Medical Practitioners Disciplinary Tribunal

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PLEASE NOTE:

NAME OF PATIENT AND RESPONDENT DOCTOR OR ANY PARTICULARS OF THEIR AFFAIRS NOT FOR PUBLICATION

DECISION NO: 86/99/44D

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 **A** medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr A M C McCoy, Mr G Searancke, Dr A F N Sutherland,

Dr L F Wilson (Members)

Mr B A Corkill (Legal Assessor)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Monday 14 June 1999 and hearing by teleconference on Monday 26 July 1999.

APPEARANCES: Ms T W Davis, Director of Proceedings

Mr C W James for A.

1. DECISION:

1.1 **THIS** Decision should be read in conjunction with Interim Decision No. 84/99/44D which issued on 29 July 1999.

1.2 **AT** the hearing in xx on 14 June 1999 Dr A faced a charge that on or about 23 August 1997 while treating a patient, he acted in such a way that amounted to disgraceful conduct in a professional respect, in that he provided services of an inadequate and inappropriate professional standard. Particularised the charge states that Dr A:

(1) Failed to inform his patient that he intended to examine her breasts;

and/or

(2) Failed to obtain his patient's informed consent for a breast examination;

and/or

(3) Touched his patient's breasts in an inappropriate manner;

and/or

(4) Undertook a clinically inadequate breast examination of his patient.

2. BACKGROUND:

2.1 **THE** written complaint made by Mrs B to the Medical Council of New Zealand on 31 August 1997 adequately summarises the background information which preceded the laying of the charge by the Director of Proceedings:

"I am writing to make a formal complaint about the manner in which I was examined by A, at xx (after hours) in xx, xx on the 23rd of August 1997.

I had come to xx *to be seen by a doctor as I had a very sore chest, especially around the lower ribs and back. I explained firstly to the nurse, that I had bronchitis, and was on antibiotics and a ventolin inhaler, and that my chest had become increasingly sore over the last 24 hours, showing her that it was my lower chest and back that were sore. She wrote this down. I then saw Dr A, and explained the exact thing to him, telling him again that I had bronchitis, and that my lower chest and back were sore. He asked me if my breasts were sore, I said no, he asked me when my last period was. He then said he wanted to listen to my chest. I was not wearing a bra which he seemed to notice, as I had taken it off earlier that evening because of the soreness of my chest/back. He listened to my chest spending a lot of time listening around my breast area. He was then called out of the room, when he came back he listened to my back quickly, then returned to listen to my breast area.*

He then stood or crouched behind me, I was sitting on a chair, and felt with both hands around my lower ribs, then slightly higher up. He then cupped my breasts and held them. It did not feel appropriate. It seemed sleazy, I felt uncomfortable and violated. He then walked away saying my lungs sounded clear, and that maybe my chest area was inflamed.

He at no time told me he was going to examine my breasts. I have also had breast examinations and know this wasn't one. As I had told him about the bronchitis, I do not feel it was necessary for him to hold my breasts, they have nothing to do with bronchitis. I have spoken with my own doctor who also feels that this examination was inappropriate, and who supports me in the writing of this complaint. I am not happy with what has happened, I feel that it was an abuse of power, and want something done to prevent this happening again."

3. THE CHARGE:

3.1 **SHORTLY** the Tribunal will proceed to a separate consideration of each particular of the charge, although it would seem that particulars 1 and 2 of the charge can conveniently be dealt with together.

3.2 **DR** A faces one charge of disgraceful conduct in a professional respect. The charge comprises four particulars and it is alleged that each particular when considered separately or when one or more particulars are considered cumulatively that they amount to disgraceful conduct in a professional respect.

3.3 **THE** Tribunal has the power to amend the charge during the hearing pursuant to Clause 14 of the First Schedule of the Medical Practitioners Act 1995 (the Act).

4. BURDEN OF PROOF:

4.1 **THE** burden of proof is on the Director of Proceedings (the Director). The Director accepts that it is for her to establish that Dr A is guilty of the charge, and to produce the evidence that proves the facts upon which the charge is based.

5. STANDARD OF PROOF:

5.1 **IT** is well established in professional disciplinary cases that the civil, rather than the criminal, standard of proof is required, namely proof to the satisfaction of the Tribunal, in this case the Medical Practitioners Disciplinary Tribunal on the balance of probabilities. At the same time, however, the cases recognise that the degree of satisfaction which is called for will vary according to the gravity of the allegations.

5.2 **IN** *Brake v Preliminary Proceedings Committee* [1997] 1 NZLR 71 the Full Court put it this way:

> *"The standard of proof is not the criminal standard. The Preliminary Proceedings Committee is required to prove the charge to the civil onus, that is, proof on the balance of probabilities. But the authorities have recognised that the degree of satisfaction for which the civil standard of proof calls, will vary according to the gravity of the facts to be proved:* ***Ongley v Medical Council of New Zealand*** *[1984] 4 NZAR 369, 375-6. The charges against the appellant were grave. The elements of the charge must therefore be proved to a standard commensurate with that gravity."*

6. ADMISSIBILITY OF EVIDENCE:

6.1 **THE** Tribunal is required to observe the rules of natural justice at each hearing (Clause 5 of the First Schedule).

6.2 **THERE** can be no doubt that disciplinary proceedings under the 1995 Act are civil in nature. This was established in *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 129, 155; *Auckland District Law Society v Leary* (Auckland, M1571/84, 12 November 1985). In *Guy v Medical Council of New Zealand* [1995] NZAR 67, Tipping J held that:

"proceedings before the Medical Council are not criminal or even quasi criminal in character. They are designed primarily to protect the public from incompetent and improper conduct on the part of the medical practitioners. The powers given to the Medical Council are exercised primarily in the interests of the public and the profession itself and are only incidentally penal in nature." (77)"

7. PARTICULAR 1 and 2:

"Failed to properly inform your said patient that you intended to examine her breasts;

and/or

Failed to obtain your said patient's informed consent for a breast examination."

7.1 **THE** first witness was the complainant, Mrs B. The first person she saw at xx was a nurse. She explained to her the earlier diagnosis and the symptoms that she was experiencing. She told her that she was sore in her lower chest and that her back was also sore. The nurse recorded something on the clinical records. Later Mrs B saw Dr A and explained the same thing to him. Dr A asked if her breasts were sore. She told him that they were not. Dr A then asked her when her last period was which she was able to tell him. After those brief questions Dr A said he wanted to listen to her chest.

7.2 **THE** detail of the examination of her chest/breasts undertaken by Dr A is covered in paragraphs 5 and 7 of Mrs B's brief and will be examined and assessed when we come to consider particular 3 of the charge. At this point suffice to record Mrs B's evidence, that Dr A listened to her chest and seemed to spend a lot of time listening around her breast area, at

which point in time he was called out of the room by, she thinks a nurse, and that when Dr A returned he listened to her back quickly and then listened to her breast area again.

7.3 **AT** no time did Dr A tell her that he was going to examine her breasts. She did not say anything to Dr A but as soon as she got out to the car she told her husband and she told him that she was annoyed with herself for not saying anything to the doctor. Throughout her attendance with Dr A she felt uncomfortable. She did not feel that he was listening to her and nor did he acknowledge what she said. She finds it difficult to put into words and also thinks that the doctor's manner was off-putting as well.

7.4 **MRS** B concluded:

"I don't understand why Dr A touched my breasts when I had already told him they were not sore. He didn't tell me he wanted to examine them. He didn't ask me if it was alright nor explain what he was intending to do and why. I was completely shocked by his actions."

7.5 **EVIDENCE** on behalf of the Director was given by Craig Henry Campbell, a general practitioner based in Hamilton. Dr Campbell has been in practice since 1972 and his qualifications include Fellowship of the Royal New Zealand College of General Practitioners.

7.6 **IN** Dr Campbell's opinion Dr A's failure to tell Mrs B that he was going to examine her breasts and his failure to obtain her consent was inappropriate.

7.7 **DR** A gave evidence on his own behalf.

7.8 **DR** A explained that doctors work under considerable pressure at xx which he described as being *"a bit of a mad house"*. In general staff numbers do not easily allow for a chaperone to be present when considered necessary. At the time Dr A felt that it was inconsiderate to seek chaperone help unless he was intending to do an examination of genitalia or a breast examination as such.

7.9 **AFTER** he had taken a history and got Mrs B to answer certain questions he had posed, he asked if he could listen to her chest. Then commenced a chest/breast examination which will be covered in more detail when we come to consider particular 3.

7.10 **AT** this point suffice to say Dr A said he recognised and accepted that he owed Mrs B an explanation and apology for not obtaining her consent and for not describing to her in advance what he intended to do and why.

8. DISCUSSION AND FINDING:

8.1 **THERE** seems to be general acknowledgement that Dr A, although not intending to carry out a formal breast examination, did encroach on that area. He did so in such a way that it was incumbent on him to inform Mrs B of what he was going to do, and to obtain her consent.

8.2 **IN** examination in chief Ms Davis asked Mrs B, if Dr A had asked her if he could touch or examine her breasts, what her response would have been. Mrs B replied *"No. I think I made it clear that they [my breasts] weren't sore and I saw no reason for him to examine them"*.

8.3 **IN** cross-examination and re-examination Dr A accepted failings to properly inform of his intentions and obtain informed consent to examine the breasts in the manner he did.

8.4 **THUS**, while not formally admitting particulars 1 and 2, Dr A acknowledged in his evidence that he both failed to tell/inform Mrs B that he intended to examine her breasts, and failed to get her consent before doing so.

8.5 **THE** Tribunal is satisfied that the facts alleged in particulars 1 and 2 of the charge have been established to the required standard.

9. PARTICULAR 3:

"Touched your patient's breasts in an inappropriate manner."

9.1 **CONCERNING** particular 3 Ms Davis' principal submission was that Dr A touched Mrs B's breasts wilfully and deliberately with sexual intent and/or for the purposes of sexual gratification. It is for this reason Ms Davis said that it is alleged the touching was inappropriate.

9.2 **AS** to whether or not the touching was wilful and deliberate, with sexual intent, seems to us to be a matter which can conveniently be considered when assessing whether the conduct in question amounts to disgraceful conduct in a professional respect. Accordingly we propose to defer considering this aspect of the matter until later. Meantime we shall endeavour to establish just exactly what did occur by reference to particular 3, including whether the touching of the breasts took place in what has been described as *"an inappropriate manner"*.

9.3 **EARLIER** in the evening during which the consultation took place Mrs B's evidence was that she had removed her bra because her chest and back were sore and the bra was constraining them. When Dr A went to listen to her chest, she said he asked her to lift up her top and sort of indicated that she hold it there for him. She felt a little exposed without her bra and with her top raised. She had it so it was bunched up under her neck. She also felt uncomfortable because she felt that Dr A noticed the fact that she was not wearing a bra. She got this feeling because of his manner. When she complained about Dr A, she used the word "*sleazy*" but now she feels that this is a really strong word. She definitely felt uncomfortable. It felt wrong right from the beginning of the consultation and she said "*I sort of tried to ignore, sort of like this is really happening to me. My head told me it was a clinical examination and I tried to ignore what I felt*".

9.4 **SHE** was sitting on a chair during her examination and after listening to her chest Dr A moved behind her. He was either standing or crouching while he examined her. He used both of his hands to feel around her lower ribs and slightly higher up. While he examined her in both areas he pressed with his fingers, and asked if it was tender or words to that effect. After that she said "*... he quite unexpectantly touched my breasts and held them. He cupped them. He did not say or ask me anything. He simply held my breasts. It did not feel appropriate and seemed sleazy. I felt uncomfortable and violated. The incident did not last long. The "cupping" felt like a last minute thing that he did and that it was not really part of the examination. That is how it felt to me.*"

9.5 **GIVEN** her understanding that Dr A's evidence would be that he lifted her breasts to test for tenderness, Mrs B said it did not feel like her breasts were being lifted to relieve any pressure from weight, and nor did it feel like he was testing for tenderness.

9.6 **THE** evidence of Dr Campbell was that in his opinion Dr A provided Mrs B with an acceptable standard of care, but performed her physical examination in an inappropriate manner.

9.7 **DR** Campbell considered Dr A was correct to consider the breasts as a possible source of Mrs B's chest pain. Dr Campbell thought a very thorough doctor might well have examined the breasts to exclude pathology within them. Assuming that Dr A asked Mrs B about breast pain as some women experience such pain as their period becomes due, if that was the case, then in Dr Campbell's opinion it was an appropriate question.

9.8 **DR** Campbell agreed with Dr A's working diagnosis and his follow-up plans.

9.9 **HOWEVER** in Dr Campbell's opinion the fact that Mrs B was not wearing a bra should have been a cause of grave concern for Dr A. In Dr Campbell's opinion for both Mrs B and Dr A's own protection, the latter should have sought a chaperone before he proceeded with the examination. Accepting that having to do this in the middle of a consultation disrupts the flow of the consultation, Dr Campbell noted that the use of a chaperone is now a well accepted procedure. However Dr A's failure to use the chaperone did not, in Dr Campbell's opinion, indicate that Dr A was inappropriate, but in his opinion it may show a certain naivety about the realities of present day medical practice.

9.10 **DR** Campbell said he did not understand why Dr A chose to examine both Mrs B's breasts at once and why he chose to do this from behind. As far as Dr Campbell is aware there is no literature to support a breast examination being done from behind the patient. From the materials examined by Dr Campbell, he said he was unable to ascertain whether or not Dr A examined Mrs B's chest wall from behind her.

9.11 **IN** Dr Campbell's opinion Dr A should have examined Mrs B's breasts from her front and in the usual manner, that is to say, noting the breasts shape, and then examining each quadrant with the flats of his fingers.

9.12 **IT** was the evidence of Dr A, in questioning Mrs B whether her breasts were sore, and when was her last period, that the purpose of these questions in the context of breast tenderness was to ascertain if this was related to a hormonal problem. Because the pain was presented to him as being quite bad, Dr A said he formed the impression it was more anterior-based than from or in the back. That is why he recorded in the notes *"pain around anterior and lower ribs"*.

9.13 **AFTER** Mrs B had given him the history and answered the questions he posed, Dr A asked if he could listen to her chest. Dr A's evidence then went on to describe his recollection of the layout of the room at xx where the consultation with Mrs B took place and where she was sitting in relation to where he was positioned. Noting that she was not wearing a bra, Dr A was emphatic that he did not ask her to lift her top up, explaining that her breasts were covered throughout the examination and were not exposed to his sight.

9.14 **WHEN** he was part way through his physical examination the nurse interrupted him to come and go to an emergency elsewhere on the premises. He left Mrs B and attended to this other matter, being away for about three or four minutes.

9.15 **WHEN** he came back he continued the physical examination where he had left off, conceding he may have lost a little of his focus as he had certainly become distracted by the interruption and requirement to address this other matter. He said *"my train of thought, concentration and focus had been broken"*.

9.16 **AFTER** quickly finishing off his auscultation to the front and moved to the right side of Mrs B, Dr A explained the detail of what he described as a *"chest wall"* examination (which we consider can be dealt with more conveniently when we come to assess particular 4 of the charge). At the conclusion of this part of the physical examination Dr A said *"... I then moved up and lifted the breasts to ascertain reaction and whether tenderness was sourced in that area"*. He added *"I can understand that my action could well be construed as cupping"*. He further added that it was a rather cursory action and would have taken no more than a second.

9.17 **DR** A concluded that Mrs B's lungs were clear and that the course of the pain was possibly inflammation in the chest area - osteochondritis. This diagnosis is confirmed by Dr A's notes made at the time.

10. PARTICULAR 3 : DISCUSSION:

10.1 **THERE** are a number of conflicts or potential conflicts in the evidence concerning this particular, which it may be helpful to mention briefly:

- It was Dr A's evidence that he asked a number of questions of Mrs B, which is confirmed by notes made by him at the time. On the other hand Mrs B could recall very few of the questions Dr A said he had asked her.
- Dr A was adamant that Mrs B's top was not lifted up, that he did not ask her to lift her top up, that her breasts were covered throughout the examination, and where not exposed to his sight. On the other hand Mrs B said the examination felt wrong because of *"the fact that my breasts were exposed"*. Although Mrs B said her top was pulled up, she conceded that her original letter of complaint did not refer to her top being pulled up. Mrs B confirmed to Mr James that there was a conflict in the evidence concerning the top: Mr James: *"He's got it down, you've got it up."* Mrs B: *"Yes"*.
- Another conflict relates to the room in which the consultation took place, and the placement of furniture in that room. In brief it was Mrs B's evidence that the consultation took place in what is termed *"a treatment room at xx"*. Having taken her three children to xx on a number of previous occasions, Mrs B said she was familiar with the cubicle-type treatment rooms. She said they were quite different to a consulting room, it being Dr A's evidence that a consulting room was used.
- An important conflict concerns where Dr A was positioned when he was conducting the chest/breast examination. In re-examination Mrs B reiterated *"I was very aware that he was behind me"*. In contrast it was Dr A's evidence that he distinctly remembered he was standing to the side of or beside his patient. In cross examination

Ms Davis sought to discredit Dr A's recollection of events. She put it to him that his recollections at the hearing were far better than they ever were during the investigation by the Health & Disability Commissioner. Despite close cross examination Dr A was not induced to resile from his evidence in chief to any material extent.

11. PARTICULAR 3 : FINDING:

11.1 **AS** discussed a number of factual issues have arisen. It was Mr Corkill's direction that determination of these factual issues may assist the Tribunal in determining the central facts, and credibility. While we have formed a reasonably clear view of the question of intent in this case, we have to say that the area of disputed questions of fact, specifically as they relate to particular 3, has been immensely difficult for us to resolve.

11.2 **IN** the event, despite these conflicts in the evidence, by paying close attention to the literal wording of particular 3, it seems obvious to us that Dr A did touch his patient's breasts in an inappropriate manner. We are able to reach this conclusion without finding it necessary to resolve the factual conflicts in the evidence. This is so because in our view these conflicts do not obscure an essential reality, that there was at least one instance of touching of breasts by Dr A in an inappropriate manner. Whether Mrs B's top was in an up or a down position preceding the event, Dr A acknowledged at the conclusion of his physical examination that he then moved up and lifted the breasts to ascertain reaction. Dr A concluded *"I can understand that my action could well be construed as cupping"*. And of course that is precisely how Mrs B construed what happened. She explained what made her initially complain was that the cupping *"felt like something my husband would do"*. Dr A

conceded that the examination was inappropriate, but only as a consequence of him having failed to explain and obtain informed consent.

11.3 **NOT** to be overlooked is Mrs B's evidence, that she had been the subject of breast examinations as part of her past medical history, and properly she knew what to expect of them.

11.4 **IN** finding it is not possible to resolve certain disputed questions of fact, we consider this is a legitimate course for the Tribunal to take. In *Big Save Furniture v Bridge* [1994] 2 ERNZ 507, (CA), the Court of Appeal (and in particular Hardie-Boys J) indicated that a decision maker should strive to resolve issues of fact, but if this is not possible, then it is proper to resolve an issue on the basis of onus not having been established.

11.5 **IT** is our finding that particular 3 has been established to the required standard, and quite irrespective of Dr A's failure to properly inform and obtain her informed consent.

12. **PARTICULAR 4:**

"Undertook a clinically inadequate breast examination ..."

12.1 **VERY** briefly it is our conclusion that there is neither adequate evidence nor evidence of sufficient quality to warrant making a positive finding that this particular has been established to the required standard. In part an inability on the part of the Tribunal to make a finding in relation to this particular, arises as a result of the difficulties we encountered in resolving the factual conflicts in the evidence.

12.2 **IT** will be recalled it was Dr Campbell's evidence he did not understand why Dr A chose to examine both Mrs B's breasts at once, and why he chose to do this from behind. Given our inability to resolve this among other conflicts in the evidence, we find it impossible to conclude that a clinically inadequate breast examination was undertaken in this case.

12.3 **IN** the Tribunal's assessment of this particular, we think it is important to stress that the *"clinical"* dimension of this particular should not be under-emphasised.

12.4 **WE** consider Dr A's explanation in response to this particular is passably credible. He said he was not engaged in conducting a breast examination as such. He explained:

"I leaned across her back and listened to her lungs at the back. I then palpated around her chest wall and pressed her ribs to the lower sides. To facilitate this, I was reaching around her back with my left hand across her back palpating her left side - my right hand palpating her right ribs. I just asked simply whether this was painful. I examined by pressing with my finger and checking for tenderness."

12.5 **THE** Tribunal finds that particular 4 of the charge has not been established to the required standard.

13. SUBMISSIONS:

13.1 **COMPREHENSIVE** and careful submissions were made by counsel. Brief summaries of their submissions follow. No disrespect is intended to either counsel in not dealing with their submissions at greater length.

13.2 **FOR** the Director Ms Davis submitted:

1. If the Tribunal finds that Dr A's conduct was either wilful, deliberate, intended or premeditated, or occurred with sexual intent or for the purposes of sexual gratification, then the Tribunal must find him guilty of disgraceful conduct in a professional respect;
2. Dr A touched Mrs B's breasts wilfully and deliberately with sexual intent and/or for the purposes of sexual gratification. It is for this reason that it is alleged the touching was inappropriate;
3. Touching of breasts except for the purpose of appropriate physical examination or treatment, amounts to sexual transgression: **SEXUAL ABUSE IN THE DOCTOR/PATIENT RELATIONSHIP STATEMENT FOR THE PROFESSION MEDICAL COUNCIL OF NEW ZEALAND** (effective from 16 June 1994);
4. The case largely revolves around an assessment of the credibility and reliability of Dr A and Mrs B;
5. The character evidence adds nothing in terms of defending the charge against Dr A, and simply provides useful evidence for the Tribunal to take into account when the charge is proved.

13.3 **FOR** Dr A Mr James submitted:

1. From the outset Dr A agreed that he was wrong in failing to explain to Mrs B the nature of the examination he wished to carry out and its purpose, and that he was wrong in failing to obtain Mrs B's consent before embarking on a physical examination that included touching of the breasts;
2. Dr A is vehement in his denial that his action was for any sexual or any improper purpose whatsoever;

3. The orderly routine sequence of the consultation had become disturbed and became fragmented as a result of the transfer of focus and concentration to another task;

4. The lifting of the breasts was more of an *"innocent"* action by Dr A as an extension of his examination of the chest wall, *"innocent"* on the basis that it was not a wilful, deliberate, intended or premeditated action with sexual intent or for the purposes of sexual gratification;

5. The evidence of Mr D and Dr E is relevant in this case because in effect character is at issue;

6. If the Tribunal was to come to a positive finding against Dr A, it could only be at the lowest level, i.e. conduct unbecoming which reflects adversely on fitness to practise medicine.

14. DISGRACEFUL CONDUCT IN A PROFESSIONAL RESPECT:

14.1 **IF** on the evidence it is established that the positive findings made against Dr A in respect of particulars 1, 2 and 3 of the charge, particular 3 especially, occurred wilfully and deliberately with sexual intent and/or for the purposes of sexual gratification, as was most forcefully submitted by the Director, then it would be open to the Tribunal to make a determination that Dr A is guilty of disgraceful conduct in a professional respect. Accordingly it becomes necessary to give some consideration to what, in law, constitutes disgraceful conduct in a professional respect.

14.2 **IN** determining whether or not the facts which have been proved amount to disgraceful conduct in a professional respect, the Tribunal must ask itself whether Dr A has acted in a

manner *"which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency"*.

14.3 **DISGRACEFUL** conduct in a professional respect is conduct deserving of the strongest reprobation. It may include conduct connected with the profession in which Dr A has fallen short, by omission or commission, of the standards of conduct expected amongst registered medical practitioners. Such falling short as is established must be grave.

14.4 **THE** full Court considered the test for disgraceful conduct in *Brake v Preliminary Proceedings Committee* (supra) and held (p7):

> ***"****The test for "disgraceful conduct in a professional respect" was said by the Privy Council in* ***Allison v The General Council of Medical Education Registration*** *to be met:*
>
> *If it is shown that a medical man in the pursuit of his profession has done something with regard to it which would be reasonably regarded as disgraceful or dishonorable by his professional brethren of good repute and competency.*
>
> *It is apparent from this test, and from the later cases in which it has been adopted, that it is an objective test to be judged by the standards of the profession at the relevant time* ***...***
>
> *In considering whether conduct falls within that category, regard should be had to the three levels of misconduct referred to in the Act, namely disgraceful conduct in a professional respect, s58(1)(b); professional misconduct, s43(2); and unbecoming conduct, s42B(2). Obviously, for conduct to be disgraceful, it must be considered significantly more culpable than professional misconduct, that is, conduct that would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct, or as it was put in* ***Pillau v Messiter****, a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

14.5 **FROM** the statement made by the Court in *Brake* it is clear, for conduct to be disgraceful, that it must be significantly more culpable than professional misconduct.

14.6 **IF** the Tribunal does not accept that Dr A's conduct amounts to disgraceful conduct, then the Director suggested that it must amount to professional misconduct. Although the Director indicated in her opening submissions that she would make further submissions as to whether Dr A's conduct amounts to professional misconduct, at the conclusion of the hearing the Director did not undertake any discussion of that nature.

15. PROFESSIONAL MISCONDUCT:

15.1 **THE** definition of professional misconduct is well established. In *Ongley v Medical Practitioners Disciplinary Committee* [1984] 4 NZAR 369, at 374-5 Jeffries J stated in the context of the 1968 Act:

"To return then to the words "professional misconduct" in this Act. .....

In a practical application of the words it is customary to establish a general test by which to measure the fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with a medical practitioner could be formulated as a question. ***Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency****, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."* (Tribunal's emphasis).

16. LEVEL OF MISCONDUCT:

16.1 **IS** a finding of either disgraceful conduct in a professional respect or professional misconduct warranted on the facts of this case?

16.2 **BECAUSE** it was the Director's principal submission that a finding of disgraceful conduct in a professional respect should be made, with professional misconduct being a much softer alternative option, we will address this submission first. Initially this will be done by reference to the evidence.

16.3 **AT** the conclusion of examination in chief Mrs B acknowledged her awareness of the severity of her accusation against Dr A, and that she actually felt quite bad about what she was doing. She added *"I'm aware that Dr A probably does far more good in the community than I will ever do"*.

16.4 **CROSS**-examination of Mrs B has assisted in assessing her probable state of mind at the time of the subject consultation. Mrs B acknowledged that initially she was greatly surprised by Dr A questioning her if her breasts were sore and when had she had her last period.

16.5 **MRS** B confirmed she felt Dr A was not listening to her. She was talking about bronchitis while he was asking her about her last period and whether her breasts were sore. Therefore she said she did not trust him from the start, which prompted the remark she made to an investigating officer from the Commissioner's office: *"Here we go, a sleazy man"*. However at hearing Mrs B qualified her remark that although she was very angry at the time, *"inappropriate"* rather than *"sleazy"* was probably a better word in retrospect.

16.6 **MR** James put it to Mrs B that assuming for a moment Dr A had explained to her right at the beginning, as probably he should have done, the reason why he was asking her about her

period and breast soreness, would she have been more comfortable at the beginning of the consultation than she was? Mrs B replied:

"If he had responded to the way I explained to him I was hurting, and then explored what he was going to do or ask me, yes I would have felt more comfortable."

16.7 **MRS** B acknowledged to Mr James that she considered Dr A's letter of apology was reasonable.

16.8 **AT** this point it should be noted that a short brief of evidence was received from Dr C, Mrs B's GP from 1992-1998. Dr C deposed that Mrs B had seen her subsequently at her former clinic and discussed the incident at xx. Dr C's experience of Mrs B was of an extremely pleasant and sensible woman. She did not believe her likely to exaggerate or fabricate an incident such as she had described. To Dr C's knowledge Mrs B had never found reason to complain about a doctor's behaviour in the past, and she knew that she gave this incident considerable thought before proceeding with her complaint.

16.9 **CLAUSE** 6(1) of the First Schedule of the Act makes specific provision in respect of evidence:

"Subject to Clause 5(3) of this Schedule, the Tribunal may receive into 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."

16.10 **IN** accordance with the power given under Clause 6(1) of the Act the Tribunal has received in evidence copies of correspondence entered into between the Health & Disability Commissioner and the Director, and Dr Lesley Rothwell, a Wellington General Practitioner. Dr Rothwell had been asked for her assessment of the background to Mrs B's complaint,

and Dr A's explanation. In her letter of 11 July 1998 to the Commissioner Dr Rothwell explained:

"The business of the night, an interruption during the consultation, indicated that he may not have been fully concentrating on Ms B's problem- a view supported perhaps by the brevity on the notes.

The fact that he was interrupted before the sequence of actions that precipitated the complaint (with the possibility of it happening again??) tends to make frank sexual abuse unlikely.

...
The crux of the complaint is the way the breasts were touched and the intent behind the touching. I cannot ascertain this from the material I was given."

16.11 **THEN** there is Dr A's evidence to be considered.

16.12 **HE** said the purpose of his asking Mrs B about her last period was that he was considering whether any breast tenderness was related to this or a hormonal problem. He said the pain was presented to him as being quite bad, and he formed the impression it was more anterior-based than from or in the back. That is why he recorded in his notes *"Pain around anterior and lower ribs"*.

16.13 **WITH** respect to the allegation of sexual misconduct Dr A described it as:

"... A worry and torment which is quite indescribable." To be portrayed as one who is sleazy or doing an examination for inappropriate purposes was likened by Dr A as *"... just contrary to my very being and all I stand for"*. He added *"The price I am paying is extremely high"*.

16.14 **CHARACTER** evidence was given on behalf of Dr A by D, , and Dr E. It will be recalled the Director submitted that the character evidence adds nothing in terms of defending the

charge against Dr A, and simply provides useful evidence for the Tribunal to take into account when the charge is proved.

16.15 **MR** D took up an appointment of Chief Justice of xx for a period of two years from September 1995. From an early stage of residence in xx Mr D learned of Dr A and what he described as his *"reputation as a thorough and devoted physician"*. Mr D and his family engaged Dr A as their personal physician during the time they lived in xx. The dominant theme of Mr D's three page brief of evidence is encapsulated in paragraph 16:

"To suggest that A has acted in furtherance of some sort of selfish, prurient interests of his own would be repugnant to the man and the doctor who I came to know and, in my view, would be wrong. To view him as acting in some prurient way, as may be suggested from the factual matters here, would be to see him acting in a way antithetic to all he stands for and to all he holds dear to himself; and in a way which would be anathema to him."

16.16 **DR** E gave evidence on behalf of Dr A. He is currently employed as a xx in the xx. He has had over 20 years of clinical practice in New Zealand and overseas. Dr E said he was responsible for bringing Dr A to New Zealand and introduced him to xx as well.

16.17 **IT** was Dr E's evidence that Dr A is a respected member of the service of xx, the xx and xx in xx, a respected colleague, confident clinician and exceptional role model for wider society. Although Dr E said there was no doubt in his mind that Dr A did not act inappropriately, he was critical of his failure to properly inform and obtain consent, and his failure to have a chaperone.

16.18 **WE** shall now endeavour to place the important evidential details which have emerged in this case, in context of helpful guidelines which are contained in a Statement published by the Medical Council of New Zealand in June 1994 which is titled:

"Sexual Abuse In The Doctor/patient Relationship".

16.19 **FOR** the purpose of disciplinary action, the Medical Council has defined sexual abuse under three categories:

- Sexual impropriety
- Sexual transgression
- Sexual violation

16.20 **SEXUAL** impropriety is defined as (including but not exclusively) any behaviour such as gestures or expressions that are sexually demeaning to a patient, or which demonstrate a lack of respect for the patient's privacy. Several examples of activities considered by the Council to amount to sexual impropriety are given. One of those examples which the Tribunal considers has some application in this case is:

"- Examining the patient intimately without their consent".

16.21 **IN** Decision No. 29/97/17D delivered on 27 May 1998 the Tribunal noted:

"Given that the listed examples are qualified as not being exclusive, the Tribunal considers that another example of sexual impropriety would be failure of a doctor to inform a patient that she (or he) has the right to have a chaperone present during an internal/intimate examination. The Tribunal considers that a follow-on further example of sexual impropriety would be the conducting of the actual internal/intimate examination in the absence of a chaperone."

16.22 **SEXUAL** transgression is defined as including (but not exclusively) any inappropriate touching of a patient that is of a sexual nature, short of sexual violation.

16.23 As was the case with sexual impropriety, several examples of conduct considered by the Medical Council to amount to sexual transgression are given. Two of those examples which the Tribunal considers may have application in this case are:

"- Touching of breasts or genitals, except for the purpose of appropriate physical examination or treatment.

- The touching of breasts or genitals when the patient has refused or withdrawn consent for the examination or treatment."

16.24 **SEXUAL** violation is irrelevant to the focus of the charge under consideration and need not be examined.

16.25 **IT** is clear to us that for either disgraceful conduct in a professional respect or professional misconduct to be established, that Dr A's conduct would need to be categorised as a sexual transgression, that is, inappropriate touching of a patient that is of a sexual nature, but short of sexual violation (which is defined as doctor/patient sexual activity).

16.26 **ON** the evidence we must conclude it has not been established to the required standard, a standard of gravity commensurate with the seriousness of the allegation, that Dr A's touching of his patient's breasts was with wilful and deliberate intent for the purposes of sexual gratification. Mr Corkill reminded us in *Guy v Medical Council of New Zealand* [1995] NZAR 67 it was said in respect of such a charge that the Tribunal must *"feel sure"*, given the gravity.

16.27 **MS** Davis' lengthy submissions why the Tribunal should find Dr A guilty of disgraceful conduct in a professional respect, seem to proceed on certain assumptions, namely:

- Mrs B's evidence minimalised what in fact happened on 23 August 1997;
- Dr A was either standing behind or beside his patient to examine her breasts; and therefore the examination could not have been of a clinical nature;
- Dr A did not offer a chaperone because he never intended to examine Mrs B's breasts for any clinically acceptable reason;
- The evidence of Dr A is unreliable and incredible because almost two years after the event, his memory suddenly appears to be better than during the investigation;
- Dr A did not record the breast examination in his clinical records because it was not a bona fide examination.

16.28 **AS** was explained earlier, the Tribunal was unable to resolve a number of conflicts in the evidence. Given this state of affairs the Tribunal is entitled to draw reasonable inferences from any proven facts, but it cannot act on conjecture. It must reach a logical conclusion, but only on the basis of any facts which have been proven. Accordingly it is simply not open to the Tribunal to make further adverse findings against Dr A additional to those which have been made already in respect of particulars 1, 2 and 3, such as would characterise his conduct as disgraceful, indeed a severe and very serious finding within the general ambit of professional misconduct.

16.29 **BY** reference to the guidance provided by *Brake* and *Ongley*, it is not possible to categorise the three adverse findings which have been made against Dr A, either as disgraceful conduct in a professional respect or professional misconduct.

16.30 **IN** this regard the Tribunal has received considerable assistance from the completely fair, unbiased and non-judgemental manner in which Mrs B gave her evidence. Her evidence came across as being entirely credible, rational, reasonable and without exaggeration.

16.31 **WE** accept that the relevance of the evidence of Dr A's good character may be both to his credibility and the likelihood that he committed the offence charged.

16.32 **IN** this case we have concluded that the character evidence is not helpful in determining whether or not Dr A has a propensity to behave in a sexually opportunistic manner.

16.33 **IT** is our opinion that such behaviour can occur in isolation from other behaviours. There are many examples of people of very high repute who have been found guilty of sexual misconduct, much to the astonishment of those who thought that they knew them. The circumstances of Mr D and his family differ greatly from those of Mrs B, and thus it may not be possible to generalise from Dr A's behaviour with Mr D to Dr A's behaviour with Mrs B.

16.34 **AS** was exhorted by Mr James, the Tribunal has carefully reviewed Dr A's conduct in the context and setting of a fragmented disrupted consultation at an extremely busy accident and emergency clinic on the night in question.

16.35 **BOTH** Mrs B's evidence and statements at earlier interviews indicate that this consultation was tainted from the very first, creating what could be termed a hostile atmosphere. It seems to us this was unwittingly caused by Dr A's early questioning about his patient's periods and her impression from the beginning that he was not listening to or acknowledging her.

Unfortunately we must agree with Mr James, as a consequence, an atmosphere of distrust and suspicion permeated this consultation.

16.36 **THE** transcript records:

"And you stated you didn't trust him from the beginning and this is what the officer is saying that you said - she immediately thought what the hell has this got to do with bronchitis. Was that a reaction that you had - Answer: yes." (Line 1, page 9, transcript)

"The whole consultation got off to a pretty awful start didn't it ... Answer: yeah." (Line 21, page 15, transcript)

"... didn't' trust him right from the start - are you able to say why you didn't trust him ... Answer: because I felt like I wasn't being listened to - because I wasn't acknowledged." (Line 23, page 18, transcript)

16.37 **FROM** the evidence it is clear that Mrs B came to the consultation with a doctor she had not met before with a firm idea of what her problem was, and from past experience, with an expectation of the type of questions she would be asked. Granted this was quite understandable, bearing in mind that she had a long history of bronchitis and chest problems which had been diagnosed and treated by the doctor she normally attended, it seems to us that Mrs B had a fixed idea about what her problem was, with an expectation as to how an examination for bronchitis would be performed. This expectation was not realised from the beginning, hence the indication in an earlier interview:

"Here we go a sleazy man" and *"She immediately thought what the hell has this got to do with bronchitis"*.

16.38 **TWO** days before, Mrs B had been diagnosed with bronchitis and despite having commenced a course of antibiotics, her condition had deteriorated sufficient for her to seek medical help from the xx Accident and Emergency Clinic on the night in question. She presented as feeling quite sick and unwell:

"She was feeling lousy". "She said she had been sick a along time with a lung infection. Almost pneumonia. She had bronchitis and had pain below her ribs front and back." (Exhibit 5, Notes of Interview).

"I was feeling really crook." (Exhibit 6, Taped Interview)

16.39 **IN** cross-examination Mrs B disclosed that she had been sexually abused in the past. She would of course be quite entitled to have a *"high suspicion index"* as a result of whatever ghastly incident occurred in the past. We find that the combination of this suspicion index, together with the unrealised expectations and different approach, gave this consultation an atmosphere of distrust and suspicion from the outset.

17. DETERMINATION:

17.1 **IT** having been established that Dr A's conduct does not amount to a sexual transgression in terms of the Medical Council's Statement, it remains for us to consider whether the conduct in question amounts to sexual impropriety.

17.2 **IN** our view Dr A's action in touching Mrs B's breasts in an inappropriate manner does meet the Medical Council's test of sexual impropriety. It was behaviour that Mrs B interpreted as being sexually demeaning to her, and also which, given our findings of failure to properly inform and obtain informed consent, demonstrated a lack of respect for her privacy. In effect, a partly intimate examination was conducted without Mrs B's consent. Dr A's basic error was to treat the breast area of the female anatomy in a way no different to the rib cage per se. Additionally his error was not to explain what he was doing, or to seek his patient's consent.

17.3 **FINALLY** the process requires us to determine whether the shortcomings identified on the part of Dr A should attract a disciplinary sanction. Regrettably we are obliged to conclude

that an adverse finding of conduct unbecoming which reflects adversely on fitness to practise medicine, should be made in this case.

17.4 **IN** *Lake v The Medical Council of New Zealand* (HC 123/96 Auckland Registry, Judgment 23 January 1998) Smellie J made the following observations which are relevant:

"A further related issue is whether, if the matter is to be judged upon the basis of what colleagues would have reasonably regarded as "conduct unbecoming", does that relate to the views of the members of the MPDC and the Medical Council - even if, as in this case, they had no or limited obstetrical expertise - or to the general body of the profession or to the views of other specialists in the same area? Gallen J addressed that question in Faris v Medical Practitioners Committee [1993] 1 NZLR 60 as follows:

> *"Mr Gendall raised a subsidiary matter as to whether the fixing of standards by the medical peers of persons subject to charges, refers to the disciplinary committee or to the wider body of practitioners. The answer to that I think is that the disciplinary committee is to be regarded as a representative body. It would be impracticable and undesirable to endeavour to set standards by some kind of referendum.* ***Those standards must be fixed by the members of the committee themselves, but in doing so they must bear in mind that they act 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****. The standards are professional in nature and need to be seen in that light. No doubt there are certain difficulties theoretically in arriving at and expressing such standards. However, this is the way in which professional bodies have always acted and in practical terms I think there would be little difficulty in determining those standards in an acceptable way. That view is in accordance with the comments in Ongley v Medical Council of New Zealand". (emphasis added).*

In the end it seems to boil down to this: if a practitioner's colleagues consider his/her conduct was reasonable the charge is unlikely to be made out. But the disciplinary tribunals 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."

17.5 **THE** charge against Dr A comprises four particulars of which we have found three to be established. It is our determination that when all three particulars are considered cumulatively,

that they amount to conduct unbecoming as statutorily qualified. As the Court of Appeal said in *Duncan v The 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. Having made the findings on the separate charges, they should arrive at a conclusion as to the overall gravity of the conduct of which they found the practitioner guilty."

17.6 **THE** seriousness with which we view particulars 1, 2 and 3 cumulatively results, in part, from the perception which led the Director to find and argue particular 3 as a sexual transgression warranting a determination of disgraceful conduct in a professional respect. Not to view the matters under focus as constituting conduct unbecoming as statutorily qualified, would in our view tend to trivialise the misconduct identified, and would have the effect of discounting patient interests and of lowering community expectations. Not to make an adverse disciplinary finding in this case would send a message to the medical profession that there are acceptable degrees of non-communication and failure to obtain informed consent. Quite obviously in this case very unfortunate misunderstandings occurred to which Dr A contributed arising out of his communication and informed consent failures.

17.7 **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).

17.8 **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* (High Court, Auckland, 11/1996, 8 July 1996) at p 15:

"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 ... 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. .... 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 standards applied by competent, ethical, and responsible practitioners. ..."

17.9 **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.

17.10 **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."

17.11 **IN** *Rogers v Whittaker* the Court accepted that medical practitioners are under a duty to exercise reasonable skill and care, not only in treatment but also in the provision of information. A practitioner owes a duty of care to his or her patient to disclose "*information*

required by a reasonable patient in the position of the actual patient". This is an objective test that recognises the particular circumstances of the actual patient.

17.12 **THE** judgment in *Rogers v Whittaker* was applied in New Zealand *B v The Medical Council of New Zealand* (supra).

17.13 **FURTHER** assistance is given by comments made by Elias CJ in her paper presented at the recent Brookfields Medical Law Symposium held in June 1999. Elias CJ 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".

17.14 **RIGHT** 5 of the Code of Health & Disability Services Consumers' Rights (the Code) 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 above approach to informed consent in *B v The Medical Council* and *Rogers v Whittaker* (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.

17.15 **THE** rights of a patient to receive information are confirmed by the Statement for the Medical Profession on Information and Consent (the Statement) published by the Medical Council of

New Zealand in 1995. This Statement makes the offering of suitable advice to patients a mandatory prerequisite to any medical procedure instituted by a medical practitioner.

17.16 **AS** we have already found, there is no credible evidence or corroboration to support the contention that there was a salacious element to Dr A's conduct. Nevertheless in the circumstances that initial interpretation was open to Mrs B because the touching of the breasts occurred without prior communication and without obtaining the requisite informed consent. Thus, as Dr A has conceded, this action was insensitive, thoughtless, lacking in basic courtesy and as such by its nature was open to an interpretation of ulterior motive.

17.17 **WE** do not agree with Mr James that Mrs B's evidence that she was not asked questions by Dr A, puts her credibility in doubt. Certainly Dr A would have obtained information from her to write up his notes. What Mr James' submission does not take into account, is Mrs B's probably rather fragile persona at the commencement of the consultation.

17.18 **DR** A's touching and lifting of his patient's breasts without explanation and consent at the conclusion of the consultation, was certainly open to an interpretation of some sleaziness or sexuality by Mrs B.

17.19 **THERE** are issues of public safety arising out of obligations imposed on medical practitioners to be effective in their communications with patients. In this instance we determine that Dr A's unbecoming conduct towards Mrs B, does reflect adversely on his fitness to practise medicine.

17.20 **COUNSEL** are invited to address the Tribunal on the question of penalties. The Director is asked to provide written submissions by **Monday 6 September 1999** followed by written submissions from Mr James by **Monday 20 September 1999**

17.21 **THE** parties are reminded of the Order made in Interim Decision No. 84/99/44D, that interim suppression of Dr A's name shall extend pending delivery of the Tribunal's written Decision on penalties.

DATED at Auckland this 20th day of August 1999

.....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal