowledged that where a patient comes away from a consultation and remains puzzled about a procedure, then the doctor has failed to communicate adequately. He conceded it is incumbent on the doctor to explain everything thoroughly, and to be sure that the patient understands everything said and agrees to what is done.

9.19 **THE** Chair understands Mr Hodson to submit that Dr Wakefield ought to have known that Mrs A had not understood his intention to conduct a full medical examination including a breast screening examination, before he can be held responsible for not obtaining her informed consent to carrying out these procedures. It is the Chair's view that whether an informed consent was obtained, is an objective test. Given the Chair's earlier finding that the patient was not properly informed by Dr Wakefield, in his view it must follow that he failed to obtain her informed consent to the procedures undertaken.

9.20 **MRS** A had the right to make a choice as to whether she had a full medical examination, and for that matter, a breast screening examination too. She could make this choice only if she had been provided with full information by Dr Wakefield beforehand.

9.21 **HAD** Dr Wakefield provided Mrs A with full information and she chose to have a breast examination, then it would be incumbent on Dr Wakefield to obtain her consent to the examination. Dr Wakefield's obligation to provide information is separate and distinct from Mrs A's consent. Dr Wakefield had an obligation to provide Mrs A with information regardless of whether or not she chose to have a breast screening examination. It therefore follows that Mrs A did not understand that she was being asked to give her consent to a general medical examination which included a breast screening examination. Accordingly the Chair finds that particular 2 has been established to the required standard.

Particular 3:

9.22 **THE** Chair believes the comments made by the Tribunal in respect of particular 3 are unsafe and demonstrate a bias against Mrs A. Having made a finding against Dr Wakefield in terms

of his failure to inform and to obtain consent to a breast examination, it should not be open to the Tribunal to use an adverse perception of Mrs A's credibility as justification for its determination that the conduct under focus is not culpable.

10. MINORITY DECISION:

10.1 **THE** Chair agrees with the Tribunal that the omissions identified on Dr Wakefield's part do not cross the threshold of professional misconduct in terms of Section 109(1)(b) of the Act. Recently a view has developed, that as findings of professional misconduct have grave consequences that the threshold for professional misconduct should be high. Mere incompetence is not enough to amount to professional misconduct. Whilst findings have been made against Dr Wakefield in terms of his failures in a number of areas, the Chair does not consider that those failures are so serious, on the facts of this case, as to warrant a determination of professional misconduct. In this context the Chair believes it may be helpful to refer to the scheme of the earlier 1968 Medical Practitioners Act which was considered in detail by McGechan J in *Cullen v Preliminary Proceedings Committee* (Wellington, AP 225/1992) 15 August 1994. In the course of his judgment His Honour noted:

"A charge of "professional misconduct" is a severe label. It could well seem disproportionate for the minor end of professional misconduct activity ... [an] addition was made by the Medical Practitioners Amendment Act 1979, adding the similar category of "conduct unbecoming a practitioner", and creating the trilogy which now exists. In part, it reflected a need to deal with some professional conduct with a lighter touch?'

These comments remain apposite where the Tribunal is to consider a charge of professional misconduct under the current legislation.

10.2 **WHILE** the Tribunal has ruled that the charge against Dr Wakefield be dismissed in its entirety, for the reasons which follow the Chair is of the view that the shortcomings identified

on the part of Dr Wakefield should be dealt with at *"... the minor end of professional misconduct activity"* and *"... with a lighter touch"*. (*Cullen* : supra).

10.3 **MS** Davis submitted that Dr Wakefield's failure to record the fact that a breast screening examination was undertaken together with the other particulars of the charge amount to professional misconduct. The Chair finds merit in this submission but considers that the appropriate charge for the degree of culpability is conduct unbecoming rather than professional misconduct.

10.4 **THE** Tribunal has the power to amend the charge during the hearing pursuant to Clause 14 of the Act.

10.5 **THERE** are four remaining components to the charge, laid cumulatively and in the alternative. The Tribunal has already considered each particular independently and has made findings in respect of them. In light of those findings the Chair has no difficulty in arriving at a conclusion that the overall gravity of the offending should and does warrant a determination of conduct unbecoming pursuant to Section 109(1)(c) of the Act. This approach was given express approval by the Court of Appeal in *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513:

"When there is a comprehensive charge as well, the Council should go on to consider it after determining the separate charges, they should arrive at a conclusion as to the overall gravity of the conduct of which they found the practitioner guilty."

10.6 **IN** electing not to arrive at a conclusion as to the overall gravity of Dr Wakefield's conduct, the Chair considers that the Tribunal was in error. As a matter of law the Chair believes that the Tribunal erred in not taking into account:

1. Importance of communication and informed consent;
2. Measurement of gravity of professional misconduct;
3. Relevance of similar facts evidence;
4. Patient interests and community expectations;
5. No prejudice to preclude making a determination of conduct unbecoming;
6. Potential to make a determination of conduct unbecoming which reflects adversely on fitness to practise medicine.

10.7 **EACH** of these factors will be discussed separately:

11. IMPORTANCE OF COMMUNICATION AND INFORMED CONSENT:

11.1 **THE** leading case on informed consent is the High Court of Australia's judgment in *Rogers v Whittaker* (1992) 175 CLR 479.

11.2 **IN** *Rogers v Whittaker*, the High Court of Australia accepted that medical practitioners are under a duty to exercise reasonable care and skill not only in treatment, but also in the provision of information sufficient to enable the patient to exercise a choice in accepting or rejecting treatment. The same principle had been accepted by the House of Lords in *Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1985] AC 871 and by the Supreme Court of Canada in *Reibl v Hughes* [1982] SCR 880. The significance of *Rogers v Whittaker* is that the High Court, in considering whether the general duty to advise had been breached, rejected the *Bolam* test (derived from *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582) by which the medical

practitioners duty is discharged *"... if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art"*.

11.3 **IN** *Rogers v Whittaker* the judgment of Mason CJ, Brennan, Dawson, Toohey and McHugh JJ, recognised a *"fundamental difference"* between diagnosis and treatment on the one hand and *"the provision of advice or information to a patient"* on the other hand:

"Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; ***whether*** *the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment. Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information."*

11.4 **GAUDRON** J in a separate concurring judgment was prepared to go even further. She considered that the *Bolam* test failed to take account of the considerable conceptual and practical differences between diagnosis and treatment, on the one hand, and the provision of information and advice on the other. There was, she considered, *"simply no occasion to consider the practice or practices of medical practitioners in determining what information should be supplied"*.

11.5 **FURTHER** assistance can be obtained from comments made by Elias CJ in her paper presented at the recent Brookfields Medical Law Symposium held in Auckland in June 1999. She commented at page 13, paragraph 36 that

"... it seems to me that the reality is that the Courts will not defer to clinical judgement of medical practitioners as to what the patient should be told. Informed consent to treatment is a precondition of such treatment. The patient's right imposes a concomitant duty on the medical practitioner to inform. Such duty necessarily arises out of the relationship between a health professional and patient. Whether that duty has been performed in the particular case depends upon all the circumstances and is not determined by medical practice. ***Rogers v Whittaker*** *is mainstream legal thinking and should be followed."*

11.6 ***ROGERS*** *v Whittaker* was applied in New Zealand by Elias J (as she then was) in *B v The Medical Council of New Zealand* (supra). At p 17-18 Her Honour noted:

"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners. In the case of adequacy of communication of information to the patient, however, wider considerations are relevant. In particular, the communication must be such as to adequately inform the patient, taking into account the patient's capacity to understand it and the purposes for which the information is relevant. What needs to be communicated may depend upon whether the information is provided pursuant to the patient's general right to know about his or her condition, or whether it is required to inform the patient's own conduct in matters such as consent to medical procedures, or co-operation with investigational treatment. These seem to me to be considerations which are relevant in assessing the conduct of a medical practitioner. Those standards to be met are, as already indicated, a question of degree; the practitioner is not a guarantor of the effectiveness of communication any more than he or she is a guarantor of the effectiveness of treatment. I accept that the burden of proof is on the balance of probabilities. Assessment of the probabilities rightly takes into account the significance of imposition of disciplinary sanction. I accept that the court must be satisfied on the balance of probabilities that the conduct of the practitioner is deserving of discipline."

11.7 **AS** was noted by the Director of Proceedings in her closing submissions (para 15), the common law approach taken in *Rogers v Whittaker* is arguably enshrined in the Code of Rights. The test incorporated into Right 6(2) of the Code of Rights includes an objective element of the *"reasonable consumer"* under the particular circumstances of the consumer whose rights are in issue.

11.8 **THE** Chair considers there is merit in her submission that standards set under the Code of Rights could be determinative in establishing whether a practitioner has departed from

acceptable professional standards. The Chair agrees with the Director that comments made by Elias CJ at the recent Medical Law Symposium support this argument. Elias CJ said at page 18 paragraph 47:

"Communication however, is central to the relationship between medical practitioner and patient. The question of adequacy in communication is not able to be evaded. This is an area where I expect the standards to be set by the Health & Disability Commissioner to have a substantial impact."

11.9 **ELIAS** CJ had earlier commented at paragraph 16 on page 5:

"... the right of patients to exercise informed choice and the corresponding obligation of health professionals to provide information which makes that choice a real one, are both now assumed by the statutes: the Accident Rehabilitation and Compensation Insurance Act 1992 and its successor statute and the Health and Disability Commissioner Act 1994. These legislative obligations cannot help but inform the professional standards enforced under the Medical Practitioners Act 1995."

11.10 **RIGHT** 5 of the Code of Rights gives every patient the right to effective communication in a form, language and manner that enables the consumer to understand the information provided. This right cannot be overlooked in disciplinary procedures such as this. In *A Complaints Assessment Committee v Mantell* (MPDT Decision No. 47/98/25C) this Tribunal affirmed the approach to informed consent which was taken in *Rogers v Whittaker* and *B v The Medical Council of New Zealand* (both supra). The Tribunal said that Rights 6 and 7 of the Code of Rights reinforced the common law concerning informed choice and informed consent.

11.11 **RIGHTS** 6 and 7 of the Code of Rights respectively govern the rights of every consumer to be fully informed and to make an informed choice and give informed consent.

11.12 **THE** rights of a patient to receive information are confirmed in a Statement For The Medical Profession On Information and Consent (the Statement) published by the Medical Council of New Zealand in 1985. The Statement explains that *"... the proper sharing of information, and the offering of suitable advice to patients, is a mandatory prerequisite to any medical procedure instituted by a medical practitioner. This applies whether the procedure is a diagnostic one, a medical or pharmacological regimen an anaesthetic, or any surgical, obstetric or operative procedure."*

11.13 **THE** Medical Council affirms in the Statement that if it can be shown that a doctor has failed to provide adequate information and thereby has failed to ensure that the patient comprehends, so far as is possible, the factors required to make decisions about medical procedures, such failure could be considered as medical misconduct and could be the subject of disciplinary proceedings.

12. MEASUREMENT OF GRAVITY OF PROFESSIONAL MISCONDUCT:

12.1 **ALTHOUGH** the Tribunal has made certain adverse findings against Dr Wakefield, nevertheless it has elected not to determine that the several particulars, considered cumulatively, amount to any degree of misconduct.

12.2 **THE** Chair has difficulty in accepting this approach. In his view the gravity of professional misconduct should be measured by the extent to which it departs from proper standards, rather than by reference to the worst cases. In this regard the Chair would adopt, with respect, the following comments which were made by the New South Wales Court of Appeal in *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 at 638:

"The gravity of professional misconduct is not to be measured by reference to the worst cases, but by the extent to which it departs from the proper standards. If this is not done there is a risk that the conduct of the delinquents in a profession will indirectly establish the standards applied by the Tribunal."

12.3 **IN** *Litchfield* the Court was considering an appeal by the Health Care Complaints Commission against orders made by a Medical Tribunal in disciplinary proceedings against a respondent doctor. Against the Tribunal's order to suspend the doctor, the Commission sought an order that the doctor's name be removed from the Register. Although the facts in *Litchfield* bear no relationship to those in this case, the Chair would adopt also, with respect, the following statement which their Honours in *Litchfield* cited with approval from the dissenting judgment of Priestley JA in *Richter v Walton* (NSW Court of Appeal,15 September 1993, unreported) at 8-9:

"The degree of trust which patients necessarily give to their doctors may vary according to the condition which takes the patient to the doctor. Even in regard to the most commonplace medical matters the trust a patient places in a doctor is considerable. In some cases, of which the present seems to me to be an example, the patient's trust cannot help but be almost absolute. The doctor's power in regard to the patient in such cases is also very great. I do not mean power in an abstract way but as a matter of fact; the extent of the power will vary according to the temperament of the patient, but the doctor with some patients and for limited periods, because of the relationship in which they are temporarily placed, is in a position to do whatever the doctor wants with the body of the patient. This is one of the reasons why doctors are subject to correspondingly great obligations and are expected to maintain very high standards: all this being very much in the public interest."

12.4 **THE** Chair considers this extract taken from *Richter v Walton* has particular application in this case. It emphasises the absoluteness of the power which patients necessarily give to their doctors, even in regard to the most trivial of medical matters. In this case the reason for Mrs A consulting Dr Wakefield could not have been more commonplace, to have a shoulder injury assessed for the purposes of an ongoing ACC claim. But, in the event, a communication failure, which has been found to be Dr Wakefield's responsibility, resulted in Mrs A

undergoing a medical examination, including a breast examination, which obviously she found stressful and caused her distress.

13. RELEVANCE OF SIMILAR FACTS EVIDENCE:

13.1 **IN** these proceedings the Chair considers that the Tribunal is entitled to take judicial notice of the adverse finding and determination of conduct unbecoming which it made against Dr Wakefield pursuant to Section 109(1)(c) of the Act in Decision No. 82/99/45D (the first Decision). The hearing which preceded the first Decision was held earlier on the same day as this hearing, and membership composition of the Tribunal was the same for both hearings. Although the facts in the two cases are quite different, one of the principal issues in the first Decision concerned Dr Wakefield's failure to communicate and obtain the consent of his patient to a particular diagnostic procedure undertaken by him. In finding against Dr Wakefield in the first Decision the Tribunal commented:

"... if he [Dr Wakefield] had obtained Mrs xx's consent, it may be arguable that any complaint would have progressed beyond that stage."

