Medical Practitioners Disciplinary Tribunal

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NOTE: NAME AND ADDRESS OF COMPLAINANT AND COMPLAINANT'S HUSBAND AND NAME AND ANY PARTICULARS WHICH MIGHT TEND TO IDENTIFY THE RESPONDENT NOT FOR PUBLICATION

DECISION NO: 103/99/49D

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 **GRANT DALE JACKSON** medical practitioner of Westport

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr T F Fookes (Chair)

Dr I D S Civil, Dr A M C McCoy, Dr J M McKenzie,

Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Christchurch on Monday 22 and Tuesday 23 November 1999

APPEARANCES: Mr M F McClelland and Ms M Thomas for the Director of Proceedings

Mr C W James for Dr G D Jackson.

1. THE CHARGE:

1.1 THE Director of Proceedings laid the following charge against Dr Jackson:

TAKE NOTICE that pursuant to section 102 and 109 of the Medical Practitioners Act 1998, the Director of Proceedings charged that on or about 17 November 1996 whilst attending on your patient, Mrs A, you being a registered medical practitioner acted in such a way that amounted to professional misconduct in that you manipulated the neck of your said patient without obtaining her informed consent.

IN PARTICULAR YOU:

(i) Failed to disclose the risks of treatment that would be considered material risks by a reasonable patient in your said patient's circumstances.

AND/OR

(ii) Failed to provide your said patient with an explanation of the options available to her, including an assessment of the risks, side effects, benefits and costs of each option.

AND/OR

(iii) Falsely represented to your said patient the likely success of the manipulative treatment.

AND/OR

(iv) Failed to explain to your said patient that the proposed treatment was not orthodox treatment by a general practitioner.

AND/OR

(v) Falsely gave your said patient the impression that you were one of only two experts in New Zealand qualified in the manipulative treatment that you were offering to provide your said patient with.

1.2 **THE** charge did not include the "statement to the effect that the Director of Proceedings ... has reason to believe that a ground exists entitling the Tribunal to exercise its powers under section 109 of (the Medical Practitioners Act 1995)" which section 102(3) of that Act ("the Act") requires to be included in the charge but, without objection, an amendment curing this was permitted at the hearing.

1.3 **FOLLOWING** an adjournment the Tribunal gave notice to counsel for both parties that it proposed to amend two of the particulars of the charge in the following respects:

Particular (ii)

By deleting the words ", benefits and costs" and substituting the words "and benefits".

Particular (iii)

By deleting the word "falsely" and substituting the word "inaccurately".

1.4 **NEITHER** counsel made any submissions in respect of the proposal and the Tribunal, which considered that the practitioner would not be embarrassed in his defence by reason

of the proposed amendments, then, pursuant to Clause 14 of the First Schedule to the Act, amended those two particulars of the charge accordingly.

2. THE PLEA:

2.1 **AT** the outset of the hearing Dr Jackson, through his counsel, pleaded not guilty to the charge. Although certain admissions (to which the Tribunal will later refer) were made this plea was maintained.

3. ONUS OF PROOF:

3.1 **THE** onus at all times lay on the Director of Proceedings. There was no onus on the practitioner to prove anything.

3.2 **IN** circumstances such as these where there is a comprehensive single charge and a series of particulars the task of the Tribunal is to examine and make a finding in respect of each particular separately. Having done that it then needs to arrive at a conclusion as to the overall gravity of any conduct of which it has found the practitioner guilty : *Duncan v MPDC* [1986] 1NZLR 513, 547. Only then can it decide whether the prosecutor has proved her case.

4. STANDARD OF PROOF:

4.1 **IT** is well-established that the standard of proof to be applied in disciplinary proceedings is the civil standard namely the balance of probabilities and 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. A finding of professional misconduct is, as McGechan J said in *Cullen v*

Preliminary Proceedings Committee (High Court, Wellington, AP 225/1992, 15 August 1994) *"a severe label"*. As the allegations made against Dr Jackson were serious, an appropriate standard of proof was applied by the Tribunal.

5. INFORMED CONSENT:

5.1 **THE** Director of Proceedings' charge is that Dr Jackson acted in a way that amounted to professional misconduct in that he manipulated the neck of his patient, Mrs A, without obtaining her informed consent.

5.2 **IN** *Sutherland v Accident Compensation Corporation* (Decision No. 34/97) the Appeal Authority referred to the following definition of informed consent by Justice Kirby in (1983) 9 Journal of Medical Ethics, 69:

"An informed consent is that consent which is obtained after the patient has been adequately instructed about the ratio of risk and benefit included in the procedure as compared to alternative procedures or no treatment at all."

This definition is not without relevance in the present case.

5.3 **SINCE** 1983, when that definition was promulgated, there have been a number of pronouncements in relation to informed consent. The requirement that a patient's informed consent to a proposed form of treatment be obtained by a medical practitioner has, in this country, at least three sources:

5.3.1 Case Law;

5.3.2 The Code of Health and Disability Services Consumers Rights;

5.3.3 A pronouncement by the Medical Council of New Zealand.

5.4 **A** leading case on informed consent is *Rogers v Whittaker* (1992) 175 CLR 479, a judgment of the High Court of Australia. In that case that patient had had to make a decision as to whether to undergo an elective operation on her eye. She was blind in the eye which was to be operated on and was concerned not to lose her sight in her "good eye". The surgeon considered that the risk that she might develop sympathetic opthalmia in her "good eye" was so small that he did not warn the patient that it was a potential complication.

5.5 **THE** Court held that there is a fundamental difference between diagnosis and treatment on the one hand and the provision of advice or information to a patient on the other.

"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 decisive role to play; whether the patient has been given the relevant information to choose between 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. … 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." (p 489 - 490)

5.6 **AS** the Tribunal noted in Decision No. 94/99/39C the concept of informed consent is based upon the patient's right to self determination. The Supreme Court of Canada has rejected a test of the adequacy of information imparted being based on the standards of medical practitioners. It said that that was inconsistent with the patients *"right to self-determination on particular therapy"*. In considering whether a doctor had disclosed risks which were material to the patient the test is based NOT on the assessment of a reasonable doctor but on the view of a reasonable person in the patient's position: *Reibl v Hughes* [1980] 2 SCR 980.

5.7 ***ROGERS*** *v Whittaker* has been followed, by Elias J (as she then was), in New Zealand in *B v Medical Council of New Zealand* (High Court, xx, HC 11/96, 8 July 1996).

5.8 **IN** a paper presented at the Brookfields Medical Law Symposium held in xx in June 1999 Elias CJ commented 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."*

5.9 **THERE** can be little doubt now that:

(a) 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 - see *B v Medical Council* at p 17*;*

(b) Informed consent to treatment is a precondition of such treatment - see para 5.8 above; (in this connection the Medical Council's September 1995 statement that it *"takes the view that (except in an emergency or a related circumstance) 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"* is relevant).

(c) The answer to whether a patient has been given the relevant information to make an informed choice between undergoing and not undergoing the treatment is a question of a different order which is to be judged <u>not</u> by the clinical judgement of medical

practitioners as to what the patient should be told nor from the perspective of the practitioner alone.

(d) The real question is whether the information relevant to choosing whether or not to undergo the treatment was imparted to the patient in terms which were reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information.

5.10 **THE** Code of Health & Disability Services Consumers' Rights provides in Right 6(1) that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive including:

"(b) An explanation of the options available ..." and

(e) Any other information required by legal, professional, ethical, and other relevant standards."

Right 6.2 provides that before making a choice or giving consent every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

6. BACKGROUND MATTERS:

6.1 **ON** 17 November 1996 Mrs A ("Mrs A") was in xx on holiday with her husband. (At that time they normally resided in xx.)

6.2 **ON** this day Mr and Mrs A drove past a clinic in xx which was advertising free mole checks.

6.3 **MRS** A had a mole on her neck which she had been a little concerned about. She had not often seen free mole checks offered in xx. She decided to have her mole checked at the clinic referred to in 6.2 and so went in and filled out a consultation form. Her husband stayed in the car.

6.4 **MRS** A had experienced neck and/or back pains for 17 years prior to November 1996.

6.5 **DR** Grant Dale Jackson was on duty at the clinic on that day.

6.6 **DR** Jackson had qualified MB ChB in 1984 and Dip Obstetrics in 1986. From 1986 to 1994 he was a general practitioner in sole practice in a small North Island town. From 1994 to the date on which he saw Mrs A, and for a time subsequently, he was a general practitioner in xx where, according to his evidence, he built a new practice involving family medicine, physical therapy and chelation therapy.

6.7 **IN** the early 1990's Dr Jackson became interested in physical medicine and studied the approach of an xx practitioner in this field. Dr Jackson made two visits to the United States to study chelation therapy. In the course thereof he attended conferences of a general nature which involved manipulative therapy and prolotherapy. Subsequently he communicated by fax, with regard to the application of some of those techniques, with an orthopaedic surgeon in the USA who used such techniques and Dr Jackson was most impressed.

6.8 **DR** Jackson told the Tribunal that in 1990 he spent a week to ten days in the xx practitioner's clinic with that practitioner after previously *"having studied the studies that he's done, the techniques that he used, the clinical patterns of musculo-skeletal things. After having basically studied the theory I spent this time with him clarifying the details of the techniques."*

6.9 **DR** Jackson said that he spent time on the telephone speaking to the xx practitioner when Dr Jackson had clients in his rooms and then referred those clients to the xx practitioner and *"followed their follow-up"*.

6.10 **DR** Jackson said he had also attended what he thought were three one day GP meetings in xx on musculo-skeletal medicine.

6.11 **HE** said that by November 1996 he was seeing daily between 15 and 20 musculo-skeletal patients, about 5 to 7 general practice patients and 25 to 30 chelation patients in his own clinic. After doing that sort of day's work he worked at the clinic referred to in 6.2. He also worked there on at least some weekends. As already noted, one of them included 17 November 1996.

6.12 **AS** at that date Dr Jackson was a general practitioner. He did not have any diploma in musculo-skeletal medicine and was not vocationally registered in that discipline.

7. THE CONSULTATION:

Mrs A's evidence (in summary) was that:

7.1 **SHE** told Dr Jackson ("the doctor") while she was seated that she was concerned about a mole on her neck. She pulled her hair up so that the doctor could look at the mole. He asked her to stand up so that he could see the mole in a better light. The doctor said to her *"you've got something wrong with your neck"* or words to that effect. She said that she did and that she had hurt it while painting years ago. She told him that she sometimes suffered from extreme headaches which were usually soothed by gentle massage and some yoga head rolls.

7.2 **THE** doctor told her that yoga exercises were doing her more harm than good and added that he specialised in the manipulation of neck, back and hips and that he could fix her neck after a few manipulations. She was positive that he said he could fix it because she remembered thinking that that was great and finally she could get it fixed.

7.3 **AS** the doctor had said he specialised in the manipulation of necks, backs and hips she told him that she occasionally got lower back pains and sometimes suffered from shooting pains from her groin to her right knee. She told him that those pains usually occurred when she lifted heavy objects or did specific yoga exercises. With her in a standing position the doctor placed his hands along the right side of her back and started to press down. She was still wearing her T-shirt and jeans. The doctor said that the joints in her vertebrae were locked which caused strain on her discs. He pushed something on the lower right side of her back which caused a shooting pain from her groin to her knee and she immediately said *"oh yeah, that's the pain"*.

7.4 **THE** doctor then told her that with manipulation the pain could go and that by following a few simple rules she could ensure the pain would not return and she would feel better than she had in a long time.

7.5 **THE** doctor took her over to a wall chart which showed a picture of the back. He pointed out on the chart what was wrong with her and explained about her vertebrae being locked, *"etc"*.

7.6 **SHE** asked the doctor whether he was qualified to do manipulation. She said that although she did not remember the exact words he said something like *"there are only two doctors in New Zealand that are qualified to do this type of manipulation"*. She told the Tribunal that he said he and the xx practitioner were the only two doctors qualified in manipulation.

7.7 **AT** no time during the discussion with the doctor did he suggest that there were any options for her apart from manipulation. She was left with the feeling that manipulation was the only treatment option she had. She was not told about any side effects at all. She said she specifically asked him whether there were any side effects. She said she asked him if there was any chance of brain damage or paralysis. (To the Tribunal she clarified that this was all rolled up into one question like *"Are there any side effects such as brain damage or paralysis?"*) She could not remember his exact reply but it was something like *"No, no, it will be fixed and it wont hurt any more"*. She conceded that she could not remember if those were the exact words used but that was definitely the impression she was left with. She felt very reassured that there were no risks involved in the manipulation.

7.8 **THE** doctor said he wanted to see if he was busy. He went to reception then came back and said that he was not busy and could do it then. Until then Mrs A had not given the doctor any indication that she wanted to be manipulated. Until that stage he had been telling her about manipulation and she had been asking questions. Now she *"felt a bit pressured"* and was not sure whether manipulation would be a good idea. (Her father had had *"a bad experience"* with a chiropractor). She told the doctor that she would like to discuss it with her husband and would also like her husband to discuss it with the doctor himself. The doctor was happy for this to happen so she went out to the car.

7.9 **SHE** estimated that by this time she had probably been in consultation with the doctor for about ten minutes. She remembered that during the consultation she felt excited at the thought that the doctor may be able to fix her back and that she would not ever have to put up with the pain again. She was, however, also feeling a bit worried because her father's experience with the chiropractor was at the back of her mind.

7.10 **SHE** spoke to her husband for a couple of minutes. She told him that the doctor had just said he could fix her back. Her husband's attitude was that if the doctor reckoned he could fix her back he was prepared to listen to the doctor.

7.11 **THEY** went into the surgery and walked straight back into the doctor's consultation room. The doctor then told her husband everything that the doctor had told her about, including what was causing the problems in her back. She was also *"pretty sure"* that the doctor also briefly took her husband over to the wall chart and told him about her discs being strained by her locked vertebrae joints. She definitely remembered the doctor telling her

husband that she would no longer have to suffer pain in her neck, back and groin after he had manipulated her.

7.12 **SHE** and her husband did not really have a discussion about whether or not she should go ahead. She remembered saying to her husband something like *"what do you reckon"* and her husband saying *"Well, if you think it's really going to help"*. At the time it all sounded feasible and good. She felt reassured that perhaps this doctor would be able to fix her. She therefore agreed to the doctor manipulating her and he did so.

7.13 **IN** the course of the manipulation of her hips and legs there were a few *"cracks"* going on. The doctor said that was normal. When her neck was manipulated there was a sudden jerk and she heard *"a very large cracking noise"*. The doctor did not explain what he was doing or what was happening.

7.14 **WHEN** the treatment was finished the doctor told her to sit up. Her husband looked hazy. She told the doctor she could see black spots and felt dizzy. She was feeling very dizzy and felt as if she was swaying. She was worried because she had asked if there could be any side effects and had been told there wouldn't be.

7.15 **THE** doctor asked her to lie down again. He cupped her hands under her chin and roller her head back and around in a circle. He asked her how she felt and she said something like *"that feels better, the spots have gone"*. When she got off the bed, though, she still felt a bit dizzy and said so. The doctor said that was quite normal after that type of manipulation.

7.16 **WHILE** she was writing out a cheque for the consultation (the doctor said she would have to pay for it even though the mole check was free) she told him that she had really bad pain in her left shoulder. He came around the counter and felt her left shoulder. He pushed it and asked *"is this where it hurts?"* She told him that it was. The doctor told her husband that he (the husband) would have to rub her shoulder and showed him how to do it. She still felt dizzy and the pain in her shoulder was bad. She was worried about her condition. She thought she may need to see the xx practitioner who she had been told was qualified in manipulation and based in xx where she then lived. She asked the doctor to write down what he had done to her. The doctor seemed to get really *"stand-offish"*. He gave her a consent form and said *"Well, first could you sign this form"*. Asked what he meant he said something along the lines that she had come into the surgery asking him to fix her back. She told him that was not how it happened. She reminded him that she had come in for a mole check and that he had suggested she have a neck manipulation. She wrote *"I requested Dr Jackson to fix my back by manipulation"* and handed the form back to the doctor. She said *"Just in case I need to see (the xx practitioner), could you please write down what you did"*. The doctor then wrote some information on the form.

7.17 **THAT** night when she lay down her back hurt. It was a very different type of pain from that which she had felt before. It was very uncomfortable lying and standing. By the second night she had a lot of pain in her neck, lower back and hips and the shooting pain from her groin to her knee was also on the left leg as well as the right. She had never had it in the left leg before.

7.18 **LATER** she saw her general practitioner and had x-rays. She is now undergoing musculo-skeletal treatment from a doctor who specialises in that field and is a member of the New Zealand Association of Musculo-skeletal Medicine.

7.19 **CROSS-EXAMINED** Mrs A said that the first part of the consultation (when she was alone with the doctor) lasted 10 minutes. The second part from when she and her husband walked back in to when she went to pay was 20 minutes or *"around 15 to 20 minutes"*.

7.20 **DESPITE** being skilfully cross-examined Mrs A did not resile from or change her evidence in any material respect. We found her to be a thoroughly credible witness. We think that after so many years of chronic pain she, after listening to what the doctor said, developed a high expectation that manipulation by the doctor would fix her back and that, when it not only did not do so but was followed by pain which she had not previously had, she was extremely disappointed and perhaps even bitter about her encounter with the doctor. We do not however consider that this of itself adversely affects her credibility and we note that much of what she says was, or was not, said during the consultation is now borne out by concessions made by the doctor during the hearing before the Tribunal.

7.21 **WE** have also seen the letter which Mrs A wrote to ACC on 6 January 1997 (50 days after the consultation). Although her evidence is more detailed than was the letter there is no startling inconsistency between the two and the letter tends to confirm the thrust of her evidence to the Tribunal.

Mr A's evidence (in summary) was that:

7.22 **HIS** wife went to the clinic on 17 November 1996 to have a mole on her neck checked. After she had been in the clinic for about 10 minutes she came back out to the car and spoke to him. She told him that she had seen a doctor who had said that he could fix her back but that she did not want the doctor to do anything to her back until her husband had heard what the doctor had had to say.

7.23 **HIS** wife had had back problems for about 17 years. Everything she had tried had not worked that well. The back pain used to get her down a lot. When she came out to the car she seemed elated that someone was finally going to be able to fix her back.

7.24 **HE** agreed to meet the doctor and he and his wife walked straight back into the doctor's consultation room.

7.25 **THE** doctor gave Mr A a fairly brief explanation of his wife's back and treatment. The doctor spoke about Mrs A's problem and said that he could fix it with manipulation. The doctor did not go into details of what manipulation was. Although the discussion with the doctor was brief the doctor did say that he was one of only two doctors in New Zealand that were trained in this type of therapy. Mr A clearly recalled that the doctor also said that through this therapy he could manipulate Mrs A's back and she would not be in any more pain again.

7.26 **MR** A remembered that the doctor was really enthusiastic about the therapy. Mr A was left with the impression that the doctor knew what he was doing and that, from what he

was saying, there was nothing to lose and everything to gain for Mrs A. Mr A felt, from what the doctor was saying, that if Mrs A did not have the treatment that day she would be missing an opportunity to be cured and that it may be the only opportunity she would have to be cured.

7.27 **DURING** the conversation the doctor gave no indication that there was any risk from the manipulation. The explanation given by the doctor was brief. Mr A thought it took about five minutes which included the doctor showing him a chart of the human back.

7.28 **AT** the conclusion of the explanation he and his wife "*sort of looked at each other*" and he gave his "*nod of approval to (his wife)*". She then agreed that the doctor should go ahead with the manipulation (which, along with what happened after it, Mr A described).

7.29 **HIS** evidence was generally consistent with his wife's. He had not heard her giving evidence as he was, by order of the Tribunal, excluded from the room while she gave her evidence.

7.30 **IN** cross-examination Mr A said (in summary) that:

(a) While he sat alone in the car his wife was away (seeing the doctor) for "*10 minutes, 12/13 minutes max ...*".

(b) What the doctor communicated to Mr and Mrs A (after Mr A went into the consultation room with his wife) "*virtually seemed a guarantee*" (that the pain might be able to be got rid of) but that he could not recall the doctor's exact words at the time.

(c) He was more sceptical than his wife (about what was likely to be achieved by the proposed treatment) but from what the doctor was saying it was a win/win situation.

(d) What had convinced him that the proposed treatment was right for his wife was a combination of the doctor's confidence in what he (the doctor) was doing or proposing to do, the fact that he indicated that there were only two people in the country qualified to carry out this type of manipulation and that if they did not take the chance now it would probably be A's last chance - this last was however his interpretation of the atmosphere; those were not the doctor's words.

(e) The doctor appeared to be quite solicitous towards Mrs A - quite compassionate and quite gentle.

(f) The gist of his concern for his wife was that she was given an indication of a result which did not occur and she was not warned of what did occur.

(g) The xx practitioner was not offered as a voluntary referral by the doctor. Mrs A had sought detail on the treatment which she had been given so that if she needed to she would have something to take to him.

7.31 **QUESTIONED** by the Tribunal Mr A said that, during the time he was with the doctor, the doctor did not tell Mr A that any risks were associated with the proposed manipulation or that any side affects might occur. Mr A also said that in his presence his wife asked the doctor whether she would need further manipulation afterwards and was told this treatment was all that would be required.

7.32 **MR** A did not recall all events with the same clarity or in the same detail as his wife but the Tribunal found him to be a credible witness whose evidence generally supported that given by his wife in his absence from the room.

Medical Evidence:

7.33 **THE** prosecution called evidence from Dr J M Borowczyk a medical practitioner who is the holder of a diploma in musculo-skeletal medicine, the immediate past president of the New Zealand Association of Musculo-skeletal Medicine and the current Chairman of Accreditation of that Association. He had been asked by the Director of Proceedings to provide his opinion in respect of Mrs A's complaint and had reviewed various documents (not all of which were produced to the Tribunal).

7.34 **IN** summary it was his opinion that:

(a) In the hands of a competent manual practitioner, the risks of manipulative therapy are very small.

(b) There are well-documented adverse effects from manipulative therapy and these generally fall into three categories:

(i) <u>High velocity thrust techniques applied to the cervical spine</u>

The medical literature contains reference to severe, sometimes fatal, neurological sequelae (strokes) occurring after cervical manipulation. There is no reliable diagnostic screening test to predict who may be at risk although thankfully the incidence of fatal outcomes is extremely low.

(ii) <u>Manipulative techniques applied in the presence of other significant disease processes</u>

There are contraindications to manual therapy in the presence of certain other disease processes. The onus is on the practitioner to exclude the presence of such disorders prior to therapy and this may only be achieved utilising a reasonable index of clinical suspicion and appropriate clinical investigation. Again, problems of this type are rare.

(iii) Immediate after-effects of manipulation

It is not uncommon for people who have undergone manipulation, especially cervical manipulation, to experience some minor but non-threatening after effects. The most common of these are transient dizziness or light-headedness, a feeling of extreme tiredness and a feeling of cold. It would be usual to explain to a patient that there may be a period of these symptoms after therapy or even an increase in their pain levels but that this is short lived and usually harmless.

(d) It could be reasonable to expect a practitioner to inform their patient, before treatment is commenced, of several different patterns of common response which are recognised after such therapy. These include, among others:

- no change in the patient's symptoms
- a worsening of symptoms followed by either a return to the previous baseline or an improvement
- an improvement in symptomatology followed by a gradual return to the baseline.
- an improvement which is sustained.

(e) In view of the long term nature of Mrs A's problem it is likely that she had already exhausted most of the medical options open to her. What remained for most patients with a chronic musculo-skeletal problem is:

- seeking out therapy alternative to orthodox medicine
- seeking treatment from a practitioner or institute specialising in chronic pain problems
- seeking treatment from a practitioner or institute specialising in musculo-skeletal problems

(given the availability of any of these options).

(f) The doctor could have advised Mrs A of the options available, both locally and in her own residential area, as outlined above, and it could have been reasonable for the doctor to outline any potential risks but also inform her that the risks from such treatment properly performed are small. It would have been reasonable to outline the possible transient side effects.

(g) The potential benefits from appropriate manipulative therapy are reasonably good in cases such as Mrs A - probably of the order of 50-70% in the longer term in terms of providing a reduction in pain and an increase in mobility. It would have been reasonable for the doctor to inform Mrs A of these benefits.

(h) The costs are dependent on the number of sessions required to produce the end result and the cost to the patient of each session and the doctor could have been expected to give Mrs A information in this regard.

(i) It would be reasonable to expect that a practitioner proposing to treat a patient for musculo-skeletal problems and/or chronic neck pain would give the patient accurate and objective information as to the perceived likelihood of the success of the treatment as well as information about the different patterns of common response to such therapy.

(j) It would also be reasonable to advise a patient how many sessions would be required to produce an effective long term response and the cost to the patient. In Mrs A's case it would be normal that several sessions of treatment, spread out over a period of time, would be required.

(k) He could not comment on how appropriate it was for a treatment provider to change the agenda in the course of a consultation but if this is done it should certainly be a very transparent process, with the sure knowledge on the treatment provider's behalf that he has a particular skill to offer and that *"all possible options and information about those options are made available to the consumer before the treatment is provided"*.

7.35 **IN** cross-examination he said that manipulative therapy was considered orthodox whether taught by the xx practitioner or anyone else. The basis of the technique is accepted and orthodox in medicine. Questioned by the Tribunal he said that he would accept the treatment is not common for a general practitioner to provide but would not accept it was not orthodox.

7.36 **HE** told Mr James that at the end of 1996 it was reasonable for the doctor to intimate to the patient the belief that he and the xx practitioner were the only two - possibly the only two in New Zealand - offering prolotherapy. (The question of course assumed that that was what the doctor had said to Mrs A. We shall deal with this further in discussing Particular (v).)

7.37 **THE** prosecution also called evidence from Dr D W Kerr an experienced general practitioner whose services to his patients include musculo-skeletal and manipulation services. He had considered the same material as Dr Borowczyk and provided an opinion.

7.38 **HE** was of the view that the material risks of the proposed treatment included the possibility of aggravation of symptoms, the possibility of no improvement whatsoever in symptoms and finally a variety of neurological and/or vascular problems. (He considered the risk of neurological and/or vascular problems to be very low). It is important that a patient with long-standing pain is advised that there is a significant risk of non-resolution or even an aggravation of symptoms. This was even more critical when the patient was going to be seen on only one occasion by the clinician.

7.39 **IN** the area of options he considered that Mrs A had the option of accepting the treatment offered by the doctor, that the doctor could have obtained relevant information from other medical advisers to Mrs A before intervening and that Mrs A could have been given (by the doctor) the option of discussing the therapy with her other medical advisers or general practitioner.

7.40 **GIVEN** that Mrs A opted to have the treatment Dr Kerr considered it was incumbent on the doctor to give her information about the risks, benefits, side effects and costs of that option prior to treatment. The absence of a clear explanation in all these areas would result in any consent being uninformed.

7.41 **IN** his opinion the likely success of a single manipulative treatment was low (the reasons being that this was a long term problem for Mrs A and her pain was long-standing and occurred at multiple levels throughout her vertebral column). He considered that the doctor oversold the benefit of a one-off treatment. Instead he should have given her a clear idea that there was no guarantee of improvement in her situation, that this was a treatment not all GP's would endorse and that the greatest risk was that no improvement may be realised and that deterioration in her pain may occur. He should also have given her information about the costs of this treatment and about his own training and experience in the area.

7.42 **AS** to Particular (iv) Dr Kerr said that a general practitioner should advise a patient that he or she has or has not been trained in this discipline, undertakes it frequently or occasionally and has used it, or not used it, in this clinical situation. In his view the type of information which should be provided to a patient and discussed prior to providing musculo-skeletal or manipulative therapy is the same, regardless of the specific technique ultimately performed.

7.43 **IN** summary he considered that the doctor over-represented the ability of this manipulative therapy to improve Mrs A's problem with one treatment, under-represented the potential downside (i.e. a possible increase in her pain) and did not obtain her informed consent before treating her.

7.44 **THE** Tribunal found Dr Kerr a good witness whose evidence when tested in cross-examination stood up well.

Other Evidence:

7.45 **PRODUCED** to the Tribunal by consent were:

(a) The form filled in at the clinic on 17 November 1996 by Mrs A and thereafter the doctor.

(b) Mrs A's letter of complaint to ACC dated 6 January 1997.

(c) The doctor's letter dated 22 October 1997 to the Health & Disability Commissioner.

(d) A transcript of an 80 minute meeting on 10 May 1999 between the Director of Proceedings and the doctor.

(e) The charge formulated by the Director.

7.46 **ALSO** produced to us in the course of the doctor's evidence were:

(a) a copy of a letter dated 9 April 1997 which he sent to the ACC;

(b) a copy of his letter dated 30 November 1998 to the Health & Disability Commissioner.

7.47 **THE** Tribunal has therefore been able to read four documents involving a response by the doctor to the matters complained of by Mrs A (those lettered (c) and (d) in 7.45 and (a) and (b) in 7.46).

The doctor's evidence:

7.48 **THE** doctor gave evidence. He answered questions from his counsel, read a document which he had himself prepared and which was called a brief of evidence (although it included material more correctly described as submissions), was cross-examined and re-

examined and answered questions put to him by members of the Tribunal. The Tribunal has had an opportunity not only to see and hear him give evidence but to compare that evidence with what he has said on prior occasions.

7.49 **AS** the hearing proceeded Dr Jackson made a number of concessions. For example, with reference to Particular (i), he recognised that there were some material risks that it would have been reasonable to have mentioned but that he did not mention, conceded that his conduct in telling Mrs A about the risks of treatment had been deficient and that there were aspects that he would most properly have added and agreed that he *"fell short"* in that he did not indicate the risks that someone like Mrs A should be aware of before he embarked on the procedure he undertook.

7.50 **BY** way of further example he agreed in respect of Particular (ii) that he had offered her one option which he considered useful but did not canvass other options and that he did not talk of other options that might have been available.

7.51 **IN** respect of Particular (iii) he made some limited concessions. He disputed Particulars 4 and 5 throughout.

7.52 **IN** relation to the Particulars of the charge his position at the conclusion of his re-examination was summed up in the following question and answer:

"So you are admitting, in essence, to 2 ½ of the particulars but taking issue with (iv) and (v) is it? I think that's right, yes."

7.53 **THE** Tribunal does not propose to set out the whole of the doctor's evidence. Instead it will detail some clear conclusions which it has reached after hearing the evidence and then deal with each of the five Particulars to the charge individually.

7.54 **THE** Tribunal has reached the clear view that because of:

(a) his enthusiasm for what he considered he had learned from the xx practitioner, from his own studies and from the conferences he had attended both in this country and the United States; and

(b) the experience which he had had in manipulating patients by a musculo-skeletal process (he told the Tribunal that as at November 1996 it would have to be well beyond 1000 patients he had so manipulated, probably several thousand) without being aware of any who had suffered a sustained worsening of their condition

in November 1996 the doctor had considerable confidence in his ability to diagnose musculo-skeletal problems and treat them effectively by manipulation.

7.55 **IT** is also the Tribunal's clear view that when Mrs A came to the clinic in November 1996 for a mole check and the doctor observed what he thought was something wrong with her neck he genuinely thought, in a well-intentioned way, that - at what was a quiet time for him in the clinic - he had both the opportunity and the ability to assist Mrs A (and make her holiday more enjoyable) by manipulating her. He thus raised with her the condition of her neck and then learned of her other symptoms. At that point he would, in the Tribunal's view, have been much wiser to outline her treatment options to her and leave her to continue her holiday. Instead he chose to treat a problem with a 17 year history by a single manipulation.

7.56 **THE** Tribunal does not consider that the consultation fee motivated him to offer the treatment (he was paid by the hour). Nor does it think that he made the offer to fill in time on a quiet day. The Tribunal considers that he thought that he had the ability to help the patient if he could manipulate her and thus raised the issue with her. Unfortunately his confidence in the treatment and in his own ability appear to have resulted in his overlooking the difference between obtaining the patient's agreement to undergo the suggested treatment (which he plainly obtained) and providing her with sufficient relevant information - as to the risks, benefits, possible side effects and other options - to enable her to make an informed choice as to whether or not to undergo the treatment he was offering her. Having decided to offer the treatment to a patient with a 17 year history of problems it was particularly important for him to fully outline the risks, benefits, side effects and possible outcomes of that treatment so that she could make an informed choice. It was not enough to explain the diagnosis; particularly in the case of a patient with a history of 17 years of problems and who the doctor had not previously met. A realistic and informative assessment was required.

7.57 **THERE** are disputed questions of fact in relation to the consultation. Where it is necessary to resolve them the Tribunal will do so in the course of its findings in relation to the individual Particulars. Some disputes are however not of significance on the view which we take of the Particulars to which those disputes relate.

8. THE PARTICULARS:

Particular (i):

8.1 **PARTICULAR (i)** alleges that the doctor *"failed to disclose the risks of treatment that would be considered material risks by a reasonable patient in your said patient's circumstances"*.

8.2 **IN** her paper on the topic of informed consent delivered at the Brookfield's Medical Law Symposium in June 1999 the Chief Justice said that:

"It is clear that where proposed treatment, ***even if skilfully performed,*** *carries a "material" risk, a patient has a right to be informed of those risks. .... The patient's right imposes a concomitant duty on the medical practitioner to inform .... Whether that duty has been performed in the particular case depends upon all the circumstances and is not determined by medical practice."* (emphasis added).

8.3 **THE** Tribunal is satisfied that, before she made a decision as to whether to undergo the treatment which the doctor was proposing, Mrs A had a right to have disclosed to her at least the following material risks:

(a) that the treatment might result in her feeling dizzy, light-headed, extremely tired or cold (for a period);

(b) that the treatment might result in no improvement in her symptoms;

(c) that it might result in a worsening of symptoms followed by a return to the baseline or an improvement;

(d) that it might result in improvement followed by a gradual return to the baseline.

8.4 **THE** Tribunal does not wish to be misunderstood. It does not say that there were no other risks which were material. What it says is that, on any view of the matter, these risks should have been but were not disclosed to Mrs A by the doctor.

8.5 **THE** Tribunal considers that the principal reason why they were not disclosed is that the doctor believed so strongly in the likely benefits of the treatment and his ability to perform it efficiently and safely that he did not direct his mind to the possible downside. This is no excuse. The patient has a right to know of material risks which might eventuate even if the treatment is skilfully performed.

8.6 **THE** Tribunal also considers that the doctor needed to be especially careful in dealing with the issue of risks given that Mrs A had specifically raised the question of possible side effects with him.

8.7 **IN** the Tribunal's view the doctor was right to make the concessions, in relation to Particular (i), which are set out in 7.49. His outline of the risks attaching to the proposed treatment was incomplete and inadequate. The Tribunal is satisfied that this Particular has been proved and that the conduct in question fell below acceptable professional standards.

Particular (ii):

8.8 **PARTICULAR (ii)** as amended by the Tribunal alleges that the doctor "*failed to provide (his) said patient with an explanation of the options available to her, including an assessment of the risks, side effects and benefits of each option.*"

8.9 **THERE** is, as noted in 7.50 above, an acknowledgement by the doctor that he offered the patient one option but did not canvass others which might have been available.

8.10 **THE** Tribunal finds on the evidence that the doctor ought to have explained to Mrs A that the options available to her included at least the following:

(a) Accepting the treatment offered by him.

(b) Not accepting the treatment at that time but on her return to xx discussing the doctor's proposed therapy with her usual medical advisers.

(c) The doctor himself obtaining full information concerning her from her other medical advisers before he intervened;

(d) Seeking treatment from a practitioner or institute specialising in chronic pain or musculo-skeletal problems.

8.11 **THESE** options were not explained. What the doctor claimed in this area was that he had referred the patient to the xx practitioner. As to this, the Tribunal accepts the evidence of Mrs A that it was only when she said that in case she needed to see the xx practitioner she wanted the doctor to write down what he had done that he then wrote on the "consent form" some notes which concluded with the sentence:

"Referred to Dr (name of xx practitioner) of xx for follow up."

The Tribunal does not consider that this constituted a referral to the xx practitioner. While the doctor may have envisaged the possibility that Mrs A might consult the xx practitioner there was no letter, telephone call or other communication from the doctor to the xx practitioner about Mrs A and none was attempted during or after the consultation. What happened here was not, in any conventional sense, a "referral".

8.12 **THE** options available to her and set out in 8.10 above were not explained to Mrs A. Nor was any assessment made for her of the risks, benefits and side effects of each. The

Tribunal finds that Mrs A was entitled to, but did not, receive that information from the doctor to enable her to make an informed choice as to whether or not to undergo the manipulation then and there. The absence of any advice of the existence of other options is probably what resulted in the patient and her husband feeling that this might be the only opportunity for her to be cured.

8.13 **AGAIN** the Tribunal considers that the root cause of the failure to advise of the existence of other options was the doctor's belief in the treatment which he proposed to offer and in his ability to perform it safely and in a manner which he expected would assist his patient. No such beliefs, however, can justify the failure to provide the patient with relevant information which she was entitled to, and needed, before she could make an informed choice as to whether to undergo the treatment which was being offered.

8.14 **THE** Tribunal considers that the doctor's concession as to Particular (ii) was correctly made. It finds Particular (ii) proven and that the failure in this regard also fell below acceptable professional standards.

Particular (iii):

8.15 **THIS** Particular originally alleged that the *"doctor "falsely" represented to (his) said patient the likely success of the manipulative treatment"*. The Tribunal was satisfied that the doctor did not deliberately misrepresent the likely success of the treatment and that he genuinely believed that it was likely to result in some benefit for the patient.

8.16 **THE** Tribunal is however in no doubt that by not advising the patient of the possibility of an unsuccessful or even adverse outcome of the manipulative treatment, he inaccurately represented to her the likely success of the treatment. Because of this failure he caused her to think that a successful outcome would result and that she would have her back problems "fixed". If he had outlined the various possible outcomes of the proposed treatment (which he did not) she could not have come to that conclusion. She would then have understood that relief was one possibility but certainly not the only one.

8.17 **THE** Tribunal finds Particular (iii) as amended proved to the necessary standard and that the doctor's conduct fell below acceptable professional standards.

Particular (iv):

8.18 **THIS** Particular alleged that the doctor *"failed to explain to the patient that the proposed treatment was not orthodox treatment by a general practitioner"*.

8.19 **BEFORE** the prosecution could succeed it would have to establish:

(a) that the proposed treatment was not orthodox treatment by a general practitioner; and

(b) that the doctor, knowing this, failed to explain it.

8.20 **THE** prosecution has failed to prove the first of those two propositions and Particular (iv) is accordingly not proved.

Particular (v):

8.21 **PARTICULAR (v)** alleged that the doctor *"falsely gave his said patient the impression that he was one of only two experts in New Zealand qualified in the manipulative treatment that he was offering to provide his said patient with"*.

8.22 **THE** manipulative treatment which the doctor was offering to provide the patient with involved manual manipulation of the neck, back and hips. The Tribunal is not satisfied, to the required standard, that the doctor said or otherwise represented that he was one of only two experts in New Zealand qualified in that treatment.

8.23 **ON** the evidence the Tribunal considers it at least possible that at some point in the discussions with Mrs and subsequently Mr A the doctor, without using the word "prolotherapy" or explaining that that technique involved an injection, claimed with reference to that technique that he and another doctor were the only New Zealanders experienced in it. The Tribunal considers it possible that this reference was misunderstood by the patient and her husband to be a reference to the manual therapy the doctor was offering her.

8.24 **WHETHER** or not that is so the prosecution has failed to satisfy the Tribunal that the doctor falsely represented that he was one of only two experts in the treatment that he <u>was</u> offering and this Particular must be dismissed.

8.25 **THE** next question for the Tribunal to consider in view of its findings in respect of Particulars (i), (ii) and (iii) is whether the proven conduct amounts to professional

misconduct as charged. The test, as laid down in *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369, 375, is:

"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?"

8.26 **THE** first point to make is that informed consent is an important aspect of medical practice. Any failure to obtain it is likely to be regarded as a serious matter.

8.27 **THE** Tribunal's view is however that even in aspects of medical practice which are demonstrably important (such as is certainly the case with informed consent) it is a question of degree, to be determined on the facts of each case, as to whether a breach of acceptable professional standards warrants the "severe label" of professional misconduct.

8.28 **IN** this case the consultation was not rushed. In the first instance the doctor saw her for at least ten minutes. No treatment took place then. Some of that time involved his explaining his diagnosis, illustrating it by reference to the wall chart and recommending treatment by manipulation. During this period Mrs A was able to, and did, ask questions. The doctor then permitted her to leave and have a discussion with Mr A in the doctor's absence. Mr A then came into the consultation room with his wife, received the doctor's explanation and had the opportunity to ask whatever questions he wished before his wife, who was of course present during this second period, made her decision. She was not in any way deprived of her right to decline to be manipulated and the Tribunal is satisfied that she was aware that that course was open to her.

8.29 **IN** total, and taking into account both the times when Mrs A was in the room, the doctor spent at least 30 minutes with her (including the time which the manipulation took) and in that time there plainly was at least some explanation and discussion of what was proposed. It did not go far enough and it fell below acceptable professional standards because it did not give Mrs A relevant information which she was entitled to and involved an inaccurate representation as to the likely success of the proposed single manipulation. The consent to treatment which she gave was not fully informed consent. For that the doctor is answerable but the Tribunal, having carefully considered the question and debated it and having had regard to all the facts of the case, is not satisfied, to the required standard, that the proven conduct meets the test for professional misconduct.

8.30 **IN** his final address Mr McClelland anticipated that Mr James would, in his address, suggest that this was a case not of professional misconduct but of conduct unbecoming. Mr James did not let Mr McClelland down. It is implicit in the submissions of both counsel that, once the Tribunal has found any of the particulars of the charge established and that the conduct in question fell below acceptable professional standards, it is then for the Tribunal to determine the level at which a finding adverse to the practitioner should be made. The Tribunal agrees this is the correct approach.

8.31 **IN** *B v Medical Council* Elias J (as she then was) said:

> *"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. .... 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."*

8.32 **WE** have no difficulty on this issue. The Tribunal is unanimous that the proven conduct covered by Particulars (i), (ii) and (iii) departed from acceptable professional standards and to an extent significant enough to attract sanction. That conduct was not an acceptable discharge of the practitioner's professional obligations. Unbecoming conduct is proven.

8.33 **BECAUSE** of the wording of s 109(1)(c) of the Act to have been guilty of conduct unbecoming a medical practitioner is not per se sufficient to expose a practitioner to the risk of an order under s 110. It must also be proved that the conduct, as well as being unbecoming a medical practitioner, reflects adversely on the practitioner's fitness to practise medicine.

8.34 **NOT** every act of "conduct unbecoming" will reflect adversely on fitness to practise medicine.

8.35 **THE** words of s 109(1)(c) do not require the prosecution to prove that the practitioner is at the time of the hearing unfit to practise medicine. As the Court said in *Complaints Assessment Committee v Mantell* (District Court, xx, NP 4533/98, 7 May 1999):

"The section requires assessment of standards of conduct using a yardstick of fitness. It does not call for an assessment of individual practitioners fitness to practise."

Earlier in its decision the Court had said that:

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

practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."

8.36 **THE** Tribunal has no doubt that the proven conduct covered by Particulars (i), (ii) and (iii), relating as such conduct does to such an important area of medical practice and involving a clear failure to disclose risks and other options which ought to have been made known to the patient, and an inaccurate representation as to the likely success of proposed treatment, is of such a kind as to put in issue whether or not the doctor is a fit person to practise medicine and is inconsistent with what might be expected from a practitioner who acts in compliance with standards normally observed by those who are fit to practise. It finds that such conduct, as well as being conduct unbecoming a medical practitioner, reflects adversely on the practitioner's fitness to practise medicine.

8.37 **THE** Tribunal finds:

(a) that the allegation that the doctor manipulated the neck of Mrs A without obtaining her informed consent is proved to the required standard in respect of Particulars (i), (ii) and (iii);

(b) that the overall gravity of the conduct of which it has found the practitioner guilty is such as to warrant that conduct resulting in a finding against the practitioner of conduct unbecoming a medical practitioner and which reflects adversely on the practitioner's fitness to practise medicine.

9. DECISION:

9.1 **FOR** the foregoing reasons the decision of the Tribunal in respect of the charge laid against him by the Director of Proceedings is that Dr Grant Dale Jackson has been guilty of conduct unbecoming a medical practitioner and that conduct reflects adversely on his fitness to practise medicine.

9.2 **THE** Tribunal requests submissions from counsel as to penalty. Counsel for the Director of Proceedings are requested to file their submissions with the Secretary of the Tribunal and serve a copy on counsel for the doctor no later than ten working days after the date of receipt of this Decision. Counsel for the doctor is requested to file his submissions with the Secretary of the Tribunal and serve a copy on counsel for the Director of Proceedings not later than ten working days after receipt of counsel for the Director's submissions.

9.3 **FOR** the purposes of 9.2 no day between 25 December 1999 and 14 January 2000 inclusive will be counted as a working day.

9.4 **COSTS** are reserved.

9.5 **THE** interim order for suppression of the doctor's name is to remain in force pending the Tribunal's decision on penalty. Whether it should thereafter be maintained, varied or lifted should be dealt with in the submissions of counsel.

9.6 **THE** Tribunal seeks full information, in the submissions as to penalty, as to whether the doctor's practice of medicine is currently under any supervision or oversight by the

Medical Council and if so the nature of any directions or requirements issued by it to or in respect of the doctor and the reasons for them.

DATED at Wellington this 15th day of December 1999

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T F Fookes

Senior Deputy Chair

Medical Practitioners Disciplinary Tribunal