13.2 **GIVEN** the adverse findings and determination of conduct unbecoming made against Dr Wakefield in the first Decision, the Chair is obliged to conclude that the failings in this case are not some isolated or passing departures from proper professional standards which amount to something less than a disciplinable breach, which is effectively the outcome of the determination of the Tribunal in this case.

13.3 **AUTHORITY** for the proposition that criminal law principles in relation to the admission of similar facts evidence are not applicable in disciplinary proceedings before a Medical Tribunal

is derived from the judgment of the New South Wales Court of Appeal in *Zaidi v Health Care Complaints Commission* (1998) 44 NSWLR 82. The Court held that evidence of similar conduct on other occasions, even if it does not comply with the strict requirements of similar fact evidence applied at criminal law, may have strong probative value.

13.4 **ADDITIONALLY** it should not be overlooked that under Clause 6 of the First Schedule of the Act the Tribunal may receive as evidence any statement, document, information, or matter that may in its opinion assist it to deal effectively with the matters before it, whether or not it would be admissible in a Court of law.

14. PATIENT INTERESTS AND COMMUNITY EXPECTATIONS:

14.1 **WHILE** policy considerations should never be determinative, the Chair considers they have received little consideration by the Tribunal in making its determination to dismiss the charge faced by Dr Wakefield. The Chair considers that the comments made by Elias J in *B v The Medical Council of New Zealand* (supra), that patient and community interests and expectations may be particularly important in the case of the provision of advice and information, were not heeded sufficiently in the making of the Tribunal determination. The Chair considers the Tribunal was wrong in law to rely almost exclusively on its perception of medical standards in determining that no disciplinary sanction should be made against Dr Wakefield. The Chair believes that the optimistic note sounded by Elias CJ in her recent address to the Medical Law Symposium:

"It is likely that, under the Health & Disability Commissioner Act 1994, there will develop in New Zealand a more principled approach to informed consent than is possible in jurisdictions where the ideal of informed consent is largely pursued through claims for negligence."

will be frustrated if decision-making in the important area of communication and consent, remains the exclusive preserve of the medical profession.

15. NO PREJUDICE TO PRECLUDE MAKING A DETERMINATION OF CONDUCT UNBECOMING:

15.1 **AS** has already been noted, the Tribunal has the power to amend the charge. There is provision in Clause 14 of the Act for the Tribunal to adjourn the hearing if it is of the opinion that the medical practitioner would be embarrassed in his defence by reason of an amendment. It was Ms Davenport's indication that the Tribunal could, if appropriate, and having considered the question of prejudice, make a finding of professional misconduct or conduct unbecoming on the facts we had heard.

15.2 **ALTHOUGH** the question now can have no more than academic interest, the Chair is of the view that Dr Wakefield would have suffered no prejudice had the Tribunal decided to amend the charge to conduct unbecoming and entered a conviction at that level. This position is reinforced by advice tendered by Mr Hodson at a Directions Conference on 14 June 1999, that Dr Wakefield was prepared to plead guilty to conduct unbecoming in respect of this charge.

16. POTENTIAL TO MAKE A DETERMINATION OF UNBECOMING CONDUCT WHICH REFLECTS ADVERSELY ON FITNESS TO PRACTISE MEDICINE:

16.1 **THERE** are now a number of Decisions defining conduct unbecoming, and more recently *"reflecting adversely on the practitioner's fitness to practise medicine"* (the rider).

16.2 **THE** most commonly referred to ruling setting out the essential features of conduct unbecoming was made by Elias J (as she then was) in *B v Medical Council* (refer paragraph 4.5). From this statement three basic and essential principles emerge:

(a) The departure must be significant enough to attract sanction for the purposes of protecting the public.

(b) A finding of conduct unbecoming is not required in every case where error is shown.

(c) The question is not whether error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations.

16.3 **THE** rider has been the subject of a Decision in the District Court, Doogue DCJ *Complaints Assessment Committee v Colin David Mantell* District Court Auckland NP 4533/98 7 May 1999. At page 16 His Honour says:

"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. In order to satisfy the requirements of the rider, it is not necessary that the proven conduct should conclusively demonstrate that the practitioner is unfit to practise. The conduct will need to be of a kind that is consistent 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 standard will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."

17. **IN** conclusion, based on his findings that in four out of five instances the facts have been established to the required standard, and that the facts have established the particulars of the charge, it is the Chair's determination that the established particulars amount to conduct unbecoming pursuant to Section 109(1)(c) of the Act.

DATED at Auckland this 6th day of October 1999

....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal