MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 237/02/89D

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 **RICHARD WARWICK GORRINGE** medical practitioner of Hamilton

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Dr R W Jones, Dr C P Malpass, Dr A A Ruakere,

Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Hamilton on Monday 19 to Friday 23 August and Monday 18 to Thursday 21 November 2002

APPEARANCES: Ms M McDowell for the Director of Proceedings, Ms T Baker, counsel assisting

Mr A J Knowsley for Dr R W Gorringe, Ms K Bicknall, counsel assisting

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HEARING AND SUBMISSIONS

1. The hearing was held in August 2002 and resumed again in November 2002 covering eight hearing days. Written submissions were received in February 2003 and the Tribunal re-convened in March 2003 to consider them.

THE CHARGES SUMMARISED

Yvonne Short

2. The charges against Dr Gorringe in relation to Mrs Short relate generally to the period 19 March 1998 to 1 October 1998. They are summarised below:

Professional Misconduct – Diagnoses (Particulars 1.1 to 1.5)

3. It is alleged that Dr Gorringe relied unduly on Peak Muscle Resistance Testing (PMRT) in diagnosing paraquat poisoning; and reached that diagnosis when it was not supported by Mrs Short's history or clinical presentation; and failed to carry out any other diagnostic tests to confirm or exclude his diagnosis. (Particular 1.1).

4. It is alleged that in diagnosing cytomegalovirus, Legionella infection and electromagnetic radiation sensitivity Dr Gorringe:

   (a) Failed to undertake an adequate clinical examination;
   (b) Relied unduly on PMRT to reach the diagnoses;
   (c) Failed to carry out any other diagnostic tests to confirm his diagnoses; and
   (d) Reached a diagnosis not supported by Mrs Short's history or clinical presentation. (Particulars 1.2 to 1.5)

Professional Misconduct – Lack of explanation – Lack of informed consent – PMRT (Particular 2)

5. It is alleged that Dr Gorringe carried out PMRT without adequately explaining this diagnostic technique. In particular, it is alleged he failed to advise Mrs Short of its advantages and disadvantages when compared to conventional and generally recognised diagnostic

investigatory techniques; and/or failed to advise her of the degree to which PMRT had been scientifically evaluated for efficacy as a diagnostic tool; and in failing to give an adequate explanation he failed to enable Mrs Short to make an informed choice and therefore failed to obtain her informed consent to PMRT.

Professional Misconduct – Lack of Explanation – Lack of Informed Consent – Other Treatments (Particular 3)

6. It is alleged that Dr Gorringe provided and/or arranged to be provided various treatments or the combination thereof, namely, homeopathic paraquat injections, homeopathic drops, laser management, and spiritual healing, and also required Mrs Short to forego conventional medical treatment including topical steroid creams and Histafen without advising Mrs Short of the risks, benefits and efficacy of the treatment options; and in failing to give such treatment/management he failed to enable Mrs Short to make an informed choice, and therefore failed to obtain her informed consent to the treatment/management.

Professional Misconduct – Documentation (Particular 4)

7. As an alternative to charges two and three, it is alleged that Dr Gorringe failed to adequately document any explanations given to or informed consent received from Mrs Short.

Professional Misconduct – Exploitation (Particular 5)

8. It is alleged that Dr Gorringe knew or ought to have known that the various diagnoses (paraquat poisoning, cytomegalovirus, Legionella infection and electromagnetic radiation sensitivity) were not supported by Mrs Short's clinical presentation and thus exploited Mrs Short for financial gain by

    (a) continually advising and/or reassuring her that her condition was improving; and/or
    (b) by advising her to purchase homeopathic treatment from him; and/or
    (c) by advising her to attend follow up appointments for the monitoring of her condition and/or treatment.

Disgraceful Conduct in a Professional Respect

9. There is a further charge in relation to Mrs Short, namely, disgraceful conduct. It is alleged:

(a) Dr Gorringe, during the period 19 March 1998 and 1 October 1998 in his management of Mrs Short knowing she had been previously diagnosed with chronic eczema and, having diagnosed her variously with paraquat poisoning, cytomegalovirus, Legionella infection and electromagnetic radiation sensitivity required her to cease her then current medication (including Histafen and topical steroid creams) which he knew, or ought to have known, were essential to the ongoing management of her condition (Particular 1.1); and/or

(b) Dr Gorringe, during the period 19 March 1998 and 1 October 1998, in his management of Mrs Short when he knew, or ought to have known, of her severe continuing physical and psychological deterioration continued to advise and/or reassure her that her condition was improving and would continue to improve when he knew or ought to have known this was not correct)Particular 1.2); and/or

(c) Dr Gorringe, between 27 March 1998 and 1 October 1998 when he knew, or ought to have known, that Mrs Short's physical and psychological condition had deteriorated and was continuing to deteriorate:

(a) failed to reinstate her former medication in a timely manner; and/or

(b) failed to prescribe other medication appropriate to her condition in a timely manner; and/or

(c) failed to advise her to seek further medical care or advice; and/or

(d) failed to refer and/or consult with an appropriate specialist regarding her clinical condition at any time during this period.

Ms Ghaemmaghamy

10. In relation to Ms Ghaemmaghamy, the Director of Proceedings has laid the following charge against Dr Gorringe relating to the period 21 March 1998 to 5 May 1998.

Professional Misconduct – Brucellosis Diagnosis (Particular 1)

11. It is alleged that during this period in diagnosing brucellosis, Dr Gorringe

(a) failed to undertake an adequate clinical examination; and/or

(b) relied unduly on PMRT to reach his diagnosis; and/or

(c) failed to carry out any other diagnostic tests to confirm his diagnosis; and/or

(d) reached this diagnosis when it was not supported by Ms Ghaemmaghamy's clinical presentation.

Lack of Explanation – Lack of Informed Consent – PMRT (Particular 2)

12. It is alleged that Dr Gorringe carried out PMRT as a means of reaching the diagnosis of brucellosis without adequately explaining PMRT and in particular

(a) failed to advise Ms Ghaemmaghamy of its advantages and disadvantages when compared to conventional and generally recognised diagnostic/investigatory techniques; and/or

(b) failed to advise her of the degree to which PMRT had been scientifically evaluated, for its efficacy as a diagnostic tool;

and in failing to give an adequate explanation regarding PMRT is alleged to have failed to enable Ms Ghaemmaghamy to make an informed choice and therefore failed to obtain her informed consent to PMRT.

Professional Misconduct – Failure to Explain – Informed Consent (Homeopathic Medication and Spiritual Healing (Particular 3)

13. Based on his diagnosis of brucellosis it is alleged that Dr Gorringe in his management of Ms Ghaemmaghamy during this period provided/administered and/or arranged to be administered spiritual healing and homeopathic medication without advising Ms Ghaemmaghamy

(a) the manner in which the spiritual healing, as a treatment modality, would be conducted; and/or

(b) whether antibiotics were available in conjunction with, or as an alternative to, homeopathic medication and/or spiritual healing; and/or

(c) the purpose of risks, benefits and efficacy of the non-conventional treatment, and, in failing to give an adequate explanation to Ms Ghaemmaghamy it is alleged he failed to enable her to make an informed choice and therefore failed to obtain her informed consent to the treatment/ management.

Professional Misconduct – Documentation (Particular 4)

14. As an alternative to charges two and three, it is alleged that during the said period Dr Gorringe failed to adequately document any explanations given or informed consent received from Ms Ghaemmaghamy.

Professional Misconduct – Exploitation (Particular 5)

15. It is alleged that during the said period when Dr Gorringe knew, or ought to have known, that the diagnosis of brucellosis was not supported by Ms Ghaemmaghamy's clinical presentation and, on being advised she had tested negative for brucellosis, he exploited her for financial gain by advising her she had brucellosis of the intracellular form which would not be detected by conventional blood tests and advising her to purchase homeopathic treatment from him.

THE PLEA

16. Dr Gorringe denied all of the charges.

THE LEGAL TESTS

Onus and Standard of Proof

17. The onus of proof is borne by the Director of Proceedings.

18. As to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. If the charges against the practitioner are grave then the elements of the charge must be proved to a standard commensurate with the gravity of what is alleged.

Ongley v Medical Council of New Zealand [1984] 4 NZAR 369 at 375 to 376.

Brake v Preliminary Proceedings Committee (Full Court, High Court, Auckland, 169/95, 8 August 1996 at page 8).

Professional Misconduct

19. The test for professional misconduct has been well established. In *Ongley v Medical Council of New Zealand* [1984] for NZAR369 Jeffries J stated:

> p.374-5:
>
> *"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 a 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 the medical practitioner could be formulated as a question: Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be 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."*

20. In Tizard v Medical Council of New Zealand (above) the Full Court stated:

> *" 'Professional misconduct' is behaviour in a professional capacity which would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct. It, too, is an objective test judged by the standards of the profession: Ongley v Medical Council of New Zealand [1984] 4 NZAR, 369, 374." (p16)*

21. The Tribunal is also mindful of the observations of the Chief Justice (Elias CJ) in *B v The Medical Council of New Zealand* (unreported, HC 11/96, 8/7/96):

> *'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. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates that usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice but patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

Disgraceful Conduct in a professional respect

22. In Allison v General Council of Medical Education & Registration [1894] 1QB 750, 763, the Court of Appeal held that the test for "disgraceful conduct in a professional respect" was met:

> *"If it is shewn 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 dishonourable by his professional brethren of good repute and competency …".*

23. In *Brake v PPC* [1997] 1 NZLR 71 at p77, the High Court set out in its judgment the test laid down in *Allison*. It stated it was an objective test, to be judged by the standards of the profession at the relevant time. The Court specifically rejected a submission that the test for disgraceful conduct required fraud, dishonesty or moral turpitude to be proved. The court stated at p.77:

> *"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 Pillai v Messiter (No. 2) (1989) 16 NSWLR 197, 200, 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."*

24. The test expressed by the New South Wales Court of Appeal in *Pillai v Messiter* (1989) 16 NSWLR 197, 200 (referred to above) related to *"misconduct in a professional respect"* contained in the Medical Practitioners Act 1938 of that state. The President of the Court (Kirby P) stated that while the court must bear in mind that the consequences of an affirmative finding are drastic for the practitioner, the purpose of providing such drastic consequences is not punishment of the practitioner but protection of the public. He observed at p.201:

> *"The public needs to be protected from delinquents and wrong-doers within professions. It also needs to be protected from serious incompetent professional people who are ignorant of basic rules or indifferent as to rudimentary professional requirements".*

25. Clinical acts or omissions can amount to disgraceful conduct, if they are of a sufficiently serious nature. In this regard, see *Tizard v Medical Council of New Zealand* (unreported, High Court (Barker (presiding), Thorp and Smellie JJ), M.No. 2390/91, 10/12/1992).

26. The High Court recently re-stated the test for disgraceful conduct. In *The Director of Proceedings v Parry and MPDT* (Auckland High Court, AP 61-SW01, 15 October 2001) Paterson J stated (para. 44):

> *"… There is more than one way of describing the test for "disgraceful conduct in a professional respect." The full Court in* ***Brake*** *[above] determined that such conduct could include "serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner." Although a single act of mere negligence could never, in my view, constitute disgraceful conduct, I see no reason for departing from the full Court's view that serious negligence of a non-deliberate nature can in appropriate cases constitute disgraceful conduct. It is not difficult to envisage cases where this could be so, or cases where only one act of serious negligence can amount to disgraceful conduct. …".*

27. The relevant principles therefore are:

28. Disgraceful conduct is very serious misconduct, whether deliberate or not-deliberate.

29. A finding of professional misconduct or conduct unbecoming is not required in every case where a mistake is made or an error proven.

30. The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

31. The departure from acceptable standards and/or the failure to fulfil professional obligations must be "*significant enough*" to attract sanction for the purposes of protecting the public.

The "*theory of medicine*" defence

32. Section 109 of the Medical Practitioners Act 1995 sets out the grounds on which a medical practitioner may be disciplined.

33. Subsection 4 provides a defence to disciplinary charges regarding the practice of alternative theories as follows (s.109(4)):

> *"No person shall be found guilty of a disciplinary offence … merely because that person adopted and practised any theory of medicine or healing, if in doing so the person has acted honestly and in good faith."*

34. A similar provision was contained in the 1968 Act with two exceptions. They are (a) the words *"or healing"* have been substituted for the words *"or surgery"* and (b) under the previous Act this defence applied only to charges of disgraceful conduct whereas under the present Act it applies to all disciplinary offences.

35. In *Tizard* the medical practitioner was found guilty of disgraceful conduct in respect of his diagnosis or management of seven patients. His diagnoses of pesticide poisoning played a central role in six of the seven cases brought before the Council. His principal diagnostic tool was an *"EAV Dermatron"*, EAV was an abbreviation of *"electro acupuncture according to Voll"*, Dr Voll being the German inventor of the device. He also used a devise known as VEGA, a similar instrument to EAV but used to measure conductivity from one acupuncture point only, taking repeated measurements from that point, VEGA being used either in conjunction with or to check EAV readings. Having claimed to have identified a particular toxin or toxins, Dr Tizard would then administer homeopathic remedies and *"hyperbaric chamber treatment"* in which patients inhaled oxygen under pressure, usually also receiving vitamin C injections. Those processes were intended to eliminate pesticide residue said to have been so identified. Further homeopathic treatment were then to be used to eliminate miasmatic toxins, which Dr Tizard had said might *"flood the system upon the removal of the pesticide"*. Dr Tizard gave evidence that the type of homeopathic treatment he administered was expected to produce *"aggravations"* or a temporary exacerbation of the patient's original symptoms and disabilities which were seen as *"a necessary precursor to genuine recovery"* and might vary in intensity from mildly uncomfortable to severe. Patients were told they would feel worse before they got better and that it was only when that process was complete could recovery occur. A further tenet of Dr Tizard's homeopathic therapy was that *"certain drugs such as steroids and also x-rays and ultrasound scans exert a blocking effect on the homeopathic remedies and may cause a temporary delay in the commencement of treatment while the patient [was] tapered off the drug or the effect of x-rays [had] worn off"*. The Court considered, at some length, the meaning of the phrase *"honestly and in good faith"*. It concluded (p.18):

> *"We accordingly hold that the meaning of "honestly and in good faith" is simply "honestly". That does not mean that it is sufficient in every case to exclude liability for what would otherwise be disgraceful conduct that the practitioner concerned be acting "honestly". That cannot be the case, since the use of the words "merely because" … make it plain that honest belief in the efficacy of a particular theory is not necessarily a sufficient answer."*

36. The Full Court, having reviewed the New Zealand legal context and the English and Canadian decisions, held (p.23-25):

> *"The cases just reviewed have to be construed having appropriate regard to their different statutory context. It is of interest that, while several have seen "theory of medicine" exceptions as being intended to provide room for minority views, no decision has recognised the idiosyncratic view of a single practitioner, unsupported by scientific proof or by a significant number of his or her fellow practitioners, as "a theory of medicine"* (emphasis ours).
>
> *That position is hardly surprising. Were it otherwise, a practitioner who honestly but mistakenly held an opinion which was seen by the rest of his or her profession as being without foundation and bound, if applied, to cause great harm, could still not be prevented from conducting his practice on that basis.*
>
> *As will later appear, we believe that in this case the Council concluded, and was entitled to conclude, that homeopathy is not a self-contained and complete system of medicine, but admits that in some respects orthodox medicine must be considered. But, if that assessment of homeopathy be incorrect we would in any event have considered that when an adherent or practitioner of alternative medicine is also a registered medical practitioner and practising as such, he or she must recognise that there are limits to both conventional and alternative wisdom and intelligently use his or her knowledge of both, not treating either as totally superior to the other* (emphasis ours).
>
> *The statutory requirements in relation to the registration of medical practitioners make it plain that knowledge of the basic principles of medical science, as they are understood at the date of the practitioner's registration, is a condition precedent to acceptance for registration. It must, in our opinion, have been intended that practitioners have regard to that fund of knowledge; or, to put it another way, that they should not totally disregard it.*
>
> *… in our view, it will seldom if ever be the case that an alternative belief can be accepted as overriding all conventional medical science."*

37. The Court upheld the Council's finding that, on the evidence, it was entitled to conclude that Dr Tizard was not merely practising an alternative form of medicine and, in that case, the

application of the *"theory of medicine"* defence to excuse conduct in breach of normal professional standards *"would clearly be inappropriate"* (p.34).

38. When considering the evidence against Dr Tizard, the Court concluded that:

> *"… the charges against him were not "merely" about his practising alternative medicine, but rather were about his failure to consider the phenomena before him in the context of the whole of the skills and knowledge relevant to his practice."*

39. The Director has made two submissions in regard to this defence. The first was that it was not clear that Dr Gorringe was in fact practising a *"theory of medicine or healing"*; the second is that the defence requires the practitioner must have acted honestly and in good faith, which she submits did not apply in the case of the two complainants.

40. With regard to her first submission, the Director submitted that Dr Gorringe described his unorthodox practice as falling under the general umbrella of complementary medicine, including the paradigms of his bio-energy and nutritional medicine, manipulation and musculo-skeletal manipulation. She contended that he also incorporated aspects of homeopathy (complex/isopathy) and acupuncture.

41. In this regard, the Director referred to the Tizard decision which was to the effect that no legal decision had recognised "the idiosyncratic view of a single practitioner, unsupported by scientific proof or by a significant number of fellow practitioners as a "theory of medicine"."

42. She submitted that while Dr Gorringe claimed that PMRT was recognised internationally, it was clear that there were a variety of methods, differing in administration and application, and that there was evidence of only one other practitioner practising PMRT as Dr Gorringe did, namely Dr Gibb; but that even then, Dr Gibb disputed that his technique could be applied in the manner in which Dr Gorringe uses it.

43. She submitted there had been no evidence from any other practitioner of the acceptance of, or manner in which, Dr Gorringe used isopathic homeopathic remedies (such as drainage or paraquat injections), and referred to the evidence relating to Dr Gibb who stated that he did not condone the practice of injecting single homeopathic paraquat. In this regard, the Director also referred to the evidence of Dr Isbell who, while practising classical

homeopathy, was trained in isopathy and did not support Dr Gorringe's homeopathic treatment methods.

44. With regard to the *"merely because"* phrase referred to in the section, the Director submitted that even if it were found that Dr Gorringe was practising *"a theory of medicine"* he was not merely practising an alternative form of medicine.

45. To support that submission, she relied upon three particular pieces of evidence:

(a) Dr Isbell was of the opinion that a medical practitioner who practised both orthodox medicine and homeopathy should not practise either in isolation from or to the total exclusion of the other, which the Director contended Dr Gorringe supported.

(b) That Dr Gorringe was clear that he practises both conventionally and unconventionally and that he was at pains to describe his unorthodox practice as *"complementary"*.

(c) That specifically in his diagnosis and management of both complainants he did not seek to confine himself to unorthodox practice.

46. The Director submitted that for the theory of medicine defence to succeed, the practitioner must have acted *"honestly and in good faith"*. She argued that while Dr Gorringe appeared to have genuinely believed in his unorthodox techniques and practice, he had failed to adequately explain his practice so as to enable his patients to make an informed choice, and in consequence he had not acted honestly or in good faith in relation to those particular patients.

47. On this issue, the Director referred specifically to her submissions on the question of informed consent and exploitation.

48. Mr Knowsley challenged the Director's submissions.

49. He submitted that the Director had misinterpreted the meaning of s.109(4). He maintained she had claimed in her interpretation that a doctor cannot be *"merely"* practising a theory of medicine if the doctor mixes the practice of that theory with conventional medicine.

50. He contended that this was not the clear meaning of s.109(4) and that it could not be said the defence was not available *"because a doctor also did some things which were conventional such as taking a history, pulse, blood pressure etc."*.

51. He submitted he did not accept that a doctor was not acting honestly and in good faith by allegedly failing to give adequate explanations. It could only be the case the doctor was acting in bad faith or dishonestly if, for example, by giving deliberately false explanations, the doctor did not believe these to be true. He added that *"the Director accepted that was not the case here"*.

52. The Tribunal is of the view that where a registered medical practitioner practises *"alternative"* or *"complementary"* medicine, there is an onus on that practitioner to inform the patient not only of the nature of the alternative treatment offered but also the extent to which that is consistent with conventional theories of medicine and has, or does not have, the support of the majority of practitioners. The Tribunal recognises that persons who suffer from chronic complaints or conditions for which no simple cure is available are often willing to undergo any treatment which is proffered as a cure. As such, they are the more readily exploited. The faith which such persons place in practitioners offering alternative remedies largely depends on the credibility with which such practitioners present themselves. Where such remedies are offered by a registered medical practitioner, it is difficult to escape the conclusion that the patient derives considerable assurance from the fact that the practitioner is so registered. It follows, therefore, that a registered medical practitioner cannot discharge his or her obligation to treat the patient to the acceptable and recognised standard simply by claiming the particular treatment was *"alternative"* or *"complementary medicine"*.

53. The Tribunal rejects Mr Knowsley's submission that there must be deliberate dishonesty. It is satisfied that medical practitioners who practise both conventional and alternative medicine must be well aware of the possibility that patients consult them to get *"the best of both worlds"* and to avoid those aspects of alternative medicine which are extreme or incredible.

54. For reasons which we set out later, the Tribunal finds Dr Gorringe cannot invoke this defence in respect of the charges.

What are the applicable standards?

55. In view of the Tribunal's subsequent finding that Dr Gorringe was practising as a *"dual"* practitioner (see below), the Tribunal has considered what are the appropriate standards to apply.

56. The Director drew to the Tribunal's attention the Medical Council's *"Guidelines on Complementary, Alternative or Unconventional Medicine"* (Ex 1 p330). She submitted that while they were issued in April 1999, after Dr Gorringe's management of the complainants, they nevertheless provided a relevant reflection of expected practice in 1998, that is, that the conduct in question was sufficiently proximate to the formulation of the guidelines for the Tribunal to derive assistance from them.

57. Mr Knowsley submitted, to the contrary, they did not have retrospective effect and could not be said to merely reflect that which had always been. He submitted they were very detailed in their requirements and were intended as a code for practitioners to follow and that before the guidelines were published it would not have been apparent to practitioners what were the requirements for documentation and consent and other relevant matters. He referred to the opening sentence of the guidelines which states *"These guidelines have been written to inform medical practitioners of the standards that would be expected of them, by the MCNZ should they choose to practise elements commonly referred to as complementary or alternative medicine"*. He submitted that a doctor would be informed not before the process of consultation and formation of the Medical Council's policies but following receipt of the guidelines, that is after they were promulgated.

58. The Tribunal observes that the preamble to the Guidelines went on to state:

> *"The Medical Council endorses comments of the editors of the New England Journal of Medicine: "There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work. Once a treatment has been tested rigorously, it no longer matters whether it was considered alternative at the outset. If it is found to be reasonably safe and effective, it will be accepted. But assertions, speculation and testimonials do not substitute for evidence. Alternative treatments should be subjected to scientific testing, no less rigorous than that required for conventional treatments."*

> *Where patients are seeking to make a choice between evidence-based medicine or alternative medicine, the doctor should present to the patient all the information available concerning his or her recommended treatment thus allowing the patient, if a competent and consenting adult, to make an informed choice which should then be treated respectfully."*

(the issue of the New England Journal of Medicine referred to was 1998: 339: 839-41.)

59. The Tribunal finds that, in carefully assessing all the evidence which was presented to it, the publication of the guidelines is sufficiently close in time (to Dr Gorringe's management of the complainants) for it to derive assistance from the content of those guidelines.

60. In the Tribunal's opinion, the guidelines fairly reflect the general standards of practice in 1998.

61. For example, the Director attached to her submissions Professor David Cole's article *"Unorthodoxy and the registered practitioner"* (Patient Management, Vol. 21, No. 9, September 1992). In particular she drew attention to the paragraph in which Professor Cole commented on the criteria for unorthodoxy as a form of misconduct:

> *"Those who espouse the traditional sequence of history, clinical examination and investigation that is accepted as good medical practice, find the dependence of some unorthodox colleagues on diagnostic devices and procedures … to be a serious problem. This short-circuiting of conventional diagnostic methods does provide the patient, in a visual and persuasive way, with a very quick and cheap answer, but what of its reliability? One characteristic of these diagnostic methods is their dependence on the operator's subjective assessment. The associated unwillingness of such doctors to accept any form of trial either by independent assessors or using epidemiological methods raises immediate doubt. Those sitting in judgement may be impressed by the contrast between diagnostic laboratory techniques and radiological equipment on the one hand, all subject to rigorous quality control, and on the other the lack of this authenticity in unorthodox bedside devices of alleged surprising accuracy."*

62. The Tribunal also refers to the publication *"Medical Practice in New Zealand A Guide to Doctors Entering Practice"* (published in 1995) in which Professor Cole wrote the chapter *"Unconventional Medical Practice"* (Ex 1 p333-4). This chapter deals with the role of the Council in monitoring unconventional and unorthodox practice by doctors and deals with various issues including informed consent.

63. Professor Cole refers to certain "postulated criteria, [which] might indicate issues of misconduct faced by unorthodox doctors". Such might be called into question if there were, for example, "shortcuts in standard methods of diagnosis with use of unproven and unrecognised methods, often pseudo-scientific"; and "treatment programmes that are inappropriate, unproven and unjustified and not supported by a substantial body of medical opinion".

64. Under the heading *"Consent in Unorthodoxy Management"* Professor Cole observed:

> *"A leading medicolegal advisor has stated that "If doctors choose to suggest therapies which are well outside what the profession at large would regard as being reasonable treatment, I believe they have a duty to their patients to tell them that [this] is outside the boundaries of conventional medicine, and would not have the support of most medical practitioners". In the light of the newer requirements for informed consent in NZ, it is imperative that such consent to unorthodoxy is given and well documented."*

65. Dr Isbell referred to the 1999 Guidelines. She stated that while she did not believe there were any written guidelines before that date, *"It has always been expected that a doctor practising alternative/complementary/integrative medicine would use their experience and background as a doctor as well"*.

66. Reference was also made to *Tizard*. That case involved issues arising out of disciplinary charges against a dual practitioner who relied on a *"Vega"* machine to diagnose serious illnesses and diseases. The issues traversed in that judgment reflected Medical Council standards relating to dual practitioners between 1987 and 1990; and thus provided a helpful guide to assessing the conduct to be expected of Dr Gorringe when he treated the complainants in 1998.

67. The Tribunal sees no material difference between the standards referred to in the *Tizard* case and those set out in the 1999 guidelines so far as this case is concerned.

Duty to Inform and Obtain Informed Consent

68. The Director referred the Tribunal to its decision 219/02/94D of 3 December 2002 as correctly setting the approach to be followed.

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

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

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

(a) Right 5(2) which provides:

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

(b) Right 6(1) which provides:

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

(c) Right 6(2) which provides:

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

(d) Right 7(1) which provides:

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

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

> *"… the right of all patients to know … the available treatments together with their likely benefits and risks"* (para 7)

and the duty of doctors to:

> *"Exchange such information with patients as is necessary for them to make informed choices where alternatives exist"* (para 11)

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

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

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

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

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

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

(c) The assessment of whether or not a doctor has discharged his/her responsibility to properly inform a patient is measured from the standpoint of the expectations of a reasonable patient and not from the viewpoint of a reasonable doctor.

Expert Evidence

74. The Tribunal has approached the evidence of expert witnesses on the following basis:-

(a) The Tribunal cannot *substitute* its own views, however expert, for the views of any expert called in the case (*Lake v Medical Council of NZ* unreptd 23.1.98, Smellie J., High Court Auckland 123/96);

(b) While such evidence may assist the Tribunal in establishing whether or not the conduct under review amounts to professional misconduct or disgraceful conduct, the opinions of experts do not of themselves determine the ultimate outcome. (*Attorney-General v Equiticorp Industries Group Ltd* [1995] 2 NZLR 135).

(c) What the Tribunal must do is reflect the professional standards which it regards as

acceptable and which are of an adequate standard to ensure that the principal purpose of the Act is upheld.

Evidence

75. As the hearing occupied some eight days, it is neither possible nor necessary for the Tribunal to refer to all items of evidence or the submissions of counsel in full. Suffice to say, in reaching its findings and decision, the Tribunal has given full and careful consideration to all of the evidence presented to it together with the documents produced and the helpful submissions of both counsels.

76. There were certain items of evidence adduced about which it was necessary to make findings of credibility. As the evidence was extensive the Tribunal has, where appropriate, made findings of either a specific or general nature.

DR GORRINGE'S QUALIFICATIONS AND THE NATURE OF HIS PRACTICE

77. Dr Gorringe is a registered medical practitioner, conventionally trained and holding a current practising certificate. At the relevant times he carried on practice at the Hamilton Medical Clinic at 168 Cambridge Road, Hamilton.

78. Dr Gorringe is educated in both science and conventional medicine. His qualifications include but are not confined to the degrees of Bachelor of Science majoring in biochemistry and microbiology (1972) and MB ChB (Otago) (1977). He is also a trained teacher.

79. Over the years, Dr Gorringe developed an interest in particular areas of unorthodox or alternative medicine.

80. In 1990 Dr Gorringe commenced a full-time practice that combined both traditional and "*alternative*" medicine which he described as *"complementary"*. He gave evidence that patients consult him from all over New Zealand, frequently by personal referral, and do so *"primarily for a second opinion"*. He stated that he reviews *"their history, bloods, previous workups, and previous progress (if any) from [his] complementary perspective"*. According to Dr Gorringe, his patients did not want him *"to reinvent the wheel and re-do standard allopathic testing when that had apparently already failed them and not provided a satisfactory diagnosis or treatment protocol"*. He stated that

the majority of his patients made that perfectly plain and that they were *"well aware of the axiom that 'if you always do what you always did, you will always get what you always got'"* and that *"it [was] senseless to repeat treatment in the expectation of a different outcome"*. He stated that it would appear that *"sometimes other doctors [felt] vulnerable because of the results [he was] able to obtain with 'their patients'. [He had] found that this may cause those doctors to react in interesting ways which [were] not always constructive or fair."*

81. One of the complainants, Mrs Short, challenged Dr Gorringe's description of himself as a second opinion doctor whose patients did not want him to reinvent the wheel and do standard testing. She stated that *"Dr Gorringe didn't give me a second opinion, he gave me the only opinion that he thought was applicable to me."*

82. Mrs Short and Ms Ghaemmaghamy stated unequivocally that they were influenced in their respective decisions to consult Dr Gorringe because of the fact that he was a medical practitioner. Both stated in evidence that they were each desperate for cure and/or relief.

83. Mrs Short told the Tribunal she was aware Dr Gorringe was a general practitioner who also practised homeopathy. She said she was open-minded about alternative medical practice although she had never before consulted an alternative practitioner but was re-assured by the fact he was also a medical doctor.

84. She said she was desperate for a cure although more realistically she was hoping for relief for her condition.

85. Ms Ghaemmaghamy said she became aware Dr Gorringe was both a conventional practitioner and an alternative therapist, but that she was open-minded about alternative therapies having previously used alternative practitioners. She stated she assumed Dr Gorringe's medical training would be likely to ensure a reasonable level of competence and that, whatever his alternative practices were, they would have some sort of sound basis.

86. Ms Ghaemmaghamy was "desperate for a diagnosis and treatment". By consulting Dr Gorringe she believed she would have the best of both worlds in that "he might be able to find a diagnosis that a purely allopathic GP may have missed."

87. It is plain to the Tribunal from this evidence and from all the evidence before it:

(a) Dr Gorringe was practising as a dual practitioner in conventional medicine and complementary remedies; and.

(b) He held himself out to the public as such.

88. Although he described himself as a doctor of "*last resort*" who specialised in second opinions (particularly with regard to his alternative modalities) he did practice as a dual practitioner.

89. He used his knowledge of conventional medicine at various stages in his treatment and management of Mrs Short, Ms Ghaemmaghamy, and the other patients whom he called to give evidence.

90. While neither Mrs Short nor Ms Ghaemmaghamy was aware of the nature of Dr Gorringe's alternative modalities at the time they consulted him, they were reassured by and felt comfortable in the knowledge that he was a conventional medical doctor.

MRS SHORT'S TREATMENT BY DR GORRINGE

91. Mrs Short is now 43 years old. She runs a small farm in Ngaruawahia (with her husband). She has had eczema all her life. There were periods when it abated and then when it would re-emerge. The eczema had occurred at different times on different parts of her person including on the backs of her legs, on her buttocks, behind her knees, in the creases of her elbows, on her feet, on her forearms, and occasionally on her face. However, it was on her hands where it gave her the most problems.

92. In addition to the eczema, Mrs Short also suffered from time to time an allergic reaction for which she was prescribed Histafen for hives on an on-going preventive basis.

93. From about 1980 to 1996 she was under the care of Dr M.B. Duffill, a specialist dermatologist. When her eczema got particularly bad he prescribed a short course of Prednisone (an oral steroid). He also prescribed topical steroid creams (such as Dermovate and Betnovate), as well as Condies crystals and coal tar products for bathing.

94. The Tribunal accepts Mrs Short's evidence that those treatments gave good relief and that on discontinuing treatment the condition would flare.

95. Mrs Short also consulted a general practitioner, Dr Stephen Bryan Joe, in April and June 1996, and Dr Duffill in May and June 1996. She consulted Dr Joe again in July 1997 because of a flare of her eczema. Dr Joe continued to prescribe steroid creams and Histafen.

96. The Tribunal accepts and finds that Mrs Short's eczema was fairly well controlled during this time.

97. On 10 February 1998 Mrs Short consulted Dr Joe following a flare of her eczema, especially on her hands. He prescribed Prednisone and Diprosone (a topical steroid cream).

98. In early March 1998, a friend recommended that she consult Dr Gorringe.

99. On 19 March 1998 Mrs Short consulted Dr Gorringe for the first time. Between then and 22 September 1998 she attended at his surgery on no less than eleven occasions. She was accompanied on every occasion (bar one with her husband) by her mother, Mrs Norma Melvis McMahon. In addition during that period all three, that is Mrs Short, her mother and her husband, made telephone contact with either Dr Gorringe or his staff.

100. At each consultation Dr Gorringe *"muscle tested"* Mrs Short by a procedure called *"Peak Muscle Resistance Testing"* which he used as a diagnostic tool. We refer to this procedure later and throughout this judgment as PMRT. It is also referred to as Bi Digital O Ring Testing (BDORT).

101. During the period March to September 1998 Dr Gorringe variously and consecutively diagnosed Mrs Short as suffering from:

(a) Chemical poisoning by paraquat;

(b) Cytomegalovirus;

(c) Legionella infection; and

(d) Electromagnetic radiation sensitivity.

102. Mrs Short claimed that she physically and psychologically deteriorated under Dr Gorringe's care.

103. Following an appointment with Dr Joe on 15 October 1998, Mrs Short made a complaint to the Health and Disability Commissioner which culminated in the laying of the present charges.

104. It is appropriate to describe in some detail what occurred during and following the various consultations Mrs Short had with Dr Gorringe.

105. The first consultation was on 19 March 1998. Mrs Short attended with her mother Mrs McMahon.

106. At the beginning of the consultation Dr Gorringe asked Mrs Short what the problem was to which she replied she had chronic eczema on her hands. She said he took one of her hands, glanced at it, and said, *"That's not eczema"*. She then explained to him that she had been under the care of a specialist dermatologist who had diagnosed eczema. She said that Dr Gorringe laughed and told her that she did not have eczema but had dermatitis due to chemical poisoning and that it was important to ascertain what chemical she had been poisoned with. He then asked her several questions as to whether she had lived and worked in a rural area. During this part of the consultation she said Dr Gorringe did some usual *"doctor"* things. Mrs Short recalled lying on a bed while he palpated her stomach, but did not recall having her blood pressure or pulse taken. She did not believe that he examined her nose, mouth and tongue. (Although Mrs Short's memory was unclear as to what the *"doctor things"* were, the Tribunal accepts Dr Gorringe checked her nose, mouth and tongue, and took her blood pressure and pulse). She stated all of this happened within the first few minutes of the consultation. Dr Gorringe did not refer to the samples of water and urine she had been requested to provide. He glanced at her medications and told her that he would do some tests to find out what she had been poisoned with.

107. Dr Gorringe requested Mrs Short and her mother to go over to a table away from his desk. As Mrs Short's hands were so cracked and sore Dr Gorringe said he would test for the chemical through her mother as a *"surrogate"*. They were asked to remove all their jewellery, except for their earrings and wedding rings. Mrs Short stated she did not at that stage ask what was going on, and was somewhat *"awestruck"* by the process. Dr Gorringe

sat on one side of the table while her mother and she sat on the other side. She was required to put her hand on her mother's arm. Her mother was required to put her hand over a square metal plate which, she thought, was connected by wires to something under the table. Her mother had to hold her ring finger and thumb together in an "O" shape, and touch little glass vials with a metal rod. Dr Gorringe held his hand over her mother's, so that their hands were touching. Before he started the testing he did something to Mrs McMahon's fingers.

108. There were a lot of little vials which were contained in a number of boxes. Dr Gorringe directed which vials Mrs McMahon should touch. Occasionally when a vial was touched, Mrs McMahon's fingers would come apart. Dr Gorringe told them that he was testing for the chemical that had poisoned Mrs Short. In all, Mrs McMahon's fingers 'reacted' to a number of vials – probably less than five.

109. Mrs Short said this process of testing took about 20 minutes, possibly longer. At the end of the testing process Dr Gorringe told them that Mrs Short had reacted most strongly to paraquat and that he needed to test for the amount and strength of the paraquat poisoning in her body. The same testing procedure was conducted again, through her mother again, although on fewer vials. At the end of the process he advised them that Mrs Short had a very high dose of paraquat poisoning. There was no suggestion at any time during the consultation of an alternative diagnosis.

110. Mrs Short said she was extremely taken aback by this diagnosis as she could not understand how she could have been poisoned by paraquat and asked how this could be. She told Dr Gorringe she had used "Grazon" and asked if this could explain the reaction. She said he replied that it was not important how she had got it, but simply that she had it.

111. Mrs Short stated that Dr Gorringe gave her two options for treatment. She could take homeopathic paraquat either orally or by injection. He added that Mrs Short had such high levels of paraquat poisoning her treatment should be by injection. Dr Gorringe advised her that the paraquat injections were homeopathic and safe to use. The treatment was to be for twelve weeks with a ten-week course of injections together with drainage drops (a homeopathic remedy) which would continue for two weeks after the injections. Mrs Short was to self-inject the paraquat and Dr Gorringe's nurse would show her how to do this.

112. Mrs Short was adamant Dr Gorringe told her that the only option for treatment was homeopathic detoxification and that he did not mention any conventional treatment options. She said he also told her she would have to stop using the topical steroid creams. At this time she was not on any oral steroids. He also restricted certain foods which were referred to in an information sheet which he gave to Mrs Short in the course of the consultation. He did not go through the information sheet with her at that consultation. Dr Gorringe also prescribed a number of other homeopathic treatments including vitamin C and grape powder.

113. Dr Gorringe told Mrs Short at that consultation that after the 12 week treatment period she would be completely cured of her skin problems; that she *"would have skin like a baby"*; and that he had never had a case of paraquat poisoning that he had not been able to *"put right"*. He also asked her how she was feeling generally to which she replied *"okay"* but he said, *"No your energy levels are far too low"*, and stated that she was probably *"so used to being low in energy"* that she had got used to it. She said he told her that after the paraquat had been eradicated from her body her energy levels would increase.

114. Mrs Short stated that Dr Gorringe prescribed pinetarsal (a soap alternative) and gave her a bottle of BK Lotion to apply to her skin for relief and softening. She noticed that the BK lotion had lanolin in it and told him she could not use it as she was allergic to lanolin. She said Dr Gorringe then *"tested"* her allergy to lanolin by placing the bottle of lanolin on the metal plate and holding her hand over it. Following the *"testing"* he told her that she was not allergic to lanolin, and that she was not *"out of balance"*.

115. Mrs Short said that at no time during that consultation did Dr Gorringe advise her of any side effects of any of the treatments he had prescribed; give her any alternative options for treatment, advise her of the side effects of stopping the topical steroid treatment she was on, or give her any advice about the testing procedure he had carried out.

116. Dr Gorringe provided her with a box of homeopathic paraquat vials (containing ten vials) and a number of syringes as well as the other homeopathic remedies. Mrs Short said she was required to purchase them from him and that Dr Gorringe told her that the homeopathic medications were cheaper from him than from anywhere else.

117. Mrs Short went next door to the nurse who administered the first of the paraquat injections and explained the process of self-injecting. The nurse asked Mrs Short what she had been diagnosed with and upon being told that it was paraquat poisoning advised Mrs Short that the treatment prescribed by Dr Gorringe would work.

118. The process of self-injecting involved half of an individual vial being injected into each of Mrs Short's ankles and a hand-span above her ankle on a point which, when prodded, was more tender than other points on her ankle. In the course of the nurse's explanation, Mrs Short asked how it was possible that she could have paraquat poisoning. The nurse replied she could get it by eating potatoes, and also told Mrs Short that occasionally the injections might cause a *"flare up"*.

119. At the conclusion of the consultation Mrs Short paid for both the time that she had spent with Dr Gorringe (nearly one hour), and the medications that he had provided. She was also given back her conventional medications which she had brought with her to the consultation.

120. Mrs McMahon stated she was puzzled by Dr Gorringe's diagnosis of paraquat poisoning as her daughter had had eczema since she was a baby. She said she told Dr Gorringe this but he responded that what her daughter had was different, and that it was not eczema.

121. While there was common ground as between Mrs Short and Mrs McMahon on the one hand, and Dr Gorringe on the other, as to what occurred at the first consultation, there were some significant areas of direct conflict which Dr Gorringe challenged.

122. While he accepted that he looked at Mrs Short's hands and concluded that she had dermatitis due to chemical poisoning and had said that it was important to ascertain just what chemical she had been poisoned with, he denied ever saying that she did not have an eczema condition.

123. He was referred by the Director to the notes he had made concerning that consultation which recorded *"NOT E"* (implying *"not eczema"*).

124. Dr Gorringe replied that meant "*not **just** eczema*" [our emphasis] not "*not eczema*".

125. He said he used the terms "*eczema*" and "*dermatitis*" interchangeably as did other doctors.

126. Dr Gorringe was referred to his letter of explanation of 14 April 1999 to the Health and Disability Commissioner in which he stated (at p.2) "*The feel of her skin … felt different from usual eczema*". When asked if he were making a distinction there between eczema and something else, he replied in essence that he was forming in his mind a differential diagnosis and testing a hypothesis and that "*… there are these other qualities here you simply can't squeeze the thing into a box and say that this is atypical eczema …*".

127. However, he did accept Mrs Short's evidence (and Mrs McMahon's) that he glanced at her hands and said "*that's not eczema, that's chemical poi*soning". In cross-examination he conceded "*I can actually remember saying these words yes I do*".

128. The Tribunal does not accept Dr Gorringe's explanation that his note meant "*not just eczema*". It is satisfied, on all the evidence, that Dr Gorringe conveyed to Mrs Short and her mother early in the consultation, and in no uncertain terms, that Mrs Short did not have eczema at all but rather had dermatitis caused by chemical poisoning.

129. There was disagreement as to whether Mrs Short told Dr Gorringe she was using a steroid cream. Mrs Short said that prior to this consultation, her husband had spoken by telephone to Dr Gorringe's nurse who told him what Mrs Short would need to take to the initial consultation. That included all medication she was taking at the time. As she was applying steroid cream at that time, she said she took this to Dr Gorringe along with her other medications.

130. Dr Joe confirmed that on 10 February 1998 he had prescribed Mrs Short Prednisone (an oral steroid) and Diprosone (a topical steroid cream).

131. Mrs Short said by the time of the first consultation with Dr Gorringe she had finished the Prednisone but was still applying the Diprosone, and that she took the cream with her to the consultation along with her other current medications. When challenged in cross-examination whether it were possible she had not taken the cream with her to Dr Gorringe, she replied if so, she "*certainly would have mentioned that [she] was using it*". In this respect, her evidence was corroborated by her mother.

132. Mrs Short also stated that she had "mentioned to [Dr Gorringe] that part of the reason [she] was going to him was so that hopefully [steroids] would not be necessary".

133. Dr Gorringe claimed Mrs Short did not tell him she was using a steroid cream. He said he listed in his notes the medications Mrs Short told him she was currently taking. He was adamant that as he had not listed the steroid cream, she could not have told him of or shown him the cream.

134. The Director submitted that Dr Gorringe's notes could not be relied on as a wholly accurate record of events because, for example, he had prescribed Betnesol on 15 June and Histafen on 29 June neither of which was recorded in his notes.

135. The Director suggested to Dr Gorringe he was changing his story and again directed him to his letter of 14 April 1999 to the Health & Disability Commissioner (Ex 47 p.1) in which he had referred to the history he said Mrs Short had given him, which included the use of steroid creams for the previous two years.

136. In this letter Dr Gorringe also stated that he was aware that Mrs Short had been taking steroids which he claimed was "*the only thing doctors could do for her*".

137. He also acknowledged in this letter that he advised Mrs Short that during the period of the homeopathic detoxification she would not be able to use her usual steroid creams.

138. With regard to this letter Dr Gorringe replied that when a doctor receives a letter of complaint he is given access to other information which he is entitled to use as part of his defence. If, by this response, Dr Gorringe was intending to suggest that, at the initial consultation, Mrs Short had not brought with her the steroid cream prescribed by Dr Joe or had not said she was currently using it, then the Tribunal rejects that.

139. Mr Knowsley submitted that Mrs Short's memory was faulty and that her recall of events was neither logical nor supported by the written record at the time. He made similar submissions concerning Mrs McMahon. He submitted that Dr Gorringe gave Mrs Short steroid creams as required (he prescribed *Advantan* on 3 September which Mrs Short acknowledged), and that he had prescribed another steroid cream at an earlier time (*Elocon* on 14 July) which she had forgotten about.

140. He further submitted that Dr Gorringe did not require Mrs Short to cease taking any medications that he was aware were current and also submitted that Mrs Short knew she

could not use steroid creams during the course of homeopathic drainage. He submitted she "*can't have it both ways*".

141. The fact is Dr Gorringe admitted he told Mrs Short she must not use steroids during the period of detoxification (12 weeks) and, in that regard, he required her not to take her current medication during that period. The Tribunal is satisfied Dr Gorringe would not have given her such a specific warning unless he has been made aware that, at that time, she was using a topical steroid or that it was one of her current medications.

142. Having regard to all of the evidence, the Tribunal does not accept what Dr Gorringe said on this issue. It prefers the evidence of Mrs Short and Mrs McMahon that Mrs Short did in fact take all her current medications to the first consultation, including the steroid cream of which Dr Gorringe was aware.

143. Dr Gorringe disputed Mrs Short's and Mrs McMahon's evidence that he had guaranteed a cure. He stated that he had not done anything differently in Mrs Short's case from his other patients, and that all he said to her was that he "*would get out all the chemicals in a time of approximately 12 weeks, all things being equal*". He stated that she had interpreted this as meaning a complete cure and had even made the "*most amazing jump*" from that to a guaranteed cure. He stated he understood, with hindsight, how she could have done so and gave an explanation about the psychology of "*perception*". He stated he "*had never promised anyone anything in medicine*" and that it was a "*complete misunderstanding*" of what she wanted to hear.

144. Mrs Short was quite definite in her recollection. She said Dr Gorringe told her he had never had a case of paraquat poisoning that he had not been able to remedy and said "*I guarantee you a cure*". She said he gave her a 12 week timeframe during which she would have 10 paraquat injections followed by 2 weeks of drainage drops at the end of which she would be cured; she would have "*skin like a baby*"; and "*there were no ifs, no buts, and no maybes*". Mrs McMahon gave similar evidence.

145. Mr Knowsley submitted that a patient's recall is not always in accord with what was said but is often what they want to hear when they are "*desperate*" for a cure.

146. The Tribunal does not accept the evidence of Dr Gorringe on this issue nor does it accept that Mrs Short heard only what she wanted to hear. It prefers her evidence and that of Mrs McMahon and finds Dr Gorringe did in fact promise a cure.

147. Dr Gorringe conceded he had diagnosed Mrs Short with paraquat poisoning in the absence of any history of contact with it.

148. When it was put to Dr Gorringe by the Director that (at the first consultation) there was no suggestion of an alternative diagnosis and that he did not give Mrs Short any advice about the testing procedure (PMRT) he had carried out, Dr Gorringe answered "… *not by the time I'd finished history examination and testing and at the end I had to come to some working diagnosis*".

149. When the Director put to Dr Gorringe that he did not tell Mrs Short whether or how PMRT had been scientifically evaluated as compared to conventional diagnostic techniques, he agreed he had not but stated he had said it was a non-conventional test which provided him with a means of "*going and looking in directions that maybe have not been used before*" because "*he always uses the proviso*".

150. When questioned further by the Director whether that was something he remembered telling Mrs Short (and Ms Ghaemmaghamy) or whether it was a phrase he believed he used as a general principle with his patients, Dr Gorringe replied "*to be honest in any individual case I know what I say overall, the wording may vary depending on how I perceive the person's education, state of health, hear me, understand me, but generally that's what I say*".

151. The evidence which Dr Gorringe gave the Tribunal as to what information he obtained at Mrs Short's initial consultation with him of her clinical and social history was unsatisfactory.

152. It is clear from what Mrs Short said that Dr Gorringe's first enquiry was to ask what was her problem. When she said she had chronic eczema on her hands, he took one of them and, having glanced at it, immediately stated it was not eczema. When she then informed him she had been under the care of a specialist dermatologist who had diagnosed eczema, Dr Gorringe laughed and said it was not eczema but dermatitis due to chemical poisoning. He

made no enquiries about her past clinical or social history before making these pronouncements.

153. Mrs Short said Dr Gorringe then asked her several questions as to whether she had lived and worked in the country (meaning a rural area). He did not ask her then or later anything about her previous consultations with the dermatologist. In her words, "*he wasn't interested in any of that*".

154. Dr. Gorringe said he had identified her involvement with a poultry farm and with farm irritants in general, which he claimed was evidenced by the worsening of her condition once she moved into the farm environment. His notes make two references to "*poultry farm – eggs only*" and they also record "*Grazon*", "*prev[ious] use of Tordon*" and "*No paraquat*".

155. When asked about this in her oral evidence, Mrs Short claimed Dr Gorringe did not know what farm irritants she may have been using or what sort of farming she was doing. She stated she was not then using any farm irritants and was very careful about what she did use. She said Dr Gorringe had not asked what chemicals she might have been coming into contact with. When considering how she could have been poisoned by paraquat, she asked Dr Gorringe if she could have been poisoned by Grazon rather than paraquat. She said he told he there was no way it could have been Grazon and that she had definitely been poisoned by paraquat.

156. The Director suggested to Dr Gorringe there was a limited history taken as to possible irritants such as food allergies and that he did not gain any information about Mrs Short's jigsaw or woodworking hobbies to which he responded '*she didn't share that with me, no*". This answer implies that it was Mrs Short's responsibility to tell him of these matters and not his to enquire. The Tribunal does not accept that.

157. Having carefully observed both Mrs Short and Dr Gorringe, the Tribunal had no hesitation in concluding that Mrs Short was open and sincere and that she was endeavouring to provide Dr Gorringe with any information which might have enabled him to alleviate her problem. This is evident, for example, from her perplexity at his diagnosis that she was suffering from paraquat poisoning. On the other hand, the Tribunal found Dr Gorringe evasive and

altogether too ready to attempt to justify his conduct by resorting to the use of information which was not available to him at the time he made his successive diagnoses.

158. At the conclusion of the initial consultation it had been arranged that Mrs Short would have a follow-up appointment in three weeks time. In the meantime, she was to undergo blood tests because Dr Gorringe said she had "*low energy levels*".

159. Upon her return home Mrs Short applied the BK lanolin lotion on her hands as instructed but then immediately tried to wash it off as it caused her hands to sting. The following day Mrs Short's hands were extremely swollen, hot and sore which was the first time she had had such a reaction in the course of having eczema on her hands. She said her hands were so sore that she could not hold a pen and had to type rather than handwrite her diary entry for that evening (20 March), this being the first time that she had done so.

160. Over the weekend 21-22 March, Mrs Short's fingers and hands remained sore, swollen and tight and while they had been sore on the day she had consulted Dr Gorringe, they had not been swollen and tight, and she had not experienced this before.

161. On Monday 23 March Mrs Short's face was a little swollen especially around her eyes. On 24 March while she could move her fingers more freely a lot of skin was falling off them, and she had oozy patches. Her eyes were baggy and her eyelids were hot, as was her neck. She felt as if her face were burning and she was restricted in her domestic tasks. On Wednesday 25 March her hands were a little better but her face was still red and her neck itchy. On 26 March her neck was hot and itchy and her chin was very sore. Her face was still swollen.

162. By 27 March Mrs Short was feeling miserable with her neck and face very hot and swollen. On this occasion Mrs McMahon telephoned Dr Gorringe's surgery and spoke to his nurse who advised her that her daughter's reaction was normal and to be expected. Mrs Short felt somewhat relieved to learn that what was happening was to be expected as she had never experienced anything like this before, but on the advice of what had been told to her mother she felt it was something she had to go through in the course of this treatment. She said she was very embarrassed by how she looked and avoided contact with others.

163. In the week commencing Saturday, 28 March and ending Saturday 4 April Mrs Short said her face remained swollen with her neck still very red and sore and oozing liquid. Her eyes were swollen and leaking. She did not know what was happening. Throughout that week she spent much time in bed and generally felt "*grotty*". She said she looked "*terrible*". Over the week Sunday 5 April to Wednesday 8 April she started to feel a little better, although her eyes continued to leak and her neck was still rather sore. Mrs Short deliberately stayed at home due to the way she looked. She was reluctant to have the paraquat injections, but continued to comply with Dr Gorringe's treatment regime. Indeed, over the entire time she consulted Dr Gorringe, she said she adhered faithfully to his treatment programme.

164. The Tribunal, having heard and seen both Mrs Short and Mrs McMahon and considered all the relevant documentation including Mrs Short's contemporaneous diary, finds this description of Mrs Short's state of health to be accurate.

165. The Director challenged Dr Gorringe as to the appropriateness of his staff giving telephone advice in such matters. He said that if what the staff are told *"sounds a little bit more severe than what we may accept as a reasonabl[e] aggravation from treatment"* then they are asked to attend his rooms.

166. When asked if the description of Mrs Short's response to the paraquat injection therapy was a normal one, Dr Gorringe replied that he had seen all range of responses in the 14 to 15 years he had been giving this treatment.

167. The Tribunal finds that Dr Gorringe's nurse was authorised by Dr Gorringe to give advice by telephone to patients and, on this occasion, did give such advice to Mrs Short through her mother, Mrs McMahon.

168. On 9 April 1998 there was a second consultation. Mrs Short said that at this consultation her face was still sore; and the problems with the skin on her face, neck and hands were rather bad and her eyes were leaking. Mrs Short said she told Dr Gorringe what her reaction had been to his treatment and about the skin problems on her face and neck explaining they were different and more severe than she had ever experienced before. She said Dr Gorringe told her that the difficulties she had been experiencing were *"normal"* and

to be expected and that the skin reaction she was experiencing proved to him that she had a lot of paraquat in her system. She said he did not examine the skin on her face and neck. As he was so unconcerned, and because he was a general practitioner, Mrs Short accepted that the reaction was normal. She felt reassured that any adverse reaction was temporary, and that the treatment would definitely work. She said there was no suggestion at this consultation she should go back on steroids or go to another doctor or specialist. Mrs Short stated she *"got hooked into thinking that [she] was making progress despite what was happening"*.

169. Dr Gorringe *'tested'* her paraquat levels using the same muscle testing he had used at the first consultation (except that on this occasion she was tested directly and not through her mother). (Mrs Short did not know at that time that the procedure was called muscle testing or PMRT and only learned this in the course of the Health and Disability Commissioner's Office investigation of her complaint). Dr Gorringe told her the paraquat levels were going down which was an improvement, and that he was pleased with her progress.

170. Mrs Short said Dr Gorringe had received the results of the blood test and advised her she was low in folic acid, B12 and iron. He suggested she take B12 tablets; but when he *"muscle tested"* her tolerance to B12 her fingers placed in an "O" shape came apart and he advised her that taking B12 would put her *"out of balance"*.

171. He suggested they say a prayer in the hope that God might help Mrs Short keep her balance if she took B12. Mrs Short had the impression that if they did not pray then she would have to wait before she could take the B12. Mrs Short thought it was very strange but consented to the prayer because Dr Gorringe said it would help. Dr Gorringe prayed. He then "*tested"* her again following the prayer, and her fingers remained in the "O" shape. She said she was "*amazed*". When she asked him how the prayer had worked he told that that was not important.

172. Dr Gorringe did not dispute these aspects of Mrs Short's evidence relating to this consultation except her allegation that he did not examine her skin. The Tribunal prefers Mrs Short's evidence on that matter. Later in this judgment, further comment is made as to the quality of Dr Gorringe's "*skin examination"*.

173. Mrs Short left this consultation feeling that the end was in sight, notwithstanding her ongoing skin problems. A follow-up appointment was made for 23 April 1998.

174. With regard to Dr Gorringe's statements to Mrs Short about her B12 level, Mrs Short said she was not shown the results of her blood tests. However, they were produced to the Tribunal and showed that Mrs Short's B12 level was within the normal range. When asked about this by a member of the Tribunal, Dr Gorringe gave a lengthy answer which was unsatisfactory and made little sense to all members of the Tribunal.

175. The Tribunal referred Dr Gorringe to his "Information Sheet" (Ex 1 p.33) which advises patients that if they are undergoing the homeopathic process then they must refrain from taking certain drugs such as B12.

176. Dr Gorringe responded by referring to his notes for this consultation where it was recorded *"Pd off"* to the left of his reference to B12. Apparently the words "Pd off" referred to a *"prayer modality"*. He said *"that means to be taken advantage of the prayer modality to counteract the effect, the negative effect of the B12 molecules on the working of the homeopathics. That's a very effective modality. So it means we can have our cake and eat it too.*"

177. The Tribunal does not accept this was credible, either as a treatment or an explanation.

178. The Tribunal was satisfied from the evidence (including the documentary evidence) that Mrs Short was not low in B12, contrary to Dr Gorringe's assertion.

179. Mrs Short described the state of her health between 9 and 23 April. She said her face, eyes and neck continued to get worse; her left hand showed some minimal improvement although her hands were still sore; she had very weepy eyes; her face felt hot, sore and tight on an almost daily basis; it grew lumpy; she stayed in bed when she could as she felt so miserable, often itchy and "*grotty*"; she could not concentrate and even reading was difficult; and that her mother and husband assisted with household and other tasks as she could do little. She said she looked "*revolting*" and that while she had previously had eczema on her face, her eyes were never involved and the eczema was never that bad or as extensive.

180. Mr Knowsley challenged Mrs Short's description of her health and made reference to her own diary entries which he said contradicted her claimed inability to undertake normal tasks.

181. While the Tribunal accepts that during this period Mrs Short could carry out some household and farming tasks, having heard her evidence and that of her mother and having carefully perused the relevant documentation (including Mrs Short's diary), the Tribunal finds reliable Mrs Short's description of her health during this period.

182. On 23 April 1998 Mrs Short attended the third consultation. At this time Mrs Short said her face was very hot and sore. She remembered crying in the reception area but could not be sure if it was for this consultation or the earlier one. She was upset at the pain and embarrassed about the way she looked. The receptionist told her that she was glad Mrs Short had had this reaction to her skin problems as it showed Dr Gorringe had got the diagnosis right. The receptionist showed her some photographs of a woman who had a terrible rash, who she claimed Dr Gorringe had cured. This gave Mrs Short inspiration.

183. Mrs Short said Dr Gorringe was pleased with her progress and said her liver was coping well and that she could continue the drainage drops. He administered her sixth injection. She said he did not examine the skin on her face, nor did he examine her eyes but he did do the muscle testing procedure again. While she told him about her skin and how terrible she was feeling, he reassured her that what was happening was to be expected and that she was getting better.

184. Mrs Short's description of events was not challenged by Dr Gorringe except her claim that he did not examine her skin. The Tribunal accepts Mrs Short's evidence. Again, the quality of Dr Gorringe's *"skin examination"* will be the subject of later comment.

185. Mrs Short described her state of health following this consultation. She said the next day her eyes were swollen shut; she was unable to make her usual diary entry; she stayed in bed over the next three days; her eyes were swollen and continually leaking; she felt like she had prickles in her eyes and her vision was blurry; by 27 April her forehead, eyelids and under her eyes were cracked and hair from her eyebrows fell out; she had weeping skin; her hands were also swollen and painful and the skin on her hands started to fall off; she felt terrible; her husband stayed home to help her between 24 and 27 April. Her parents regularly visited

to help with the farming and domestic duties. While the situation slightly improved over this period (in the context of how she had been) she still had a sore face and hands when she next saw Dr Gorringe on 7 May.

186. The Tribunal accepts Mrs Short's description of her state of her health during that period.

187. On 7 May 1998 there was a fourth consultation. Mrs Short stated that at this consultation she explained to Dr Gorringe what had been happening and how terrible she felt. She said Dr Gorringe carried out the muscle testing procedure and expressed surprise at how much paraquat was still in her body, and at the condition of her hands, but continued to reassure her, telling her they were *"on track"*. Mrs Short said Dr Gorringe did not examine her face. She said her skin was worse than it had ever been before and that while she had had patches of eczema on her arms before, it was never with such intensity. Her whole forearm was red, weepy and swollen. She received her eighth injection at this consultation.

188. Dr Gorringe did not challenge Mrs Short's description of what took place at this consultation except her statement that he did not examine her skin.

189. Mrs Short stated that over the next two weeks the situation did improve a little. She thought that, at last, she was getting better but there were days when her eyes were swollen and leaking, and her hands swollen and sore; some days she could work; while both her hands and face had dead skin on them she did not feel as sick as she had during the previous weeks and she managed to do some farm work. On 20 May she said the situation got bad again; her hands were sore and swollen; she had leaky eyes; she was itchy; her arms and neck were lumpy. She said she had not had eczema on her arms or neck for years before her consultations with Dr Gorringe and that she was in a worse condition than she had ever been but she was nearing the end of her 12-week course of paraquat injections and thought the end was in sight.

190. Dr Gorringe challenged her claim that she had not had eczema on her *"arms or neck for years"*. (The Tribunal notes from Mrs Short's medical records she had a flare of her eczema in June 1996 which involved her forearms and the sides of her neck).

191. On 21 May 1998 Mrs Short attended a fifth consultation. On this occasion Dr Gorringe administered the final injection. Again Mrs Short was muscle "*tested*" following which Dr

Gorringe *"lasered"* the remaining paraquat from out of an *"energy spot"* in her ear. She described the laser he used like a pen with a red light in the end of it which teachers use to point to things out on boards. He kept it under a pillow on the bed in his surgery. He pointed the light into her ear. Following his *"lasering"* of her ear, he muscle tested her again. He told her that everything was going well. She told him how miserable she was feeling. She said he did not respond and did not examine her skin.

192. They discussed follow up and further treatment. Mrs Short was to undergo a blood test six weeks hence, with a follow up appointment in seven weeks. She was to keep on the drainage drops for four weeks. Mrs Short was surprised how far out the appointments were, given the condition of her skin but as the twelve week period was nearing an end she was quite hopeful when she left his surgery.

193. Mrs Short said the following weeks were *"terrible"*. Initially the situation seemed alright, but by 25 May her hands were swollen and sore again. She developed sores on her feet. Over the next few days the skin on her arms became involved. They were covered in yellow spots. Her face and eyes also became sore and swollen. By 5 June she said *"[she] had had enough"*.

194. She telephoned Dr Gorringe's surgery with the intention of speaking to him but ended up speaking to his nurse who told her that her problems were only to be expected as paraquat was very hard to get rid of. The nurse suggested that Mrs Short double her drainage to 8 drops and told her about a woman whose arms were so swollen that she had to get home help. Mrs Short accepted what she was told. The Tribunal finds that Dr Gorringe's nurse had his authority to give such advice by telephone.

195. Throughout the following days Mrs Short said her condition continued to deteriorate. Her inner thighs became sore, weepy and smelly. She had never had eczema on her inner thighs before. Her feet and toes were also sore and cracked. Emotionally she was not coping and became depressed. She could not sleep or concentrate. She said she had difficulty moving and could only do very little around the house or farm. She could not get any relief from the itching, burning, irritation and pain. She was *"fed up"* and *"miserable"*, as the three-month deadline had passed and she was in a worse condition than when she started. She made an appointment to see Dr Gorringe on 15 June.

196. Mrs Short stated that at the sixth consultation on 15 June Dr Gorringe said something had *"gone wrong"*. She said he looked at her feet, and may have looked at her arms, but did not examine her thighs; and did not closely examine her face. Then he muscle "*tested*" her with a number of vials.

197. She said Dr Gorringe told her that she had a long standing infection related to glandular fever which she may not have ever known she had had. She said he did not ask her for any history about glandular fever which, to the best of her knowledge, she had never had. She said he did not physically examine her nor require her to have a blood test; he relied on the muscle testing to make this diagnosis and told her, following the muscle testing, that the paraquat injections had worked, but that she had some *"higher frequencies left"* which he "*lasered*" from her right ear (as he had done at the previous consultation). She understood from Dr Gorringe that once he had cured her glandular fever infection, her skin would clear; and she also understood from him that it was this glandular fever infection which was causing her skin problems.

198. He prescribed a two-week course of Zyrtec (an anti-histamine) and a number of other homeopathic drops. He relied on the muscle testing to determine what drops she should be given and how many drops she should have.

199. Mrs Short said he held her hand over the drops which were placed on the metal plate and told her specifically the number of drops she needed and that she could throw the rest away. She said she was not advised of any alternative options for treatment nor referred to another doctor. He suggested a follow up appointment in two weeks, on 29 June.

200. Dr Gorringe's counsel asked Mrs Short what she meant by Dr Gorringe not closely examining her face. She explained that when she had consulted other dermatologists they had looked at her face under lights and examined it from every angle which Dr Gorringe did not do.

201. Mrs Short took the Zyrtec and homeopathic medicines immediately when she got home. She said the following day was the first time in weeks that she was not itchy. Between 16 June and 22 June the situation seemed to improve. She took the Zyrtec for approximately 10 days and completed the course. However, her right leg started to get sore and by 23

June it was lumpy, painful and shedding skin. Between 25 and 29 June her face and neck began to get worse again – red, swollen and hot. Her leg was blistery and oozing. On 28 June her back started to get itchy. She said she had never had eczema on her back before.

202. The Tribunal accepts Mrs Short's description of her health during this period, that is 16 to 28 June.

203. There was a seventh consultation on 29 June 1998. After muscle testing Mrs Short, Dr Gorringe advised that all the paraquat had gone from her system. However, he told her that she had developed another infection which was affecting her leg and face. He examined those areas and prescribed her antibiotics. He also told her to take four drops of aurum metallica "*to get rid of the glandular fever*".

204. He prescribed, among other things, Klacid (an antibiotic appropriate to treat skin infections).

205. Mrs Short said she believed what Dr Gorringe told her. Although the twelve-week timeframe was up, Dr Gorringe reassured her that these infections were simply set-backs and that she would be cured. She was very hopeful as a result of his assurances. A follow-up appointment was arranged for 9 July.

206. Between 1 July and 9 July Mrs Short said she took the antibiotics which provided some improvement. Although there were days in that period where her knee and right eye were sore, generally the skin on her face and leg began to heal. There was one day when the skin behind her ears was "*leaking*". Her hands were a little better, although she was quite "*scabby*".

207. On 9 July Dr Gorringe "*muscle tested*" Mrs Short again, this being her eighth consultation. She said he told her she was doing very well considering what her hands had been like and the amount of things that were wrong with her. He gave her two more sets of drainage drops to take over the following five weeks and told her she should then be fine. Mrs Short was to have another blood test in seven weeks and return to see Dr Gorringe in eight weeks. She said she understood from Dr Gorringe that by that time she would be cured, but was surprised at the length of time until the next consultation, given the condition of her skin. Dr Gorringe informed the Tribunal (which it accepts) he also prescribed Elocon (a potent steroid cream) at this consultation.

208. Mrs Short stated the following few weeks were a little better although her hands started to deteriorate again from about 16 July. There were some good days but generally they were worsening – that is, cracked, hot, swollen and sore. Between 25 and 30 July her hands grew so sore she said it was difficult to do very much at all.

209. By 30 July Mrs Short was so *"sick of it"* she telephoned Dr Gorringe's surgery to speak to him but was told by his receptionist that either she or Dr Gorringe would call back and that Dr Gorringe was doing some reading on her condition. The call was not returned.

210. The following day, 31 July, Mrs McMahon telephoned Dr Gorringe's surgery at her daughter's request. The receptionist told Mrs McMahon that there was a lot wrong with Mrs Short when she started with Dr Gorringe and that her cure would take time. The nurse telephoned Mrs Short later and told her Dr Gorringe would send two new kinds of drops. She added that *"the squeaky wheel gets the most oil"* and that Mrs Short should ring Dr Gorringe in a week if she were not happy.

211. The drops arrived. According to the label they were for back pain. Mrs Short had previously asked Dr Gorringe why he was giving her drops to treat things like "*hopelessness*" and "*depression*". He had explained at an earlier consultation that the drops had been traditionally used for those symptoms. Mrs Short said Dr Gorringe has phone-in times and that she tried several times to call him at those times but could never get through.

212. Between 1 and 5 August Mrs Short developed a cold. On 5 August, she telephoned Dr Gorringe to see if she should go to her usual doctor regarding this. He said he would see her, which he did that afternoon, with her husband, who also had a cold. This was her ninth consultation. Dr Gorringe checked her nose and throat, told Mrs Short and her husband they had an infection, and prescribed antibiotics for six days. He *"muscle tested"* her to check the antibiotics he was giving her. He also advised Mrs Short to apply teatree oil and arnica to her hands. She said the focus of this consultation was not on her skin problems, although she told him what had been happening with her hands. Dr Gorringe told her that everything was *"going fine"*, that she had had *"a few hiccups"* but that they would get to the end of the problem and everything would be fixed.

213. Again Mrs Short's hands worsened over the following weeks. She said she could not bend her fingers. There were also days when her neck and face were red and sore. She had good days and bad. Her hands and fingers became swollen and cracked. She reached the stage of not being able to do much again. She started to feel that Dr Gorringe had *"conned"* her. She said she had spent a great deal of money (over $1000 by then), the timeframe of twelve weeks which Dr Gorringe had given her was long past, and yet she had doggedly complied with the treatment (including the diet) which he had prescribed.

214. By 23 August she said she was *"fed up"*. She said she had some Advantan cream (a topical steroid) left at home. On the evening of 23 August she applied it to her hands for some relief. She said this was the first time she had used steroid creams on her skin since consulting Dr Gorringe. However, the Tribunal accepts the evidence of Dr Gorringe that he had prescribed Elocon (a topical steroid) at the previous consultation. He produced Mrs Short's Prescription Details Report to substantiate this. The Tribunal accepts Mrs Short obtained that prescription and, presumably, must have used it. Mrs Short said the next day she telephoned Dr Gorringe to tell him about her hands, and to tell him that she had used the steroid cream. She said he seemed perplexed by her ongoing problems, but did agree to prescribe her some more Advantan; and that he did not seem unduly concerned that she had applied the cream the night before. The Tribunal notes that the prescription record presented at the hearing shows Dr Gorringe prescribed Advantan (a topical steroid) which Mrs Short obtained on 25 August.

215. Between 24 August and 3 September Mrs Short's hands were a little better with the application of Advantan cream. She said while it relieved the tightness, it was not treating the condition. On 1 September she had another bad day where her fingers were so swollen her mother had to assist with her farm and domestic duties.

216. Mrs Short returned to Dr Gorringe on 3 September for a tenth consultation. She had been contemplating returning to Dr Joe (her previous GP) but was embarrassed because of her worsened condition and worried as to what he might say. She was also of the view that she had gone through so much with Dr Gorringe that she did not want to give up. At this consultation while her face had improved, her hands were still quite bad (notwithstanding the Advantan) and were shedding skin. She said Dr Gorringe checked her tonsils but did not

otherwise give her an examination. She believed he may have had her blood test results as she had been to the laboratory on 27 August. She underwent extensive *"muscle testing"*.

217. At the completion of the *"muscle testing"* Dr Gorringe told her she had Legionnaires' Disease. She was *"stunned"*, but also a little sceptical as she knew that Legionnaires' Disease was a serious disease and thought that people could die from it. She said Dr Gorringe did not explain to her how she got it or what were its symptoms. He told her that once he got rid of the *"bug"* her skin would settle. She understood him to say that there was a link between Legionnaires' Disease and her skin condition.

218. Mrs Short said Dr Gorringe did not give her any treatment options at that stage but suggested they pray. After the prayer, Dr Gorringe muscle tested her again and this time her fingers did not react. He declared the bug *"dead"*. She was *"amazed"*. She thought that the prayer had worked. After that he gave her drainage drops and a course of iron tablets. He said her B12 levels were also low but he did not prescribe a course of B12 at this consultation.

219. She said Dr Gorringe said a prayer and advised her that God had told him that she needed to take six more pills of Histafen and that, thereafter, she would not need them. She was not sure if this last advice occurred at this consultation or the previous one.

220. At this consultation Mrs Short said that when she asked Dr Gorringe about the diagnosis, he told her that he had been on the internet and that there was newly discovered research on it. She said he did not want to tell her much about it and resisted her questions. A follow-up appointment was arranged for four weeks. Mrs Short undertook her own research on the internet regarding a link between the disease and psoriasis (a skin disorder).

221. Mrs Short told the Tribunal it was difficult to describe how she was completely *"taken in"* by Dr Gorringe and his methods. She had resolved, prior to this consultation, not to go back onto drainage, but when she was in the consultation everything he said seemed to make perfect sense. It was only when she got home that she reached some degree of perspective and thought *"this will be the last try"*.

222. Between 4 September and 22 September she took the drainage drops and occasionally applied the Advantan but her hands and fingers remained rather sore. There were days

when she thought they were getting better and days when she could do very little due to the pain. On 18 September her arms and face began to get red and itchy. On 21 September her hands were so painful and her face and arms so red and itchy that she asked her mother to telephone Dr Gorringe's surgery. As a result of what the receptionist told her mother she was fearful that she may have been chemically poisoned again. It was arranged that she would see Dr Gorringe the following morning.

223. On the morning of 22 September when she attended her eleventh consultation, Mrs Short stated the first thing Dr Gorringe said when she walked into his surgery was: *"What have you done?"* Mrs Short was offended and felt he was blaming her for the state of her skin. She said he did not examine her skin other than to observe the way it looked when she entered the surgery. He then *"muscle tested"* her and told her she had had a bad reaction to the sun. He also talked about electro magnetic radiation sensitivity. He told her that she had got this from things like the computer, microwave, and stove, that her system had been *"short-circuited"*, and that she was *"full of electricity"*. He told her this was why she felt so tired. She was upset at yet another diagnosis, and another set back. She started to cry and told him she was sick of it all. He told her to hold on with the treatment and that she would be all right. He told her she was getting better. She believed it was also at this consultation that she understood Dr Gorringe to have told her that he had changed her DNA. Dr Gorringe's treatment for this condition was another prayer and further homeopathic drops. He also prescribed B12.

224. Dr Gorringe on this occasion, at Mrs Short's request, prescribed repeats on her other medication – Estrofem, Aropax, Pulmicort, and Advantan. A follow-up appointment was made for two and a half months' time. This concerned Mrs Short as it seemed to her an extraordinary length of time given what had been happening. Her thinking was that she would be lucky if she made it that far. It also reinforced her view at this time that she was in the *"too hard"* basket and was being *"fobbed off"* by Dr Gorringe.

225. Following this consultation with Dr Gorringe, Mrs Short said her faith in him diminished considerably. She was very sceptical at his diagnoses and his treatment. She felt completely let down. She was having ongoing problems particularly with her hands. Her feet at that time also started to get sore. She resorted to taking oral Prednisone which she had left from

a previous prescription (not from Dr Gorringe). On 6, 8, 9 10, 11 and 12 October she took Prednisone and her skin started to improve. She was also applying Karicare ointment. During this period however, she was not taking Histafen, on the advice of Dr Gorringe.

226. On 14 October she awoke with large welts over her face, neck and arms. They were very itchy. She put this down to the fact that she had not been taking her Histafen. She had her husband call Dr Gorringe in an effort to obtain an appointment and a prescription for Histafen. They were advised that he would not be available until 27 October. For Mrs Short this was *"the final straw"*.

227. The following day, 15 October, she made an appointment and saw her usual General Practitioner, Dr Joe at Ngaruawahia. She told him about her experiences with Dr Gorringe.

228. Following Dr Joe's advice, that same day she wrote a letter of complaint to the Health and Disability Commissioner which culminated in the laying of the present charges.

229. Dr Joe gave evidence at the hearing. He said that Mrs Short had been treated at his surgery by Dr Robertson, a colleague of his (1993 to 1995), and he himself had been her general practitioner since February 1996.

230. Between February 1996 and March 1998 Dr Joe had treated Mrs Short periodically for atopic eczema for which he regularly prescribed topical steroid creams. He also regularly prescribed Histafen (an anti-histamine) to control itchiness from which she occasionally suffered. He said her eczema during this period was not particularly serious and was well-controlled. It was largely confined to her hands which gave her the most problems.

231. Mrs Short had two flare ups of hand eczema during that time. One was on 24 April 1996 when she saw Dr Joe. As it did not settle on Dr Joe's initial treatment, she referred herself to Dr Duffill, a specialist dermatologist under whose care she had been in the past and whom she consulted on 4 June 1996 (the clinical notes produced showed she had consulted Dr Duffill approximately seventeen times between November 1980 and July 1989 and on four occasions between May and June 1996. Mrs Short had eczema on her forehead, cheeks and sides of her neck and was treated with Diprosone and Bactroban (to treat secondary infection)).

232. On the second flare up of her eczema on 1 July 1997, Dr Joe changed her steroid cream from Diprosone to Elocon cream, following which her eczema apparently settled.

233. There were no other occasions during the period May 1996 to February 1998 that Mrs Short required specialist assistance for her eczema. Dr Joe continued to regularly prescribe steroid creams and Histafen for her during this time when her eczema was fairly well controlled.

234. On 10 February 1998 Mrs Short had consulted Dr Joe with quite bad eczema on her hands which were cracked and dry. She also had a more widespread Urticarial rash on her sun exposed areas – that is, her arms, face and legs, which was itchy and blotchy. On this occasion, Dr Joe prescribed Prednisone (an oral steroid), Doxepin (an anti-depressant which has some anti-histamine properties) and Diprosone (a topical steroid cream). He intended to review Mrs Short in two weeks with the possibility of doing some skin testing if the treatment he prescribed for her did not work.

235. However, he did not see Mrs Short again until 15 October 1998 (following her decision to discontinue consulting Dr Gorringe). Dr Joe said that on this occasion Mrs Short's eczema was the worst Dr Joe had ever seen it. It was more widespread than it had previously been and was more severe than when he last saw her in February 1998. Her skin was also more inflamed than it had ever been.

236. Dr Joe referred her to another specialist dermatologist, Dr Marius Rademaker. Dr Joe told Mrs Short to continue with the treatment that he had previously prescribed, and renewed a prescription for Histafen.

237. Dr Joe saw Mrs Short again on 21 October 1998 for the purpose of treating her itchy and inflamed skin (as her specialist appointment was for the following week).

238. Since then Mrs Short has been under the regular care of Dr Rademaker. Her eczema is controlled with topical steroid creams, occasional Prednisone and immuno-suppressants, the latter medication requiring Mrs Short to undergo regular blood tests for monitoring. Dr Joe reviews Mrs Short's skin regularly and has ongoing contact with Dr Rademaker regarding her management.

239. Dr Joe told the Tribunal it was his opinion that while Mrs Short's skin has improved since the referral to Dr Rademaker, it was still worse than it was prior to Mrs Short seeing Dr Gorringe.

240. Dr Rademaker also gave evidence. He confirmed Mrs Short has been under his care and management since her first consultation with him on 30 October 1998 when she presented with severe endogenous eczema on her hands and feet. On that occasion, she had difficulty walking into his clinic.

241. Dr Rademaker said that Mrs Short's eczema is very severe falling within the worst 2% to 3% of his patients. She has very unstable skin and, at the time of the hearing, was being treated with Cyclosporin, one of the more potent immuno-suppressants.

242. On 30 October 1998 Dr Rademaker diagnosed Mrs Short with three skin conditions:

(a) Endogenous eczema on her hands and feet. Endogenous eczema is an eczema which *"comes from within"*. It is more common in women, particularly in their 20s and 30s, and presents in a cyclic pattern. It is often chronic over a number of years (5-10 years) and then starts to improve. It begins with an intense itch. Tiny blisters (vesicles) form beneath the skin which, after about 3-5 days, break, weep and dry out. The skin is often left with splits and cracks, which can be very painful. At this stage, patients often cannot walk, clothe themselves (as they are unable to do up buttons), write, wash their hair, etc. One sign of endogenous eczema is the occurrence on both the hands and feet. When Dr Rademaker first saw Mrs Short, her involvement was severe necessitating treatment with the most potent topical steroid cream available and included discussion on the likelihood of starting her on immuno-suppressant drugs.

(b) folliculitis on her arms and legs. folliculitis is an inflammatory condition of the hair follicles which often makes eczema much more active and is caused, in Mrs Short's case, by the bacteria staphylococcus aureus for which she was prescribed a variety of moisturisers.

(c) Chronic urticaria (hives) (unrelated to either eczema or folliculitis). Chronic urticaria is an allergic reaction which can be triggered by a number of allergens (eg food, medication and infection), but for a large number of sufferers the cause is unknown.

It is itchy and presents with welts. Chronic sufferers can be treated long term with anti-histamines. Dr Rademaker noted that for the previous two weeks (prior to her first consultation with him) Mrs Short had been taking Cimetidine and Histafen (both anti-histamines used in the treatment of urticaria) prescribed by Dr Joe which would have provided her with some relief.

243. Initially Mrs Short responded to the treatment Dr Rademaker prescribed, but one month later she was as bad as before. At this consultation Dr Rademaker explained to her once again that her skin condition could not be cured, but that it could be managed. They again discussed short and long term treatment. She was prescribed Prednisone (an oral steroid) and Azathioprine. Azathioprine, an immuno-suppressant, may be used for severe cases of eczema to minimise steroid use in patients who have been on Prednisone for a long time. A combined drug therapy allows a reduction of Prednisone over time. Mrs Short's endogenous eczema settled well and after eight months Dr Rademaker stopped her treatment.

244. Four months later, Mrs Short had a major flare of her atopic eczema. Her hand dermatitis remained settled. Mrs Short had first developed atopic eczema as a child In Mrs Short's case, her eczema settled in childhood, but reappeared in 1985 when it affected mostly her face and neck. In the three years that Dr Rademaker has been treating Mrs Short, she has had occasional flare ups of her atopic eczema. He has used a variety of medication combinations – including topical steroid creams, oral steroids, immuno-suppressants, and other moisturising agents. He has noticed that Mrs Short's atopic eczema generally gets worse during summer months which indicates that she has a photo (sun)-aggravated atopic eczema. Most people's eczema improves with sunlight but in 5-10% (often young women) sunlight can make it worse.

245. On the last occasion Dr Rademaker saw Mrs Short (13 May 2002) her skin was clear, itch free and looked relatively normal.

MS GHAEMMAGHAMY'S TREATMENT BY DR GORRINGE

246. Ms Ghaemmaghamy is a counsellor in Hamilton. Since 1976 at the age of nine she has been diabetic. In August 1997 she said she developed a number of unusual symptoms.

247. She initially consulted a general practitioner, Dr Marcus, who undertook a number of investigations and subsequently referred her to Waikato Hospital to a number of specialists for further investigations.

248. While she was awaiting specialist appointments (no definitive diagnosis having been made), Dr Gorringe was recommended to her by a friend.

249. Ms Ghaemmaghamy consulted Dr Gorringe on 21 March 1998 when he diagnosed "brucellosis of the intracellular kind" and "maldesen poisoning". At this consultation Dr Gorringe also prayed for Ms Ghaemmaghamy . At the second (and last) consultation on 5 May 1998 Dr Gorringe advised Ms Ghaemmaghamy that the prayer (undertaken at the previous consultation) had killed the brucellosis bug. At both consultations Dr Gorringe used "Peak Muscle Resistance Testing" and prescribed homeopathic remedies.

250. On 2 July 1998 Ms Ghaemmaghamy made a complaint to the Health and Disability Commissioner which culminated in the laying of the present charges.

251. It is appropriate to deal with Ms Ghaemmaghamy's experience with Dr Gorringe and the background to it in some greater detail.

252. In August 1997 Ms Ghaemmaghamy developed a number of unusual symptoms which included muscle fatigue, weakness and pain especially on exertion. She also had blurry vision, together with concentration and memory problems. Additionally she had fluctuating temperatures which caused her to feel flushed quite often.

253. As a result, she consulted her general practitioner, Dr Ian Marcus of Raglan. He undertook a number of investigations including blood and urine tests and later referred her to a number of specialists for investigations to ascertain the cause of her muscle fatigue. In late 1998 she was diagnosed with fibromyalgia which was made after the exclusion of other diagnoses.

254. Prior to the fibromyalgia diagnosis and while Ms Ghaemmaghamy was awaiting various investigations which might ascertain the cause of her symptoms, she began looking around at other alternative possibilities for diagnosis and treatment. She explained that she was open minded about alternative therapies having previously used alternative practitioners but that she was also aware of charlatans and poorly trained practitioners and was concerned to

ensure that any alternative practitioner she consulted had some validity as she did not have money to waste.

255. Dr Gorringe was recommended to her by an Anglican Minister in Raglan with whom he had had professional contact. Upon learning that Dr Gorringe was both a conventional practitioner as well as an alternative therapist she was of the view that he would not therefore be a *"goof-ball"* and assumed his medical training would be likely to ensure a reasonable level of confidence and that, whatever his alternative practices were, they would have some sort of evidential basis. The purpose of seeing Dr Gorringe was to obtain a diagnosis and that by consulting him she would have the best of both worlds and that he might be able to find a diagnosis that a purely allopathic GP may have missed. At the time she consulted him she was *"desperate"* for a diagnosis and treatment.

256. In January 1998 Ms Ghaemmaghamy telephoned Dr Gorringe's surgery to make an appointment. She had to wait until 21 March 1998 to see him. She was sent an explanatory handout sheet which had a detailed list of instructions about necessary preparation for the first consultation. This included a requirement that she take all medications, supplements and herbs that she was currently using. She was also required to write out from memory her own medical history including all illnesses and surgeries throughout her life which she considered an unusual and time-consuming requirement.

257. On 21 March 1998 Ms Ghaemmaghamy attended at Dr Gorringe's surgery. She stated he did not appear particularly interested in the samples, medications and the information she had gathered for the purposes of the first consultation and that while he asked a few questions to clarify some of her written information, he did not go through the list in any detail with her. She stated he appeared *"in a big hurry and would cut off [her] explanations before [she] could finish"*.

258. Dr Gorringe did some *"basic doctor things"* such as taking her blood pressure and pulse.

259. Following a preliminary discussion, Dr Gorringe proceeded to *"muscle test"* her using his muscle testing apparatus. Ms Ghaemmaghamy stated there was no discussion prior to this testing procedure that Dr Gorringe would be confining himself to alternative medicine.

260. She underwent the muscle testing procedure and felt Dr Gorringe was rushing through it. She found the procedure disorientating. She found the whole process of touching the vials with the rod occurred very quickly and was of the view that Dr Gorringe was pulling her fingers apart in two different ways. She said he would either apply pressure in an outwards motion which was easier for her to resist and therefore make her hand seem stronger while at other times he would push upwards which meant that it was easier for him to pull her fingers apart.

261. She was becoming somewhat confused about which vials to touch in accordance with his instructions and began to ask him questions about what was happening. She said Dr Gorringe offered her very brief and insubstantial answers; that he was abrupt and kept insisting she pay attention; and she had a sense that she should stop bothering him. The brief explanation he did offer gave her the impression that somehow the energy in the vials transferred to her body. She stated she *"found the whole procedure both weird and emotionally uncomfortable"*.

262. At the conclusion of the muscle testing procedure Dr Gorringe told Ms Ghaemmaghamy she had brucellosis which was very common and which he diagnosed all the time. He told her that she had brucellosis of the intracellular kind which could not be diagnosed by traditional blood tests or by other doctors. She stated that he did not tell her how she could have contracted it and nor did he ask her any questions about her contact with meat or animals. He told her that with treatment she would be feeling better in about a week.

263. She stated that at this consultation Dr Gorringe also advised her she had maldesen poisoning; but gave her no explanation as to how she could have contracted it. He said it was a common ailment; and advised her that he could give her some homeopathic remedies which would treat the poisoning but did not explain to her how they would work.

264. With regard to the brucellosis, she said Dr Gorringe gave her two options for treatment. He told her he could give her a 7-10 days course of antibiotics and alluded to there being typical side effects which could be quite powerful but did not give detail as to what they were.

265. Dr Gorringe then asked her whether she was *"open to spiritual healing"*. Ms Ghaemmaghamy replied *"Yes"* to his question. She stated that in answering *"yes"* she was

not aware that she was agreeing to receive spiritual healing from him or anyone else and that she took this as an open question but which he took as some form of consent which it was not and that she was therefore totally unprepared for what happened next. She stated that Dr Gorringe then *"launched into an elaborate and charismatic prayer with very Christian content"*; and that he required her to bow her head during the prayer.

266. Ms Ghaemmaghamy stated that she was *"completely stupefied, and absolutely floored at what had happened"*. She said she was not a Christian and her religion was not discussed with her but that straight after the prayer Dr Gorringe began writing notes with his head bowed over his work and he told her to *"thank the Lord"*. She stated that after a period of silence Dr Gorringe said again *"I haven't heard you thank the Lord"*. At that point she said she felt completely mortified but complied.

267. Prior to leaving the consultation, Ms Ghaemmaghamy said Dr Gorringe required her to purchase some homeopathic medication from him but he did not advise her what it was for and nor did he give her any option of purchasing the medication from anywhere else other than his office. She added that she was not given the opportunity at that time of having antibiotics prescribed. She said Dr Gorringe definitely told her she would be feeling better in one week. With this, she was elated and made a follow up appointment for 5 May 1998.

268. In between the two appointments, Ms Ghaemmaghamy said that she followed, to the letter, all of Dr Gorringe's requirements in relation to the homeopathic medication.

269. Ms Ghaemmaghamy stated that despite her reservations about Dr Gorringe he had given her *"a lot of hope that [she] would feel an improvement in seven days"*. However, when she did not, she telephoned his practice nurse who told her that with some people the improvement took longer to occur.

270. In between her two consultations with Dr Gorringe, Ms Ghaemmaghamy also consulted her GP Dr Marcus and discussed Dr Gorringe's diagnoses. She understood Dr Marcus telephoned a medical laboratory to ask if there was a standard test for maldesen poisoning but that the laboratory had not heard of it. Dr Marcus also took a blood sample and sent it to a laboratory for testing for brucellosis and was subsequently advised that the blood

sample tested negative. There was no brucellosis. This result was forwarded to Dr Gorringe in March by Dr Marcus.

271. Before her next consultation with Dr Gorringe, Ms Ghaemmaghamy underwent further investigations at Waikato Hospital.

272. On 5 May 1998 Ms Ghaemmaghamy returned to see Dr Gorringe because she stated she *"was still desperate for a diagnosis"*. Having had time to think about his diagnoses between consultations she had made up her mind to discuss with him the benefits of a course of antibiotics. She stated that despite her scepticism and her research (she had looked up brucellosis on the internet) Dr Gorringe was not 100% convinced that her diagnosis was not brucellosis. She had also made up her mind to challenge Dr Gorringe on his treatment but stated that she did not have the courage to express her concerns at the second consultation.

273. At the second consultation she told Dr Gorringe that she understood that the prayer did not exclude antibiotics or other medical treatments for the brucellosis. She stated that he advised her that there was no need for her to undergo antibiotic treatment as the prayer had *"killed"* the brucellosis *"bug"*. She stated that he then conducted more muscle testing in order to show her that the brucellosis was, in his words, *"as dead as a doornail"*.

274. She also told Dr Gorringe that in between the consultations with him, she had had an admission to hospital and had had x-rays taken and that he was *"very angry"* to learn of this raising his voice and saying words to the effect *"you knew you were not supposed to have an x-ray"*. She thought his conduct was *"completely inappropriate and appalling"*.

275. At the conclusion of the consultation she said Dr Gorringe prescribed further homeopathic remedies which she was required to purchase from him.

276. The two consultations had cost a total of $415.00.

277. Ms Ghaemmaghamy stated that she took the new remedies for two weeks by which time she had come to the conclusion that *"the consultations were entirely a sham"*.

278. At that point, she arranged for an advocate to make a complaint on her behalf to the Health and Disability Commissioner.

THE EVIDENCE ABOUT PEAK MUSCLE RESISTANCE TESTING (PMRT)

279. The issue of PMRT is important because the various charges allege that Dr Gorringe relied "*unduly*" on it in treating Mrs Short and Ms Ghaemmaghamy.

280. It was appropriate for the Tribunal to hear and consider expert evidence on the subject of PMRT (also referred to as Bi Digital O Ring Testing (BDORT)).

281. Expert evidence which was called by both parties and by the Tribunal itself.

282. With regard to PMRT, evidence was heard from the following witnesses:

Called by Director of Proceedings:

283. Dr Richard Otto Doehring, of New Plymouth, a registered medical practitioner in the vocational group of pathology whose sub-specialty is medical microbiology including healthcare epidemiology. He was called as an expert in his capacity as a medical specialist in the field of medical microbiology and communicable disease. He was called as an expert.

284. Dr Wendy Isbell, who practises as a dual practitioner, that is, as a general medical practitioner, physician and homeopath in her own practice at Christchurch. She was called as an expert.

Called by Tribunal:

285. Professor Mark Bryden Cannell, who at the time of the hearing held the Chair of Physiology at the School of Medicine at the University of Auckland before which he held a personal Chair as Professor of Biophysics in the University of London. He teaches medical and science students, post graduate science students and conducts research programmes which employ state of the art techniques in cell biophysics to help clarify the mechanisms underlying normalcy and disease. Most of his scientific work has centred on the biophysics of muscle contraction. He has published extensively in international journals on excitation contraction coupling and is recognised as a world expert in this area. He was called as an expert.

286. Dr John Charles Welch, a registered medical practitioner, vocationally registered in general practice, currently practising as a Defence Force Medical Officer, based at Woodbourne

near Blenheim, and who was trained in certain alternative medicines and has maintained an interest in them. He was called as an expert.

Called by Dr Gorringe:

287. Dr Anna Elizabeth Rolfes, of New South Wales, Australia, a registered natural healthcare consultant in private practice and currently the Director of the Institute of Vibrational Medicine teaching energy medicine through courses in kinesiology. In her private practice, clients consult her for improving their postural and physical fitness, nutritional health and emotional and spiritual wellbeing. She was called as an expert and gave evidence by video link.

288. Dr James Logan Oschman of Dover, New Hampshire, United States of America, whose qualifications include degrees in Biophysics and Biology. He holds, among other posts, membership of the Scientific Advisory Board National Foundation for Alternative Medicine. He has published widely and has explored the basis for complementary and alternative medicines. He also lectures on energetic phenomena occurring in the therapeutic situation. He gave evidence as an expert via video link.

289. Dr Marc Cohen of Victoria, Australia, who is a Professor of Complementary Medicine and Head of Department at RMIT University, Bundoora, West Campus, Victoria. He was called as an expert and gave evidence via video link.

290. Dr Gorringe gave evidence as to the background relating to PMRT (or BDORT) and attributed the origin of it to a Dr Yoshiaki Omura and produced some written material relating to the Omura technique (exhibits 31 and 42). However, it would appear from a perusal of those materials that the technique which Dr Gorringe practises is different from that practised by Dr Omura and therefore the Omura materials do not assist the Tribunal to any real extent.

291. Dr Gorringe stated that PMRT is reliable not only as a diagnostic tool but also as a means of establishing the appropriate treatment for and management of his patients. He emphasised that it is a complementary modality which allows him a different perceptional window into a patient's presentation.

292. The Tribunal asked Dr Gorringe to give a physical demonstration of PMRT, which he did. It also asked him to provide a written description of the method, which he prepared and made available prior to the hearing resuming in November (ex 41). His description of the apparatus and method is as follows:

> *For using the BDORT I use quite a simple piece of apparatus. It consists of a square aluminium plate measuring 200mm x 200mm x 10mm which is joined by a wire to another square block of aluminium measuring 100 x 100 x 20mm (called a "honeycomb" because of the holes drilled in it), into which you can place various vials, or onto the flat surface of which you can place larger objects/substances.*
>
> *When the person who I am testing, (the patient) places their left arm on the plate, they are in the circuit with whatever is in, or on the honeycomb and/or on the plate they are resting their forearm on.*
>
> *The patient begins by placing their left hand on the plate, in a palm down position. The method used is by sparking the patient with a Piezo electrical instrument using high voltage and negligible current. (Similar to what you light your barbecue with). Usually 10 sparks on three ting points on the left and right hands is sufficient to temporarily diminish the body's bio-energetic defense system, so that the input test stimuli are not "blocked" out by the body's bio-energetic defence systems, like the body does to keep us protected normally from the "electromagnetic smog" that surrounds all of us in our modern electrical worlds.*
>
> *The equipment used is purely for convenience, for presenting a vial, or substance to the patient, by holding it in the honeycomb, or on the plate while in contact with the patient. Actually, none of the equipment as such is needed as a person can simply hold any item and a muscle test can be performed. It can be any muscle group, such as an arm or even a leg as long as the tester can get the patient to produce a consistant muscle movement.* (our emphasis)
>
> *The exact mechanism of the neuromuscular response, whether it be strong or weak, is not fully known but can be applied to any bioenergetic test method using a muscle response.* (our emphasis)
>
> *I get the patient to put their hand, palm up, with thumb and forefinger together. This forms the "O" ring. My right hand slides down and grasps the thumb. My other hand comes and picks up the 4th and 5th finger. The test is when I ask the person to squeeze their thumb and 4th finger together, using their muscular strength of the adducter muscle of the thumb and forearm muscles that innervate the 4th finger. I attempt to generally separate the fingers apart using a "squeezing/gentle pulling" type of motion. If the muscle reaction is strong, the fingers will stay together. If it is weak they will come*

> *apart or a "giving way" feeling occurs with muscle weakening perceived by the tester.*
>
> *I get the patient to take a little rod made of aluminium, but they could just as easily use their finger. To do the test, the patient then touches one of the vials and I ask them to "squeeze". I ask the patient to touch a series of vials to check that various areas of the body are open to testing. That is to say are they "testable", or in "test mode".*
>
> *The principle of the test is that we are challenging the patient's body fields or bio-fields with the any compound which we bring into their field, that I might choose to test. This might happen to be a chemical, food, or they could be vials made up from infective micro-organisms, or components that a person is in contact with or handling at work, or around the home. We are challenging the patient's body to what is being added into the circuit.*
>
> *The mechanism that best fits the observations is that of Electromagnetic resonance. …*
>
> *…*
>
> ***Any diagnosis obtained with BDORT is presumptive,** and must always be considered in the **context of the presenting complaints** in the history, and where possible, be checked with a standard laboratory test if one is available.* … (Dr Gorringe's emphasis)

(The reference in Dr Gorringe's description above to "*4th and 5th finger*" was also referred to, in evidence, as the ring finger and little finger respectively.)

293. In his written statement Dr Gorringe has emphasised that "*none of the equipment as such is needed*". The equipment is used as a matter of "*convenience*" for presenting a vial.

294. The written statement also stated that "*the exact mechanism*" of PMRT is not "*fully known*", and emphasised that the PMRT "*diagnosis*" must always be considered in the context of the presenting complaints, and checked with a standard laboratory test if one is available.

295. In evidence Dr Gorringe stated that while it was "*ideal*" that the practitioner administering the PMRT be in good health, he did not accept that a lack of good health disqualified the practitioner from the process. He stated that it was necessary for the tester to concentrate while the patient's "*biofield*" was being "*challenged*"; and that if the tester's concentration wandered, it could wrongly influence the test result.

296. The Director called Dr Richard Otto Doehring, an expert in the field of medical microbiology and communicable diseases.

297. Dr Doehring stated (BOE para 31):

> *It should be noted that no reputable diagnostic laboratory will offer a test which has not been thoroughly evaluated for sensitivity, selectivity, and positive and negative predictive values (the probabilities that, given a positive test, the patient has the disease, or, conversely, given a negative test, that the patient does not). Such information is vital to the rational selection of tests to confirm or refute a diagnostic possibility, and to the interpretation of the results.* (BOE para 31);
>
> *The only way objectively to know whether a treatment is effective is to subject it to trials in which the expectations of both subject and investigator are controlled by double blinding. Dr Gorringe's diagnostic method of "biokenetics" is without objective validation. It confirms what he expects it to confirm, without any reality check against an independent diagnostic method. In my view there is no plausible basis in the natural sciences for the biokinetic diagnostic methods used by Dr Gorringe …"* (BOE para. 74)
>
> *"Dr Gorringe states that "a complementary medical modality … can be accepted and used widely even though the underlying mechanisms involved remains the subject of research". I do not agree. … There are many treatments and procedures in medicine whose mechanisms are not understood, but which have been tested and shown to be effective. BDORT [PMRT] has not been properly tested or shown to be effective."* (BOE para 11)
>
> *"The reference [by Dr Gorringe] to "we are dealing with a completely new language" is an example of how those subscribing to such modalities cope with scientific rejection. A new language and science is created."* (BOE para 14)
>
> *"… there is no evidence that BDORT [PMRT] has been subjected to a "randomised placebo-controlled trial". This of course is the gold standard in medicine for evaluating new therapies. Blind testing is essential to isolate the beliefs of the tester, and patient, who could otherwise influence the results through wishful thinking. The lack of this process with BDORT [PMRT] means it is not correct to claim, "the scientific method supports its clinical use"."* (BOE para 25)

298. Dr Doehring was asked by the Director whether he had any comment to make in respect of Dr Gorringe's statements about the PMRT apparatus. Dr Doehring stated:

> *I would say first of all I don't believe that the testing apparatus either relies on a plausible theory nor has evidence been presented that its results are reliable. I think the point is made elsewhere by Dr Gorringe that certainly we sometimes use tests for which we don't have a full theoretical explanation but in those circumstances we currently do have the results of empirical testing which demonstrate their effectiveness. It is very difficult to make any comment at all. I just do not accept any of the statements made. Some of the examples he has given in fact I think raise the degree of scepticism somewhat."* (NOE 216 25-27; 217 1-7)

299. Dr Doehring reaffirmed this view in further questions from the Director.

300. Mr Knowsley put to Dr Doehring in cross-examination that Dr Gorringe was offering something different by way of diagnostic technique and asked if it was *"such a bad thing to try and offer something different"*. Dr Doehring responded that in itself it was not but that what one would hope for is that *"the something different"* would be based on scientific reasoning and tried diagnostic method. He stated that:

> *"in the absence of an appropriate diagnostic method certainly trials of therapy are not unreasonable or unusual in medicine. What I believe is a problem here is that a very suspect diagnostic method was used, the PMRT, and [a] fairly unequivocal diagnosis was made on the basis of that and then an untested, unproven therapy embarked upon."*

301. The Tribunal shares Dr Doehring's concerns.

302. Dr Doehring was of the view that there was no plausible mechanism by which PMRT could work. He stated:

> *"In my opinion there is no plausible mechanism by which the contents of these vials could interact at a distance with organisms in the patient, still less a mechanism to explain how this interaction could manifest as a muscular twitch in the patient."*

303. He stated that Dr Gorringe had previously referred to the phenomenon in physics known as "*resonance*" to explain the working of PMRT (Doehring BOE para 35,36). Dr Doehring stated:

> *"The explanation that there is some form of resonance I think cannot go unchallenged. I certainly think it has been stated that this is a physical, energy or force transmitted down the wire, not electrical. However, of the 4 forces known to physics, the electromagnetic, gravitational, the weak and strong,*

> *only the electrical would be expected to be transmitted along a conducting metallic wire. Even if this is a physical force or energy not known to science the phenomenon of resonance does require the transfer of energy from one source to another."* (emphasis ours)

304. Professor Mark Cannell was called by the Tribunal.

305. Professor Cannell referred to some 14 references in the literature which examined scientifically whether there was any reliability in applied kinesiology (AK) methods, which include PMRT or BDORT. He stated that none of those studies reached the conclusion that PMRT was a reliable diagnostic technique.

306. Professor Cannell stated:

> *"In summary, I find the descriptions of the AK [applied kinesiology] methods and in particular the BDORT test to be inconsistent with known physical principles. Even if it were possible to produce a "field" with these methods, AK [applied kinesiology] methods (and BDORTing) [testing] have not been shown to produce an electrical field which is required to alter the electrical activation of nerve and muscle. A limited survey of the literature shows that the AK [applied kinesiology] testing results are unreliable – and this idea is apparently supported by some organisations that support complementary medicine. I find it deeply disturbing that the only people who seem to claim reliable diagnostic results are those who make a living from applying it and some controlled scientific tests reveal no validity to these claims."*

307. Professor Cannell stated in answers to questions by the Director that it would have been quite simple to set up a blind trial of the PMRT technique Dr Gorringe uses and that he had made such an offer to Dr Gorringe who was unwilling to undertake such a trial and did not offer any explanation as to why he would not.

308. Professor Cannell confirmed that there was no scientific or physical explanation for how touching a vial with an aluminium rod could result in a muscle result in the patient.

309. The Tribunal accepts Professor Cannell's evidence.

310. Professor Cannell was also asked about the issue of surrogacy. The Director asked Professor Cannell if he were able to provide any scientific explanation for how some substance in a vial and its resonance could somehow bypass the surrogate in order to test the patient. Professor Cannell replied:

> *"well I'm afraid I don't quite understand the need for a surrogate because it was asserted that the connections are not necessary, that there needs to be no physical connection between the vial and the patient, so I don't understand why a person would be required either."*

311. In answer to a question from the Tribunal regarding the surrogacy issue, Professor Cannell stated that he could not, as a scientist, make an understanding of that particular manoeuvre. He did not understand why, for example, if the life force which is alluded to is present it is not in fact contaminated by the mother's life force. It did not make any logical sense to him as a scientist.

312. Professor Cannell continued:

> *"Nevertheless, if electrical currents are used to alter cell firing they should be measurable by modern methods. To my knowledge no such recording has ever been made successfully during AK [applied kinesiology] testing. Furthermore, it is quite unclear how electric currents are supposed to escape vials made of insulating materials or even why the electro chemical potential of the test vial should create an electromotive force (voltage) to cause current flow."*

313. Dr John Welch was called by the Tribunal.

314. When addressing PMRT and, in particular Dr Gorringe's compilation (Ex 41), Dr Welch stated

> *"BDORT is operator dependent, meaning that what actually happens is that the operator diagnoses whatever it is that he believes in. One cannot scientifically evaluate "belief". In the context of testing, then, it would be impossible to challenge the practitioner's belief in his apparatus. (Refer Steeper, NZMJ, 25 April 1990, page 194-5)."*

315. When questioned by the Director to comment further, Dr Welch stated that he was "referring to a proper scientific test to see whether the practitioner can reproducibly diagnose conditions in a double blind placebo controlled manner which is the gold standard for medical practice".

316. Dr Welch also stated:

> *"I think the big problem with the Bi-Digital O-Ring Test is the fact that it's not been properly tested to make sure that the results are reproducible. As*

> *Professor Cannell alluded to in his evidence, the key thing about science is a naive observer anywhere in the world should be able to reproduce the results using the same apparatus."* (NOE 387 22-27)

317. The Director also relied upon the evidence of Dr Isbell (whom she described as a dual practitioner and therefore an important expert witness) who was clear in her view that PMRT was not an appropriate technique for making significant decisions or diagnoses.

318. Dr Isbell was of the opinion that results of muscle testing can be significantly changed by many variables and that, arguably, a number of suspect conclusions can be drawn from muscle testing. Dr Isbell described muscle testing as a subjective testing form best used for minor testing when there were no real or clinical diagnostic issues; and was critical of Dr Gorringe's practices in that regard. Dr Isbell's evidence was consistent with the evidence of Dr Doehring, Professor Cannell and Dr Welch.

319. Dr Rolfes was called by Dr Gorringe in support of his use of PMRT.

320. Dr Rolfes said she was not familiar with the mode of Dr Omura's BDORT and that she did not know whether his technique was the same or different from that advocated by Dr Gibb, to whom we shall refer shortly.

321. The Tribunal concluded from all of Dr Rolfes' evidence that she would appear to practise a different kind of muscle testing from that of Dr Gorringe.

322. However, Dr Rolfes did state that indicator muscle tests do not replace a medical diagnostic test but are complementary tools.

323. When asked by the Director whether she would rely on the indicator muscle test as a diagnostic tool, in the absence of a history and clinical examination that supported that diagnosis, she responded that she would not and stated that one needed the history and a clinical examination while adding that she had used the indicator muscle test for quite some time in her clinic and that it was "*amazing*" what people told her in their case histories.

324. When asked if she would use BDORT to diagnose or exclude a diagnosis of chemical poisoning she replied that if she thought a person was so poisoned from her clinical

observations then she would do blood tests and that *"blood poisoning is a medical diagnosis"*.

325. Overall the Tribunal did not find much of Dr Rolfes' evidence of assistance. The Tribunal found her presentation at places confused and not particularly comprehensible or credible. It appears Dr Rolfes practises a different kind of muscle testing from Dr Gorringe. She did not know of Dr Omura's technique or whether it was different from Dr Gibb's. She was not able to identify what testing would prove the reliability of PMRT. She was in no doubt, however, that she would not rely on an indicator muscle test as a diagnostic tool in the absence of a history and clinical examination which supported that diagnosis; and with regard to chemical poisoning or Legionella infection she would follow up with blood tests.

326. Dr Oschman, who also gave evidence on behalf of Dr Gorringe, described himself as one of the few academic scientists who have explored the basis for complementary and alternative medicine. He challenged the evidence given by witnesses called by the Director and by the Tribunal.

327. However, when cross-examined by the Director as to whether he agreed that new phenomena in science needed to be capable of some kind of reliability or efficacy, he said he understood the perspective but that it was not his field of expertise.

328. Again, the Tribunal did not find Dr Oschman's evidence of assistance. He is not medically qualified. He tended to speak in generalities. We agree with the Director's comments that he made sweeping, general statements about the use of PMRT without reference to independent literature or studies; that he made significant reference to homeopathy and acupuncture in general, which is not relevant to the issue of whether PMRT works or not; that he asserted that there were limits on the extent to which BDORT could be shown to be reproducible *"given the nature of human beings"*; that later in his evidence, when cross-examined, he agreed that *"you would want to have your [diagnostic] tests to be reliable, definitely. Particularly if it is a destructive test"*; but that overall he disclaimed expertise in the area of efficacy testing.

329. Dr Gorringe also called Professor Marc Cohen whose written statement was confirmed via video link.

330. With regard to the evidence of Professor Cohen, the Tribunal noted that the two articles which he produced contained propositions of a general nature and from which it did not derive assistance in addressing the pertinent issues.

331. The Director, during her cross-examination of Dr Gorringe and in her closing submissions, suggested that PMRT is subjective, very operator-dependent, and in any event subject to error.

332. There was evidence of such subjectivity from Ms Ghaemmaghamy. At the first consultation, Ms Ghaemmaghamy was of the view that Dr Gorringe was pulling her fingers apart in two different ways. She said Dr Gorringe would either apply pressure in an outwards motion which was easier for her to resist and therefore make her hand seem stronger but at other times he would push upwards which meant that it was easier for Dr Gorringe to pull her fingers apart. The Tribunal accepts Ms Ghaemmaghamy's description.

333. There was significant evidence, which the Tribunal accepts, that "*results*" are affected by patient fatigue which can arise during the process.

334. Dr Gorringe produced and placed much reliance upon a volume of material (ex 43) entitled *"Course in bioenergetic medicine"* compiled by Dr J.W.G. Gibb of Auckland. It was understood that this compilation (which was undated), was produced in or about 1996. Dr Gorringe told the Tribunal that he had learned how to apply PMRT from Dr Gibb and also from a Dr Percival.

335. However, Dr Gibb's material does not really assist Dr Gorringe. In that material, Dr Gibb himself refers to *"energetic medicine"* (which he distinguished from biochemical medicine) as being a *"subjective method"* and *"prone to great errors"*.

336. When this was put to Dr Gorringe, he stated that the phrase *"prone to"* used by Dr Gibb was a "*proviso*". Dr Gorringe said the procedure was prone to errors unless *"people [were] prepared to go through all the pre-procedures, follow the known rules that minimise all the possible errors or sources of errors"*. He added *"just being subjective doesn't mean to say you can't get proper data out of it …"*.

337. The Director referred the Tribunal to a letter dated 25 October 2000 from Dr Gibb to Dr Gorringe's counsel, who had in turn forwarded it to the Health & Disability Commissioner as part of his submission on Dr Gorringe's behalf during the complaint investigation process (Ex 46).

338. Dr Gibb stated "… doctors should always confer with colleagues before withdrawing any drugs which may be a first and foremost priority in the patients interest".

339. At page 2, Dr Gibb stated: "There are some specific areas where, in my opinion, Dr Gorringe has erred in treatment. The evidence for stating the presence of an infectious disease or any chemical pollutant cannot be made definitively by the techniques he uses."

340. When this was put to Dr Gorringe by the Director he replied "that was one of the biggest surprises I've ever heard Gerald [Dr Gibb] say … that's a question Gerald will need to answer himself …". Dr Gorringe did not call Dr Gibb to give evidence.

341. Dr Gibb continued in his letter:

> *"… there is a need to go back and carry out serology tests or confirm by other orthodox means that the specific toxin is acting as or contributing to the mean toxic load of the patient"*
>
> …
>
> *"Dr Gorringe uses many diagnostic and therapeutic techniques quite different to those I teach"*
>
> …
>
> *"All medically trained doctors are fully cognisant of the fact that objective and established disease is best treated by orthodox medicine and this should take priority over complementary medicine but often there can be an advantage in combining the two."*

342. The Director also referred Dr Gorringe to Dr Gibb's instruction manual which stated:

> *"biokinesiology … may not be used as the sole or exclusive method to diagnose any disease, defect or condition in the human body. Any data obtained as a result of the Biokinesiology system must be, and should be, confirmed and verified using diagnostic methods that are approved for use in New Zealand and recognised by the New Zealand Medical Council. No*

> *diagnosis should be based, nor claim made, nor any course of therapy be instituted, modified or terminated, solely as a result of any information obtained from use of the Biokinesiology system"*. (Ex 43 p.111).

343. Despite this Dr Gorringe continued to maintain before the Tribunal that PMRT could be used to diagnose an infectious disease or chemical pollutants.

344. The Director submitted that Dr Gorringe's view was contrary to the weight of evidence.

345. The Tribunal agrees with the Director's submissions. The Tribunal is also concerned that Dr Gorringe patently misrepresented Dr Gibb's position.

346. In support of his contention that PMRT works, Dr Gorringe called some fourteen patients who expressed their satisfaction with his management and treatment; and a CBA Patient Outcome Study (Ex 49).

347. In answer to a question on behalf of the Director that the difficulty was that there was no system by which to test the practitioner's proficiency when he commences to use the PMRT technique, Dr Oschman said it was his belief that the test of the proficiency of the practitioner was in the outcome for the patient and that the case studies spoke for themselves. However, he clarified this by saying that being satisfied was not a very reliable scientific measure and that a more reliable measure would be, for example, a measure of the patient's anxiety level which was something which could be quantified. While satisfaction was a good and desirable thing, in terms of science and reproducibility he said that was *"a little tricky"*.

348. The Director said that while she did not question the sincerity of the patients' beliefs that Dr Gorringe assisted their recoveries, their evidence did not support the assertion that PMRT was reliable.

349. She submitted:-

(a) The Tribunal did not hear evidence from the medical practitioners who had purportedly failed these patients in the past;

(b) No past or contemporaneous medical notes were provided to support, or refute, the various claims made; and

(c) In any event, the Tribunal must be concerned with the manner in which Dr Gorringe

used PMRT in relation to Mrs Short and Ms Ghaemmaghamy with reference to the various symptoms that were presented, and the extent to which Dr Gorringe obtained their informed consent.

She added that the patients' evidence in this respect was largely irrelevant.

350. In this regard, the Tribunal notes that, quite co-incidentally, Dr Rademaker (to whom Mrs Short was referred and who also gave evidence) had been consulted by one of Dr Gorringe's witness patients, Ms C.F. (whose written evidence was admitted by consent in her absence). Dr Rademaker was able to comment to some extent on this patient's evidence. He cast a different light on it and raised the distinct possibility that, with a little conventional treatment, Ms C.F. might have avoided considerable suffering which she underwent on and off for a significant period (August 1993 to March 1996) while under Dr Gorringe's care, even though she expressed complete satisfaction with him.

351. Mr Knowsley submitted it was not a question of arguing that the evidence in Dr Gorringe's cases was anecdotal but rather what was possible with PMRT, and that his case studies provided powerful evidence for the efficacy of PMRT.

352. Dr Gorringe also relied on Dr Oschman's opinion that *"outcomes"* were a reliable measure.

353. With regard to the CBA Study, the Director submitted that this was of limited value in the assessment. She referred to the evidence of Drs Doehring and Isbell and Professor Cannell, submitting that the study was subjective, biased and of little scientific value.

354. The Tribunal notes Dr Doehring's reservations about the methodology of the survey which he explained in some detail and what conclusions, if any, could be drawn from it:

> *"Many medical conditions are self-limiting, people do get better, even if they have chronic conditions those conditions can wax and wane and the fact that people feel better does not necessarily mean they have had the correct treatment and it most certainly doesn't mean that they have had the correct diagnosis. The correct treatment can sometimes be given in the absence of a correct diagnosis."* (NOE 221 3-17)

THE TRIBUNAL'S FINDINGS REGARDING PMRT

355. Professor Cannell provided credible, coherent and compelling evidence which significantly assisted the Tribunal in considering and determining the relevant issues.

356. The Tribunal was similarly assisted by Dr Doehring and Dr Isbell whose evidence it accepts on this issue.

357. It notes and accepts the evidence of Dr Welch to which we have referred above.

358. With regard to the issues surrounding PMRT, the Tribunal found much of Dr Gorringe's evidence lacked credibility and was deliberately evasive.

359. The Tribunal accepts and agrees with the evidence of Dr Doehring that there is no plausible mechanism by which the contents of vials could interact at a distance with organisms in a patient, and no plausible explanation to explain how this interaction could manifest as a muscular twitch in the patient. The Tribunal also accepts the evidence of Professor Cannell who stated that it was unclear how electric currents or energy could escape vials made of insulating materials where there is no input of energy to the test object; and that even if energy were put into the test object, such energy would be capable of being measured.

360. Dr Rolfes did not really challenge in any comprehensible or relevant way Professor Cannell's evidence in this regard, but rather provided confused and irrelevant evidence on the skeletal muscle system. We also agree that while Dr Rolfes offered her own view on the concepts of electro-magnetic waves she did not attempt to apply her science to the operation of PMRT. We further agree that Dr Rolfes' discussion about her thesis research, and oral evidence, was neither relevant nor understandable in the context of these proceedings except to the extent that there is a component of involuntary muscle action in indicator muscle testing.

361. We accept the Director's submission that Dr Oschman made broad statements with no supporting body of knowledge, such as, "we have evidence that fields exist"; "we have learnt through a lot of research that living systems are very sensitive to small fields"; "it is not difficult to explain how a vial with solution could resonate with molecules in the body". The Tribunal noted that no evidence was produced to support those assertions.

362. The Tribunal accepts Dr Doehring's evidence that in diagnostic medicine there is an expectation of quality assurance procedures in relation to all items of testing materials including the vials and their contents. We do not accept Dr Gorringe's explanation that none was necessary. We agree also with the Director's submission that a lack of independent verification/certification calls into question the reliability of the testing materials.

363. We therefore accept that PMRT is not a plausible, reliable or scientific technique for making medical decisions. We find there is no plausible evidence that PMRT has any scientific validity. It therefore follows that reliance on PMRT to make diagnoses to the exclusion of conventional and/or generally recognised diagnostic/investigatory techniques is unacceptable and irresponsible.

364. For the reasons advanced by the Director, the Tribunal is not persuaded there is any credible evidence to support the claims made for PRMT. Moreover, the evidence of Dr Rademaker casts serious doubts on the worth of the evidence of Dr Gorringe's patients who are said to have derived benefit from its use. Doubtless they are sincere, but that is not the issue. The evidence Dr Gorringe adduced does not withstand careful scrutiny.

THE CHARGES

365. We now consider each of the charges against Dr Gorringe as described above.

Dr Gorringe's defence under section 109(4) (*"theory of medicine"*)

366. Dr Gorringe relied on PMRT at every consultation.

367. This theory has no scientific validity.

368. The evidence he adduced regarding PMRT did not substantiate the manner in which he himself practised it.

369. His methods were positively contradicted by Dr Gibb, the practitioner whose practices he claimed to follow and therefore validate his own.

370. The Tribunal is satisfied that Dr Gorringe's use of PMRT was idiosyncratic and was not supported by any of his fellow practitioners.

371. It will be evident from the findings the Tribunal makes in respect of the particulars that he did not intelligently use his knowledge of both conventional medicine and alternative treatment when treating either Mrs Short or Ms Ghaemmaghamy.

372. Indeed, the Tribunal finds he disregarded conventional medicine and prescribed for both patients alternative remedies when there was no credible basis for doing so.

373. Whilst section 109(4) recognises that a practitioner is not to be found guilty "***merely***" because he has adopted or practised a theory of medicine or healing, it does not follow that his adoption and practice of any theory of medicine or healing is by itself a sufficient answer.

374. On the basis of the findings the Tribunal makes in respect of the particulars, the Tribunal is satisfied that Dr Gorringe did not act honestly and in good faith.

Professional Misconduct – Mrs Short

Particular 1.1 - Paraquat poisoning

375. The first particular alleges that the first consultation on 19 March 1998 when Dr Gorringe knew his patient Mrs Short had been diagnosed previously with chronic eczema, in diagnosing her as suffering from paraquat poisoning he;

(a) Having obtained Mrs Short's clinical and social history relied unduly on PMRT to reach his diagnosis; and /or

(b) Having undertaken a clinical examination and obtained her clinical and social history, reached his diagnosis when it was not supported by her history and/or clinical presentation; and/or

(c) Failed to carry out any other diagnostic tests to confirm or exclude his diagnosis.

376. It is not in dispute that at the consultation on 19 March 1998 Dr Gorringe diagnosed Mrs Short as being chemically poisoned by paraquat.

377. Dr Gorringe claimed to have diagnosed something like 150 cases of paraquat poisoning in the last 14 to 15 years.

378. Before the Tribunal, Dr Gorringe contended his diagnosis of Mrs Short was based partly on his assessment that Mrs Short's skin condition accorded with his other experience of

paraquat poisoning (including his own personal and family experience) and partly on his reliance on PMRT. He could not seriously contend his diagnosis was based on her clinical or social history or by reference to conventional dermatological or medical literature.

379. Dr Rademaker deposed there was very little evidence in conventional dermatological/medical literature that paraquat was a topical allergen, that is, that it caused a skin reaction on contact, or that absorption such as by spray drift or eating sprayed foods or walking through sprayed paddocks, caused skin problems.

380. Dr Doehring stated that while a contact dermatitis could be a manifestation of paraquat poisoning, it was a self-limiting condition and was associated with direct contact with the chemical. He considered descriptions of the dermatological manifestations and epidemiology of paraquat poisoning in comprehensive reviews did not accord with Mrs Short's lifelong dermatological problems and "*relatively transient exposure to the agent*".

381. In fact, on the evidence presented to the Tribunal, Mrs Short had no direct exposure to paraquat prior to Dr. Gorringe's diagnosis.

382. Dr Gorringe maintained there was nothing wrong with observational diagnosis in dermatology as most diagnoses were made that way.

383. When asked to comment on this, Dr Rademaker confirmed that most diagnoses in dermatology were clinically based (visual clinical examination together with history) "*through experience*". However, he observed there were certain tests, such as patch testing or skin swabs, which would be done in order to identify whether there were aggravating factors.

384. He stated that the patient's history was crucial in determining what the aggravating factors were for the eczema so that if a doctor suspected an allergic contact dermatitis, then it was essential to define the products with which the patient came into contact that might cause the dermatitis; hence the practice was to take a careful and detailed history from the patient.

385. When asked what examination he would undertake in order to diagnose atopic eczema, Dr Rademaker replied that the most important aspect was taking an appropriate history from the individual and then examining as much of the skin as possible which, in most individuals, meant disrobing them to their underwear.

386. Dr Rademaker was asked if he were not considering eczema as the diagnosis, what other clinical examinations or investigations he would undertake. He stated that assuming the patient had an inflammatory dermatosis of the hands and he did not think it was eczema, then he would look at doing a skin biopsy because any doctor needs to know if the skin problem was an inflammatory process. Microbiology might be undertaken by way of a skin scraping to ascertain whether there were an infection or skin swabs taken and tested to rule out secondary infection and contact dermatitis or patch testing undertaken if the doctor thought there was a contact component involved.

387. Dr Isbell was asked what examination she would have undertaken on a first consultation with Mrs Short whose primary complaint was eczema on her hands. Dr Isbell responded that she would want to look at her hands, to note particularly the skin of the hands - what was abnormal - and to document this so that she could look at it objectively at a later date or to ensure that there was some objective assessment so that others would be able to follow her notes. She also considered it would be important to check the rest of the patient's skin in order to see how generalised the problem with the hands was.

388. In both her written brief and oral answers, Dr Isbell stated that skin infection was a recognised risk of eczema and if there were a probable infection present, a swab could be taken (as well as oral antibiotics given).

389. With regard to the taking of a history, Dr Gorringe said that he identified Mrs Short's gradual deterioration, that in particular he identified her involvement with the poultry farm and with farm irritants in general, as was evidenced by the worsening of her condition once she shifted into the farm environment. He added that he *"was not aware of it at the time"* but noticed from Mrs Short's diary (produced following her complaint to the H & D Commissioner) that she had had long term exposure to wood dust irritants from her hobby of jigsaw making.

390. Dr Gorringe stated that at the first consultation with Mrs Short, he was able to recognise that while she had a clear eczema history, she had become less and less responsive to standard suppressive eczema therapy of steroid cream and Prednisone. He added that in the immediate few months prior to consulting him, she had deteriorated while under Dr Joe and that according to Dr Joe's notes she had become, from Dr Joe's observations, non-

responsive to steroid cream and Prednisone. He stated that from the skin of her hand and in particular the thickened skin of her arms and neck, which he referred to as "*lichenification*", he was able to judge with some degree of certainty, based on his past experience and successful treatment of patients with similar presentations, that a highly probable diagnosis was paraquat poisoning complicating the background eczema.

391. He stated that Mrs Short had been seen by five other general practitioners and referred to dermatologists by each of them, often repeatedly and with regular reviews either initiated by the dermatologist or by herself.

392. He added that Mrs Short had been deteriorating over the last four to five years and especially, under the care of Dr Joe, within the last two months in spite of the standard suppressive medical therapy of steroid creams and Prednisone and referred to the notes of Dr Joe. He also stated that Mrs Short presented at the first consultation with a natural history of intermittent flares of eczema since a very young age.

393. Mrs Short disputed these assertions.

394. She stated that Dr Gorringe did not examine her entire skin at this first consultation or, indeed, at any consultation. He confirmed he did not disrobe her to check areas of her skin other than her face or hands.

395. When it was put to Dr Gorringe that he did not obtain any prior medical history by accessing Mrs Short's dermatologist's notes or her other general practitioner's notes, he replied that he took at face value what she told him - which was recorded in his notes as the history - and that this was what any person acting in the place of first action did, that is, they listened and wrote down what patients told them. He insisted that he took at face value what Mrs Short was prepared to share with him as her history, that she was *"rather economical with her history"* and that he had therefore recorded on page 2 of his notes the words *"nil else"*.

396. When pressed by the Director that the onus was on him to make the enquiries, Dr Gorringe replied that he asked if there was anything else Mrs Short needed to tell him and that it was not his job to be a mind reader or to make an assessment as to whether the patient was telling an untruth. His job, he said, was to record the facts as they (the patients) tell him at the time they tell him.

397. Dr Gorringe accepted that he was placing the onus on the patient to identify the information which was clinically significant. As the Tribunal has already observed (see para.157), it was his responsibility to ask the questions necessary to elicit all the relevant information from his patient, not his patient's responsibility to guess what information might be relevant to a proper diagnosis.

398. Mrs Short disputed Dr Gorringe's assertion that her skin had deteriorated over the previous four to five years. She said that there was a long period during that time when she had not been to a dermatologist and that her condition was not deteriorating and did not deteriorate under Dr Joe. She said that while the topical steroid cream (Diprosone) may not have cured her condition that it *"certainly relieved it"* and that it made her *"hands feel a lot better"* and that she *"was able to function as such"*.

399. With regard to her history of contact with dermatologists and repeated reviews, Mrs Short said she told Dr Gorringe at the first consultation, when he gave her the diagnosis of paraquat poisoning, that she had been to other dermatologists who said her condition was eczema. She did not specify who she had consulted and Dr Gorringe did not ask.

400. With regard to reference to general practitioners, Dr Gorringe did not ask and Mrs Short did not give him any information about general practitioner contact.

401. The Director submitted that as Dr Gorringe described himself as a doctor of last resort who gives second opinions then, in providing a second opinion, there was an onus on him to ascertain the relevant clinical/social history for a patient (if necessary from other health professionals) so as to canvass all diagnostic options.

402. The Tribunal accepts that submission.

403. The Director accepted that Dr Gorringe had obtained some of Mrs Short's clinical and social history, but submitted that, notwithstanding, he relied unduly on PMRT to reach the diagnosis of paraquat poisoning. The Director referred to Dr Gorringe's evidence that there were no conventional tests available in New Zealand to diagnose paraquat poisoning and to his further evidence that a diagnosis reached by PMRT was presumptive and should always be supported with clinical history and other conventional tests as appropriate.

404. She submitted that, given there were no conventional tests available to confirm or exclude this diagnosis, Dr Gorringe must have relied on PMRT to make the diagnosis. She referred in this regard to his view, based on his past experience, that Mrs Short's symptoms were consistent with his diagnosis.

405. She submitted that if the Tribunal were to find that PMRT was not an appropriate technique for making significant diagnoses or decisions about treatment, then Dr Gorringe should not have relied upon it to diagnose paraquat poisoning, particularly so in the context of the anticipated treatment and the likely effects of treatment. She also submitted that his preconceived views of the diagnosis could have influenced the test results.

406. The Director further submitted that Dr Gorringe's clinical examination of Mrs Short, particularly the examination of her skin, was cursory and inadequate for the purposes of supporting his PMRT diagnosis of paraquat poisoning. She contended he gave insufficient consideration to other diagnostic options and failed to exclude other diagnoses by conventional means such as those referred to by Drs Rademaker, Doehring and Isbell. She also contended that Dr Gorringe's history taking was inadequate for the purposes of making his diagnosis and, accordingly, he did not adhere to his own principles of using PMRT as a "*complementary*" diagnostic tool.

407. Mr Knowsley made a number of submissions challenging the reliability of the evidence given by Mrs Short and her mother, Mrs McMahon. While their recollection was not entirely accurate in all respects, the Tribunal found them to be reliable and credible witnesses in nearly every relevant respect.

408. Mr Knowsley submitted that the note, "*not E*", which Dr Gorringe made, meant "*not only eczema*".

409. The Tribunal has already found against Dr Gorringe on this piece of evidence.

410. Mr Knowsley contended that Dr Gorringe used his experience of paraquat poisoning on a clinical basis; and that he had "*a clinical suspicion backed up by BDORT*".

411. He submitted that Dr Gorringe took a full history which was combined with his visual perception of Mrs Short including her hands, arms and face. He submitted that Dr Gorringe

did examine Mrs Short's skin and that in order to examine it, it was not necessary for Dr Gorringe to touch her skin as a skin examination could be a visual one. He relied on the fact that Dr Gorringe also held Mrs Short's hands when undertaking BDORT.

412. Mr Knowsley asserted Mrs Short had eczema with paraquat aggravation, not simply eczema (which would have responded to steroids). He argued that the prosecution witnesses described symptoms which were relevant to the diagnosis not of chronic paraquat poisoning but to acute paraquat poisoning.

413. In his submissions, Mr Knowsley posed the question that if Mrs Short plainly had eczema "*why did it not respond to conventional steroids*". He answered his own question that it had not responded because there had been "*something else on top of it*" which Dr Gorringe had been looking for and that Dr Gorringe was not just saying "*sorry nothing I can do for you that hasn't already been tried*".

414. Mr Knowsley concluded that "*just because Dr Joe was considering patch testing*" did not make it necessary or useful and that there were no other tests for paraquat aggravation of eczema.

415. He submitted that Dr Rademaker could not be sure that Mrs Short had an infection at the relevant time and there was no evidence to say that she did and that when she was infected at a later time, Dr Gorringe treated her appropriately for it.

416. The Tribunal does not accept Mr Knowsley's submissions. The Tribunal accepts the evidence of Drs Joe, Rademaker and Isbell.

417. After a cursory examination, Dr Gorringe made an unequivocal diagnosis of dermatitis caused by chemical poisoning and then subjected Mrs Short to PMRT to identify the chemical and determine its strength.

418. If it were necessary for Dr Gorringe to conduct PMRT to ascertain the nature of the chemical poisoning and its strength, then, plainly, he relied on PMRT for those purposes. The Tribunal has already held that PMRT is not an appropriate technique for a medical practitioner responsible for making significant diagnoses or decisions. Accordingly, it finds Dr Gorringe unduly relied on PMRT in diagnosing Mrs Short had paraquat poisoning.

419. At the first consultation Mrs Short could provide no history of prior contact with paraquat and was puzzled by the diagnosis. The Director has submitted that Mrs Short's presentation was not typical of paraquat poisoning, particularly as she did not have repetitive, prolonged exposure to paraquat, and that Dr Gorringe's own notes that Mrs Short had suffered from eczema since she was a baby was not consistent with his diagnosis. The Director referred to the evidence of Drs Rademaker and Doehring and even Dr Gorringe himself detailing expected symptomotology for paraquat exposure. The Director submitted that Mrs Short's clinical presentation was consistent with endogenous eczema which was of the type typically affecting women of her age and was characterised by appearance of the hands and feet. Dr Gorringe accepted this in cross-examination.

420. The Director contended that a reasonable medical practitioner would not have diagnosed paraquat poisoning on the basis of the data available to Dr Gorringe at the time and submitted that in a situation where an unorthodox diagnostic technique was being undertaken, Dr Gorringe, as a conventionally trained medical practitioner, was obliged to consider the possibility of an orthodox diagnosis, which plainly he did not.

421. While Mr Knowsley did not make any specific submissions regarding this particular, the Tribunal has, nonetheless, taken into account Dr Gorringe's evidence and Mr Knowsley's entire submissions in considering this matter.

422. The Tribunal accepts the submissions of the Director on this issue.

423. As it has already found Mrs Short did not give a history of prior contact with paraquat at the first consultation. She did not do so because she had not had contact with paraquat.

424. Indeed, Dr Gorringe admitted in evidence that he had diagnosed Mrs Short with paraquat poisoning in the absence of any history of contact with it.

425. The Tribunal accepts the evidence of Drs Rademaker and Doehring that Mrs Short's clinical presentation did not fit with the expected symptomotology of paraquat exposure. Mrs Short's presentation at this consultation was consistent with endogenous eczema. The Tribunal is satisfied that in the light of Mrs Short's history and/or clinical presentation, there was no basis upon which Dr Gorringe could support his diagnosis of paraquat poisoning.

426. It is abundantly clear that at this first consultation, Dr Gorringe did not have an adequate knowledge of Mrs Short's clinical and social history. Many of the references in his evidence to her clinical history were obtained after her complaint to the Health and Disability Commissioner. He cannot utilise this information as evidence that he made adequate enquiry as to Mrs Short's clinical social history at that first consultation. Further, that information does not in fact justify his diagnosis, as he attempted to persuade the Tribunal.

427. The Tribunal accepts that Dr Gorringe failed to carry out any proper diagnostic tests to confirm or exclude his diagnosis.

428. The Director submitted that, given the non-conventional nature of his diagnosis and the absence of any history of exposure of Mrs Short to paraquat or other possible irritants, Dr Gorringe was obliged either to confirm or exclude his diagnosis by conventional means. In this regard she relied on and referred to the evidence of Drs Rademaker and Isbell which the Tribunal accepts.

429. The Director submitted there should have been a full examination of Mrs Short's skin, and that Dr Gorringe should have taken skin swabs and/or undertaken patch testing.

430. The Tribunal finds the allegations in particular 1, 1.1(a), (b) and (c) proved.

Particulars 1.2 to 1.4

431. Particulars 1.2 to 1.4 allege that in diagnosing cytomegalovirus, Legionella infection and electromagnetic radiation sensitivity Dr Gorringe:

(a) Failed to undertake an adequate clinical examination.

(b) Relied unduly on PMRT to reach his diagnoses.

(c) Failed to carry out any other diagnostic tests to confirm or exclude his diagnoses.

(d) Reached diagnoses not supported by Mrs Short's history and/or clinical presentation.

432. Each of these successive diagnoses can be dealt with separately.

Cytomegalovirus (CMV/CMV Toxin) (particular 1.2)

433. The sixth consultation on 15 June 1998 was initiated by Mrs Short because of her worsening skin condition over the preceding 12 weeks and her deteriorating health (as earlier described).

434. At this consultation, Dr Gorringe carried out PMRT as a result of which he concluded that Mrs Short's *"skin was responding to an old toxin from a previous cytomegalovirus infection"*. He said that Mrs Short did not present with any symptoms of infection. He said he was seeking to determine whether there may have been an internal cause for her endogenous eczema and therefore he had no choice in trying to advance her healing process but to try a complementary technique, such as PMRT, which demonstrated to him that her skin was responding to an old toxin from a previous cytomegalovirus infection, since overcome. His evidence was that at no time had he claimed nor did his notes suggest that the virus was still alive. However, the Tribunal finds that was not how he presented the matter to Mrs Short and her mother. He told them that Mrs Short had a long standing infection relating to glandular fever, which was causing her skin problems, and he led them to believe that once he had cured that infection, Mrs Short's skin would clear.

435. Dr Gorringe's diagnosis of a *"viral residue"* or *"viral toxic residue*" is not a conventional one.

436. Neither Drs Doehring, Rademaker, nor Isbell was aware of these terms.

437. Dr Doehring explained that glandular fever was a manifestation of infection (commonly) with the Epstein-Barr virus or the relating cytomegalovirus and that both infections were common and most adults would have had both infections at some time in their lives but would be unaware of it as the infections were sometimes subclinical. The viruses were integrated into host DNA and so persisted for life generally without causing any symptoms. He stated that there was no evidence that PMRT could detect viral DNA and that if it could, then almost all of Dr Gorringe's patients would have come up positive.

438. Dr Doehring added that there was no indication in the documentation that Dr Gorringe did any conventional testing to establish his diagnosis of cytomegalovirus. He stated the clinical features were not adequately specific to make a diagnosis; so it needed to be confirmed by

serology which would have shown any past exposure to viral antigens or to an ongoing production of viral protein. He explained that the term *"toxin"* to describe persisting viral DNA was "*non standard and misleading"*.

439. Both Drs Isbell and Rademaker also gave evidence to similar effect. Neither was aware of Dr Gorringe's theory of *"toxic viral residue"*. Dr Isbell stated that this theory was "*not supported in any way by a credible scientific rationale"*. She stated that although Dr Gorringe had provided some material about *"viral residue"*, that material seemed to be based on his individual opinion and none of it seemed to have been supported by peer review. She was not aware of any trials that had proper methodology or had been peer reviewed. She also stated it was wrong to use the terminology of infection when it did not exist.

440. Dr Rademaker was asked whether *"viral residue"* caused skin problems. He was not aware that such syndrome was specifically associated with skin rashes or problems, or the kind of skin condition which Mrs Short was experiencing.

441. Dr Gorringe did not provide any evidence that CMV or CMV toxins were associated with skin conditions other than to state that "The only interpretation that could be made with the extra excoriation was that something had triggered more histamine release and that could have been almost anything in her environment, diet, internally or constitutionally".

442. Dr Gorringe confirmed that "there have been no trials done on specific viral toxins". He asserted that from "the biochemical point of view, this would be a nightmare area to research …".

443. The cross-examination of Dr Gorringe was revealing. He had to admit that there was no scientific literature or peer review literature at all on CMV toxins. When it was put to him that this diagnosis was *"just theory"* and "*purely speculative"*, he declined to agree but could not provide any rational basis for his claims regarding CMV toxins or their symptomotology.

444. Dr Gorringe's clinical examination, which preceded his diagnosis, involved his looking at Mrs Short's feet and arms but not her inner thighs (which she told him were sore, weepy and smelly).

445. The Director submitted that Dr Gorringe's assertion that there were no signs of infection was not sustainable on the evidence. She referred to Dr Rademaker's evidence that pain, smelly exudate, and yellow spots were signs of infection. She further submitted that Mrs Short developed cellulitis (an infection of the deeper skin tissues) two weeks later on her face and leg which, in Dr Rademaker's expert opinion, supported the view that Mrs Short's skin was likely to have been infected at this consultation. In these circumstances, the Director submitted that a close examination of Mrs Short's skin should have been undertaken and skin swabs should have been taken.

446. With regard to a diagnosis of cytomegalovirus, both Drs Doehring and Isbell stated that clinical examination would need to include temperature, lymph node examination, checking for spleen enlargement, enquiring as to muscle tenderness, and general physical examination. In addition, a blood and liver function screening test should be sought.

447. Dr Gorringe did not dispute he did not undertake any of the examinations described above, claiming he did not need to do so as he did not diagnose a "*live*" virus.

448. In response to that, the Director submitted that if Dr Gorringe were considering CMV/CMV toxin and conveying this as the diagnosis to Mrs Short (which the Tribunal finds he did), then he was under an obligation to examine Mrs Short physically in order to confirm or exclude his clinical suspicions, particularly given his reliance on PMRT to make the diagnosis.

449. The Director submitted that in all respects therefore both as to Mrs Short's skin problems and Dr Gorringe's diagnosis of CMV/CMV toxin, Dr Gorringe failed to undertake an adequate clinical examination at this consultation.

450. Mr Knowsley submitted that Dr Gorringe diagnosed cytomegalovirus or cytomegalovirus toxin residues affecting the skin and was not diagnosing and treating a *live* cytomegalovirus or cytomegalovirus toxin virus. He submitted there were no other tests that could "*pick it up*" and that if there were no conventional tests available, then it was not correct to say a failure to undertake other tests was Dr Gorringe's responsibility.

451. He submitted that when Dr Gorringe examined Mrs Short, he was of the view that infection was not present on clinical findings.

452. With regard to the examination of Mrs Short's face, Mr Knowsley submitted that Mrs Short had admitted in cross-examination that Dr Gorringe did examine her face but that it was not as close an examination as she considered necessary.

453. With regard to Mrs Short's face, Mr Knowsley relied on Dr Gorringe's evidence that "*she [Mrs Short] was only sitting 3 ft away from me, it wasn't hard to see her*".

454. The Tribunal does not accept Mr Knowsley's submissions.

455. The Tribunal does not accept that looking at a patient's exposed areas 3 feet away amounts to an adequate clinical examination.

456. Dr Gorringe did not examine Mrs Short's thighs although she had told him they were sore, weepy and smelly. He did not examine her feet and toes, which were sore and cracked. He should have examined them. This was a failure on his part to undertake an adequate clinical examination.

457. The Tribunal agrees with the submissions of the Director and accepts the evidence of Drs Doehring, Rademaker and Isbell.

458. The Tribunal is therefore satisfied that Dr Gorringe in reaching the diagnosis of cytomegalovirus failed to undertake an adequate clinical examination.

459. In answer to the Director, Dr Gorringe agreed that CMV toxin could not be diagnosed by any conventional means. When it was put to him that he was "*absolutely reliant on PMRT to make that diagnosis*" he agreed stating there was no standard test.

460. The Director submitted there was no independent evidence that PMRT was capable of diagnosing CMV or CMV toxin. Relying on her submissions that PMRT was unreliable/unproven, she submitted that absolute reliance on PMRT was not an appropriate means of diagnosing Mrs Short with CMV/CMV toxin, particularly in the absence of an adequate clinical examination and other diagnostic tests.

461. While Mr Knowsley did not make any further submissions on this aspect, (other than those referred to above) the Tribunal nevertheless has had careful regard to Dr Gorringe's overall evidence, particularly the statements in his written evidence.

462. In view of the Tribunal's findings regarding PMRT, it is satisfied Dr Gorringe did place undue reliance on it to make his diagnosis. This was unacceptable, particularly when there had been inadequate clinical examination of Mrs Short.

463. The Director submitted that CMV is the terminology of viral infection and if Dr Gorringe were contemplating it as a possible diagnosis and proposed to advise his patient accordingly, then he should have undertaken blood and liver function tests to confirm or exclude any previous contact with CMV. In support, she relied on the expert opinions of Drs Doehring and Isbell.

464. Relying on Dr Rademaker's evidence, the Director contended that, given the likely infection of Mrs Short's skin at this consultation, Dr Gorringe should also have arranged to take skin swabs.

465. Mr Knowsley's submissions on this issue repeated his earlier submission that Dr Gorringe had diagnosed CMV toxin residues affecting the skin and was not diagnosing and treating a live CMV virus. Since there were no conventional tests available, it was not correct to say a failure to undertake other tests was Dr Gorringe's responsibility. He also submitted that when Dr Gorringe examined Mrs Short, he was of the view that infection was not present on clinical findings.

466. The Tribunal rejects these submissions. It has already found Dr Gorringe did not undertake an adequate clinical examination and it is satisfied Mrs Short's skin was infected when she presented herself to Gorringe at this consultation.

467. The Tribunal is also satisfied that Dr Gorringe failed to carry out any other diagnostic tests to confirm or exclude his diagnosis when, plainly, he should have done so.

468. Dr Rademaker stated it was his opinion that during the time Mrs Short consulted Dr Gorringe, she suffered endogenous eczema and urticaria, which worsened when she stopped her conventional medications, and that her symptoms were also consistent with atopic eczema with secondary infection.

469. Dr Isbell stated that it was her opinion the symptoms with which Mrs Short presented to Dr Gorringe were consistent with worsening eczema, possibly complicated by infection. She

did not consider *"that the diagnosis of cytomegalovirus was in any way based on an adequate patient assessment or supported by objective evidence"* .

470. Dr Doehring gave evidence of the symptoms associated with glandular fever, as did Dr Isbell. The symptoms which they described were not the symptoms which Mrs Short presented at this consultation.

471. Despite this, during his evidence Dr Gorringe continued to adhere to his diagnosis of CMV/CMV toxin.

472. The Director put to him whether he agreed that the eczema which Mrs Short presented at this consultation was much worse and much more extensive than when he first saw her. Dr Gorringe replied that what Mrs Short presented with *"was a flare. And a flare obviously by definition is worse than when she is in a cyclical low"* .

473. The Director submitted that what Mrs Short did present at this consultation was consistent with worsening and infected atopic eczema, that she had no history of CMV and no physical signs of infection other than on her skin.

474. She submitted that Mrs Short's clinical presentation had to be seen in the context:

(a) of her long standing history of eczema;
(b) her skin problems were more widespread and severe at this consultation than they had been at the initial consultation;
(c) Mrs Short described the symptoms as being worse than ever before in her clinical history;
(d) Mrs Short was no longer on conventional medication at that time (such as topical steroids); and
(e) eczema left untreated would have deteriorated and presented in a manner which was consistent with Mrs Short's presentation.

475. The Director submitted that there was no evidential basis to find that Mrs Short's clinical presentation was consistent with CMV/CMV toxin and that Dr Gorringe had not produced any evidence of any pathogenic link to this effect.

476. Mr Knowsley's submissions dealt with the matter only briefly. He repeated his earlier submissions. Again, the Tribunal considered all of the evidence on behalf of Dr Gorringe including the specific references to this particular in his written brief.

477. The Tribunal agrees with the Director's submissions.

478. The Tribunal finds the diagnosis which Dr Gorringe made was not supported by Mrs Short's clinical presentation or by her history.

479. The Tribunal finds the allegations in Particular 1, 1.2(a), (b), (c) and (d) proved.

Legionella infection (particular 1.3)

480. Dr Gorringe made his diagnosis of Legionella infection on 3 September 1998, his tenth consultation with Mrs Short, using PMRT. From what Dr Gorringe said, Mrs Short and Mrs McMahon both thought that Mrs Short had been diagnosed with Legionnaires' Disease and that there was a causal nexus between it and her skin condition. The Tribunal is satisfied that Dr Gorringe made no effort to explain to Mrs Short what the symptoms of Legionella infection were or how she could have contracted it.

481. Dr Gorringe explained to the Tribunal how he had come to reach this diagnosis. He stated that with PMRT he was able to ascertain that Mrs Short had a bacterial infection centred within the tonsils and larynx and that he was able to find a match with the streptococcal set of vials so that the diagnosis was a streptococcal infection.

482. He stated that the results of the blood tests "while improved still showed a degree of inflammation that I had not expected. The skin on the hands was still peeling. PMRT showed that there was still a significant signal from skin. Putting together these signs I was able to locate a bacterial signal relating to a Legionella infection species." He stated that it could not have been the respiratory form, namely Legionella pneumophila, as Mrs Short did not show any of the signs but that "it could have been one of the other nearly 40 forms of Legionella infection species". Dr Gorringe then referred to an article in the Medical Journal and in the local media.

483. Dr Gorringe stated that "PMRT proved invaluable to complement the standard blood screen, which combined with the lack of other signs and symptoms showed that there was another potential thing" that he could immediately treat so as to improve her skin.

484. He stated that antibody testing for Legionella infection species is only commercially available for Legionella pneumophila. He referred to a NZ Medical Journal article published on 9 June 2000 which identified other species of Legionella infection in water supplies which were known to affect other organ systems including the bowel but that there are only in-house antibody kits to test for those organisms and are not available as commercial kits.

485. Dr Gorringe claimed that the treatments offered to Mrs Short at this consultation were entirely appropriate given the diagnoses. He stated:

> "*The homeopathy, the ongoing iron to raise the ferritin, (and to decrease the likelihood of further infection) and B12 was not yet prescribed as with the presence of Legionella infection in the bowel it was not yet in a state to properly absorb the minerals. I therefore decided that it was more cost efficient for Mrs Short to have B12 at a later date, when the infection and the Legionella infection toxins were out of her system*."

486. While Dr Gorringe claimed that the Legionella infection which he had diagnosed was of a bowel type he did not identify the particular species of the genus which he diagnosed.

487. The Director carefully cross-examined Dr Gorringe about this, and pressed him to identify which of the 42 forms of Legionella infection he had picked. He replied it was *"a non respiratory form, we don't have research available yet to determine which of the ones that have been isolated are actually responsible for bowel symptoms*". He stated that he had managed to exclude Legionella pneumophila using PMRT. With regard to which of the other 41, he was unable to identify which of those he had diagnosed. He replied:

> "*there are currently no diagnostic vials available to differentiate the species, it is simply a connection made up from multiple forms and they don't come as separate diagnostic vials*"

488. When asked if it were an original finding of his that the 41 other Legionella infection stereotypes were implicated in skin conditions, Dr Gorringe said it was not but he then referred to "*a group in the USA*" who had been giving a drug:

> *"for people with bowel involvement and psoriasis and the hypothesis is from that group that they are treating an as yet unidentified bowel bacteria and it is the job of a clinician like myself to try and draw together apparently disparate information where I think it may have a bearing on patients, that's called lateral thinking.*"

489. Dr Gorringe did not identify the *'group in the USA'* nor did he identify or provide any research or reputable articles to substantiate his claim.

490. The only article he produced which he claimed as supporting his stance was the one published on 9 June 2000 in the NZ Medical Journal. However, the article does not in fact support Dr Gorringe's claim. The article discussed the prevalence of Legionella infection species in domestic hot water. The authors of the article were careful to note that their results did not show that the presence of Legionella infection species in domestic hot water systems presented any particular risk of Legionnaires' disease to humans.

491. The Director put to Dr Gorringe that he appeared to pick on very obscure pieces of information and apply them to his practice when other medical practitioners would not even consider the possibility that the 41 other options of Legionella infection could have caused disease in Mrs Short. Dr Gorringe replied that he was sure other people had considered it but that *"if you lack a tool to cross-check the possibility then the reason why the research is scanty in this area is because of the difficulty of researching this sort of area"*.

492. However, his assertions regarding this diagnosis were unsubstantiated and the Tribunal does not accept them.

493. When considering Dr Gorringe's evidence, Dr Doehring, stated there were *"at the latest count 42 counts of the genus Legionella"*. Dr Doehring explained that of those humans who are infected with Legionella infection, 85% of them have Legionella pneumophila and that Legionellae are a ubiquitous part of the natural environment, found in all natural waters, soils, large numbers often in composting vegetation but only very occasionally did they cause disease in humans.

494. With regard to Dr Gorringe's claim that Legionella infection was present in Mrs Short's bowel, Dr Doehring stated that:

> "*Although there is a single paper* [which Dr Doehring identified] *reporting the isolation of the organism from faeces, there is none indicating a pathological role in the bowel. Indeed, Legionella infection species are generally inhibited by competition with other gram negative organisms. The intestine, which teams with a diverse population of bacteria, would thus not be expected to be a favourable environment for Legionella infection replication or invasion.*"

495. Dr Rademaker explained that Legionnaires' disease classically did not give rise to skin rashes. In a severe infection, however, Legionnaires' Disease could give rise to an allergic skin reaction called Steven's Johnson syndrome but it was a *"one-off reaction"* and that such a skin condition bore *"no resemblance to eczema at all"* which was the condition from which Mrs Short suffered.

496. Dr Doehring confirmed this. He stated that while legionellosis is a multi system disease, skin involvement is rarely described. He said that what Dr Gorringe had described Mrs Short as suffering from was a transient macular rash (reddish spots) but Mrs Short's *"eczematous dermatitis could by no stretch of the imagination be described as a macular rash"*.

497. Dr Isbell gave evidence as to the appropriate examinations to be conducted where Legionella Infection/Legionnaires' Disease was suspected. A clinical examination would include taking temperature and a careful examination of the respiratory system. A general physical examination would include the cardiovascular and gastrointestinal systems. Sputum or other fluids should be sent for microscopic staining and specific culture. Blood should be sent for serum testing.

498. Although Dr Gorringe examined Mrs Short's tonsils and larynx, he accepted that he did not conduct a physical examination of her, did not examine her respiratory system, cardiovascular system or gastrointestinal system and did not order sputum tests or any further blood tests.

499. The Director submitted that, notwithstanding the *"results"* obtained from PMRT, once Dr Gorringe considered Legionella infection was a possible cause of Mrs Short's symptoms, he should have undertaken the examinations and arranged the tests to which Dr Isbell referred. The Director submitted that the onus on Dr Gorringe to do so was increased given:

    (a) The unconventional nature of the diagnosis;

(b) Legionella pneumophila accounts for 85% of Legionnaires' Disease in humans and is a serious illness;

(c) Dr Gorringe's reliance on PMRT;

(d) The blood tests were normal; and

(e) On Dr Gorringe's evidence the bacteria was gastrointestinal but there were no symptoms of gastrointestinal upset.

500. The Director further submitted that Dr Gorringe should have considered conventional diagnoses, such as infected eczema, and that he should have undertaken appropriate skin examination, which he did not.

501. In reply, Mr Knowsley submitted that evidence which related to Legionella infection of the pneumonia type was irrelevant where there was bowel presentation, there were no symptoms of Legionella infection of the pneumonia type and, in their absence, there were no other tests that could be used. He submitted skin swab and patch testing of a bowel organism was not appropriate.

502. The Tribunal accepts the evidence of Drs Rademaker, Doehring and Isbell. Even f Dr Gorringe did suspect Legionella infection of the bowel, the Tribunal finds he should have conducted a thorough clinical and physical examination and arranged for sputum and blood tests. He should also have considered conventional diagnoses including, specifically, infected eczema and undertaken a skin examination, which he did not. The Tribunal is satisfied the symptoms which Mrs Short presented on 3 September 1998 and the limited examination which Dr Gorringe gave her provided no medical or clinical foundation for his diagnosis of Legionella infection of the bowel.

503. With regard to the allegation that Dr Gorringe relied unduly on the results of PMRT to reach the diagnosis of Legionella infection, the Director referred to her submission that there was no independent evidence that PMRT was capable of diagnosing Legionella infection (of any kind), that PMRT was unreliable and unproven and that absolute reliance on PMRT was not an appropriate means of diagnosing Legionella infection, particularly in the absence of an adequate clinical examination and other diagnostic tests.

504. Dr Gorringe made the Legionella infection diagnosis immediately following extensive muscle testing. He expressly accepted that he diagnosed Legionella infection by PMRT, and even claimed to be able to exclude the serotype Legionella pneumophila using PMRT.

505. The Tribunal finds that there is no evidence that PMRT was capable of diagnosing Legionella infection. The Tribunal is satisfied that Dr Gorringe's reliance on PMRT was inappropriate and improper in the circumstances.

506. To support the charge that Dr Gorringe failed to undertake any other diagnostic test to confirm or exclude his diagnosis of Legionella infection, the Director relied on the evidence of Drs Doehring and Isbell.

507. Dr Doehring stated that there was nothing in the supporting documentation which he had perused to suggest that Dr Gorringe did any conventional test to confirm his diagnosis, either by culture or serology.

508. Dr Isbell stated that the diagnosis of Legionnaires' Disease required special laboratory testing, that sputum or other fluids should have been sent for microscopic staining and specific culture and that blood should have been sent for serum testing. She also stated that a urine test would have been available in some areas.

509. Dr Gorringe did not dispute that he did not undertake any of the tests suggested by Drs Doehring and Isbell, as he did not believe they were needed.

510. The Director submitted that for the same reasons she advanced that Dr Gorringe should have undertaken an adequate clinical examination, he should have arranged full laboratory testing once he suspected Legionella infection.

511. Additionally, she submitted that, given Mrs Short's ongoing skin presentation and Dr Gorringe's non-conventional diagnosis, he had a duty to exclude conventional diagnoses and that skin swabs or patch testing should have been considered.

512. Mr Knowsley submitted that the evidence was irrelevant as it related to Legionella infection of the pneumonia type, not of the bowel. In the absence of symptoms of the pneumonia type, no other tests could be used and that skin swab and patch testing of a bowel organism was not appropriate.

513. The Tribunal finds there is no substance to Dr Gorringe's claim that Mrs Short was suffering from a Legionella infection of the bowel.

514. It accepts the evidence of Drs Doehring and Isbell that conventional tests to confirm the diagnosis of legionellosis included culture or serology, suspected Legionnaires' Disease required special laboratory testing. And blood and other samples should have been sent for testing, none of which was undertaken.

515. With regard to the allegation that Dr Gorringe reached the diagnosis of Legionella infection which was not supported by Mrs Short's history and/or clinical presentation, the Director relied on the evidence of Drs Rademaker and Isbell.

516. Although at this consultation Mrs Short's face had improved, her hands were still quite bad and were shedding skin. Dr Rademaker stated that eczema causes peeling of the skin. Dr Gorringe also accepted that part of the cycle of exfoliative eczema was peeling of the skin.

517. With regard to Mrs Short's clinical presentation, Dr Gorringe stated, in an answer to the Director, that he did not suspect Legionella infection looking at Mrs Short's symptoms;

> *"… clinically I didn't suspect Legionella infection looking at the symptoms either. A conventional doctor looking at the presentation of a cough almost resolved, no other respiratory symptoms, improving facial skin, would probably not have put in his differential diagnosis the possibility of Legionella, I agree with that*."

518. Dr Gorringe added, following further questioning –

> *"The interesting thing is that I really don't find any clear clinical syndrome in the bowel with people who have this, there are hundreds of bowel bacteria that live in bowel that apparently don't produce any obvious clinical syndrome."*

519. Dr Isbell gave her opinion regarding Mrs Short's clinical presentation at this consultation. Dr Isbell relied on Mrs Short's diary and written brief of evidence. The Tribunal has already found Mrs Short's description of her state of health at that time to be accurate. Dr Isbell stated that Mrs Short was presenting with an ongoing deterioration of her skin condition, that she had had periods of open, weeping, reddened, inflamed and raw skin, that these symptoms had been ongoing (although mildly fluctuating) for a period of approximately 5

months by the time of this consultation, that there was one occasion where Dr Gorringe had diagnosed cellulitis (an infection of the connective skin tissues) and she was presenting with peeling hands.

520. Dr Gorringe's notes record the peeling hands and also that her tonsils and larynx were normal.

521. On this basis, Dr Isbell expressed the opinion that Mrs Short was presenting with symptoms consistent with ongoing, possibly infected, eczema. She added that:

> *"These skin symptoms, together with normal tonsils and larynx are not suggestive at all of Legionella infection."*

522. The Director submitted there was no clinical basis upon which Dr Gorringe could have diagnosed Legionella infection.

523. Mr Knowsley repeated his earlier submissions.

524. The Tribunal accepts the evidence of Dr Isbell and agrees with the submissions of the Director. Neither Mrs Short's history nor her clinical presentation supported Dr Gorringe's diagnosis.

525. The Tribunal finds the allegations in Particular 1, 1.3(a), (b), (c) and (d) proved.

Electromagnetic Radiation Sensitivity (EMR) - (Particular 1.4)

526. On 22 September 1998, Mrs Short consulted Dr Gorringe for the eleventh time. Her hands and fingers were sore and her face and arms were red and itchy.

527. Dr Gorringe undertook PMRT and diagnosed Mrs Short with EMR.

528. The Director relied on the evidence of Drs Rademaker and Isbell to support the charge that Dr Gorringe failed to undertake an adequate clinical examination of Mrs Short on this consultation.

529. Dr Rademaker was asked to express an opinion on Dr Gorringe's diagnosis of EMR, bearing in mind the symptoms with which Mrs Short had presented at this consultation (and taking into account her history). Dr Rademaker commented that while he had heard of EMR

and was generally aware of its supposed aetiology and symptomotology, it was not a diagnosis in conventional medicine and he could not therefore comment on its association with skin conditions. However, he emphasised that Mrs Short's skin condition was quite unrelated to EMR.

530. Dr Rademaker queried whether Mrs Short had a photo aggravation of her eczema when she consulted Dr Gorringe in September. He emphasised that September was fairly early for photo aggravation of eczema which results from exposure to ultra violet light from the sun. He indicated it generally starts to become a problem in mid summer. He added that in his experience of Mrs Short in subsequent years, it was always January/February when she had photo aggravation of her eczema on her face and neck but not on her hands. He added that if, at this consultation, the eczema involved Mrs Short's palms, then it was unlikely to be sun related because the palms of the hands do not get exposed to significant quantities of ultra violet light.

531. Dr Rademaker explained that when a medical practitioner diagnoses photo aggravated eczema he/she would look very carefully and closely at the distribution, because a significant sun exposure is required to aggravate the eczema. Certain parts of the body are relatively protected, so a practitioner would see sparing on the upper eyelids, behind the ear, underneath the chin and if sparing was visible in those areas but the rest of the face was involved, that would suggest sun-induced aggravation. At the September consultation, whether Mrs Short had photo aggravated eczema would depend on whether she had that distribution.

532. When asked about the role of history in making a diagnosis such as photo dermatosis (when skin is reddened in exposure to the sun), Dr Rademaker said it was important to determine the length of sun exposure, what time gap there was between sun exposure and the development of the rash, how quickly it settled, and whether it occurred the previous year, because it was a condition which could be expected to occur repeatedly.

533. Dr Isbell was also questioned about this consultation and Dr Gorringe's evidence that Mrs Short's symptoms had been going well until she stood in the sun and suddenly her skin went *"yucky"*. Asked what examination and history she would take, Dr Isbell said she would want to know how the skin was before the episode and whether it became worse as a

baseline for this episode. Next she would want to know what Mrs Short had noticed in the way of symptoms and how they had developed since and she would want to look at Mrs Short's skin to see what was showing at that time and compare the exposed areas of the skin to the unexposed areas of the skin and in general to check how the rest of her skin was in relation to her previous presenting problems of eczema and urticaria (and possibly skin infection). The diagnosis she would be considering would be photo dermatosis.

534. The Director has submitted that Mrs Short was clear that Dr Gorringe did not examine her skin except to look at it as she walked into the surgery and that he did not make full enquiries as to what had occurred.

535. The Director submitted that Dr Gorringe accepted he did not disrobe Mrs Short to examine her skin as *"a cursory inspection can see the difference between where a sun exposed area starts and finishes"*; that he could not remember whether he made specific enquiries in relation to the sun exposure, although he did not consider this history relevant, and that his clinical notes did not outline any significant history taken. Accordingly Dr Gorringe had failed to undertake an adequate clinical examination to reach the diagnosis of EMR.

536. Mr Knowsley submitted:

(a) EMR sensitivity caused by standing in the sun was photo sensitivity.

(b) An experienced practitioner could see the results of photo sensitivity without the sort of examination that was put forward as a counsel of perfection.

(c) Mrs Short said the rash appeared after being in the sun and that there was nothing unclear about the history.

(d) There was not an absolute reliance on PMRT; there was a visual diagnosis together with the history she gave.

(e) This was not just a continuation of eczema but a different presentation of sun aggravation.

(f) Sun sensitivity was a subset of EMR and that was the diagnosis Dr Gorringe made based on all of the factors.

(g) Mrs Short had said she did not have to avoid going in the sun prior to seeing Dr Gorringe but her diary recorded keeping out of the sun which she explained was if she had a flare or problems; and that problems with sun exposed areas were also

confirmed by Dr Joe's notes and letters.

(h) Mrs Short had had previous photo reaction.

537. Mr Knowsley argued that evidence supported Dr Gorringe's diagnosis of EMR/sun sensitivity after Mrs Short had stood in the sun and had a reaction on the sun exposed parts of her body.

538. The Tribunal rejects these submissions on behalf of Dr Gorringe. In this regard, it accepts the evidence of Drs Rademaker and Isbell and Mrs Short.

539. The Tribunal accepts Mrs Short's evidence that Dr Gorringe did not examine her skin except to look at her when she walked into his surgery. It also accepts the submissions made by the Director are substantiated by the evidence. The cursory attention Dr Gorringe gave on that occasion was quite inadequate. The Tribunal rejects Dr Gorringe's claim that an experienced practitioner did not need to undertake the sort of examination advocated by Drs Rademaker and Isbell which he described as a "*counsel of perfection*". It was clear to the Tribunal that Dr Gorringe should have undertaken the kind of full, careful and close examination of the skin both in relation to the sun exposed and non sun exposed areas as described by Drs Rademaker and Isbell.

540. Further, the Tribunal accepts Mrs Short's evidence that Dr Gorringe did not confine his comments to sun exposure but told her she had got EMR from things like the computer, microwave and stove, that her system had been "*short-circuited*" and that she was "*full of electricity*".

541. The Tribunal finds his diagnosis of electromagnetic radiation sensitivity was plainly reached without any adequate clinical examination.

542. On the charge that Dr Gorringe relied unduly on the results of PMRT to reach his diagnosis, the Director again referred to the evidence of Drs Rademaker and Isbell.

543. The Tribunal has already found that Dr Gorringe made the diagnosis immediately after he had undertaken PMRT.

544. The Director submitted that there was no independent evidence that PMRT was capable of diagnosing EMR and to that extent she relied on her earlier submissions on PMRT.

545. Mr Knowsley's submissions are set out above.

546. In view of the findings which the Tribunal has already made with regard to PMRT, it agrees with the submission made by the Director.

547. Dr Gorringe was also charged with failing to carry out any other diagnostic tests to confirm or exclude his diagnosis of EMR.

548. The Director submitted that in view of Mrs Short's presenting history over the previous six months and the unconventional diagnosis of EMR, Dr Gorringe was obliged to exclude possible conventional diagnoses or aggravating factors and that he should have considered infections or allergies and, therefore, patch testing or skin swabs should have been undertaken.

549. The Director further submitted that such testing should have occurred given Dr Rademaker's evidence that September was early for photo aggravation of eczema and his experience with Mrs Short in subsequent years.

550. The Director contended that it was relevant that only three weeks after Dr Gorringe's diagnosis, Dr Joe described Mrs Short's eczema as the worst he had seen it.

551. Mr Knowsley's submissions are earlier referred to.

552. The Tribunal agrees with the submissions of the Director which, again, it finds are substantiated by the evidence. It finds Dr Gorringe failed to carry out any other diagnostic tests to confirm or exclude his diagnosis.

553. The remaining particular in respect of this consultation was that Dr Gorringe's diagnosis of EMR was not supported by clinical and/or patient history.

554. The Director submitted Dr Gorringe's diagnosis of EMR was not one that the reasonable medical practitioner would consider (and one which the experts including Dr Isbell had difficulty meaningfully commenting upon).

555. The Director submitted Dr Gorringe had not provided any description, or independent literature of the symptoms associated with EMR, although he clearly regarded a skin reaction to the sun as one such symptom. In the absence of a full history, or adequate clinical

examination, she contended there was no basis upon which to find that Mrs Short's symptoms were consistent with Dr Gorringe's diagnosis.

556. The Director referred to the clinical history which Mrs Short had experienced over the previous six months under Dr Gorringe's care; and also that in October 1998 Dr Rademaker diagnosed Mrs Short with three skin conditions: endogenous eczema, folliculitis and urticaria, but did not diagnose photo-aggravated eczema on that occasion. She maintained that by inference therefore, and with reference to Mrs Short's previous clinical condition, her presentation at the 22 September consultation was not consistent with an EMR diagnosis.

557. Mr Knowsley's submissions are earlier referred to.

558. The Tribunal agrees with the Director's submissions and finds Dr Gorringe reached his diagnosis which was not supported either by Mrs Short's history or her clinical presentation.

559. Before concluding this topic, the Tribunal wishes to record that Dr Gorringe did not provide any meaningful explanation of the condition of "*electromagnetic sensitivity*" or any credible reason for having diagnosed Mrs Short as having it.

560. The Tribunal finds the allegations in particular 1, 1.4(a), (b), (c) and (d) proved.

Particular 2 - Informed Consent diagnostic technique - Mrs Short

561. Particular 2 alleges that between 19 March and 1 October 1998 Dr Gorringe carried out PMRT without adequately explaining this diagnostic technique. In particular, it is alleged he failed to advise Mrs Short of its advantages and disadvantages when compared to conventional and generally recognised diagnostic/investigatory techniques; and he failed to advise her of the degree to which PMRT had been scientifically evaluated for efficacy as a diagnostic tool. In failing to give an adequate explanation regarding PMRT, he is alleged to have failed to enable Mrs Short to make an informed choice and therefore failed to obtain her informed consent to PMRT.

562. The Director referred the Tribunal to its decision 219/02/94D of 3 December 2002 (which the Tribunal has discussed earlier).

563. She also relied on the various publications of Dr Cole (also discussed earlier) and Right 7(6)(b) of the Health and Disability Commissioner (Code of Health and Disability Consumers' Rights) Regulations 1996 ("the Code") which provides that where informed consent to a health care procedure is required it must be in writing if the procedure is experimental.

564. However, the Tribunal does not accept that PMRT as Dr Gorringe practised it was an evolving or experimental technique.

565. Taking into consideration the relevant law and standards the Director submitted that with regard to diagnoses and diagnostic technique Mrs Short had the right to be properly informed about:

(a) Her medical condition and the diagnoses.
(b) Dr Gorringe's diagnoses were not ones that reasonable, conventionally trained medical practitioners would, or in fact could, diagnose by conventional means.
(c) His diagnostic method (PMRT) was not a conventional technique.
(d) The extent to which PMRT had/had not been scientifically evaluated for its efficacy as a diagnostic tool.
(e) PMRT's advantages/disadvantages when compared to conventional diagnostic techniques.

566. She submitted when informing Mrs Short about these matters Dr Gorringe needed to have regard to Mrs Short's circumstances, her existing knowledge, and her understanding, and that the Tribunal needed to assess informed consent from the standpoint of the expectations of the reasonable consumer in Mrs Short's circumstances.

567. The Director submitted that both Mrs Short and Ms Ghaemmaghamy offered "similar fact evidence" in relation to the extent to which Dr Gorringe provided information about his practice, techniques and treatment, and that the Tribunal could take that into account. In this case, the Tribunal is not prepared to consider the evidence of either Mrs Short or Ms Ghaemmaghamy as supplementing the other. In reaching its conclusions, the Tribunal has considered only the evidence directly relevant to each complainant.

568. The Director relied on Mrs Short's evidence that Dr Gorringe did not like answering questions, that she felt *"fobbed off by him"*, and that despite asking questions (for example about paraquat poisoning/PMRT) she was told it was not important. The Director also referred to Mrs McMahon's evidence that she got the impression that Dr Gorringe did not like to be questioned about his procedures or how they worked. *"As far as he was concerned his way was the only way and we should accept what he told us*". The Tribunal accepts the evidence of Mrs Short and Mrs McMahon in this regard.

569. The Director referred to Dr Gorringe's evidence when he said that when he introduces PMRT to his patients he explains some of the philosophy of his practice; that he would like to take a different look at their problems using a bio-energy paradigm utilising PMRT; that he points out that this is not a conventional technique but that it is useful to indicate directions that have not been thought of before; and that he gives the proviso that, where possible, PMRT findings can be confirmed by conventional tests.

570. When cross-examined, he conceded that this was what he generally said. He could not be certain he said this to Mrs Short (or Ms Ghaemmaghamy).

571. Mrs Short was clear in her evidence that Dr Gorringe did not explain this to her and she certainly did not know what the name of the technique was until her complaint was progressing through the Office of the Health & Disability Commissioner.

572. The Tribunal accepts Mrs Short's evidence in this regard.

573. The Tribunal also accepts the evidence of Mrs Short and Mrs McMahon that the so-called testing by *"surrogacy"* was not explained to them. As Mrs McMahon said *"I wondered how it would ever work"*.

574. The Tribunal finds Mrs Short was given no preliminary information about the technique at all prior to its use on the first consultation. All Dr Gorringe did was to tell Mrs Short he was testing for the chemical by which he claimed she had been poisoned. There was no description of how PMRT worked. Mrs McMahon corroborated this evidence. Indeed neither Mrs Short nor Mrs McMahon were ever told at any consultation how PMRT might or might not work.

575. Dr Gorringe accepts he did not advise Mrs Short of the extent to which PMRT had been scientifically evaluated nor did he advise her that PMRT did not have general acceptance among medical practitioners.

576. In all the circumstances, the Tribunal finds Dr Gorringe did convey misleading information to give Mrs Short the impression PMRT had a scientific validity it did not have. The Tribunal does not propose to enumerate all the factors which have led to that conclusion. Some examples are:

(a) the authoritative manner in which he gave his successive diagnoses;
(b) his use of pseudo-scientific language; and
(c) his claim to use this diagnostic technique (which he claimed was extensively used overseas) ahead of his peers in New Zealand.

577. In view of the Tribunal's findings that Mrs Short was given insufficient and misleading information regarding PMRT, she was not able to make an informed choice and give informed consent to its use. We agree with the Director's submissions that such fundamental findings had significant flow-on effects for Mrs Short's subsequent decision-making, her so-called *"consent"* to treatment, and in her continuing to consult Dr Gorringe.

578. The Tribunal agrees the departure from the standard of care was significant enough to warrant a finding of professional misconduct.

Particular 3 - Informed Consent – Management and Treatment – Mrs Short

579. Particular 3 alleges that between 19 March and 1 October 1998 Dr Gorringe:

(a) provided or arranged to be provided various treatments, namely, homeopathic paraquat injections, homeopathic drops, laser management, and spiritual healing, and required Mrs Short to forego conventional treatment including topical steroid creams and Histafen without advising Mrs Short of the risks, benefits and efficacy of the various treatment options; and
(b) failed to give her adequate information regarding that treatment/management to enable her to make an informed choice and therefore failed to obtain her informed consent.

580. The Director submitted with regard to management and treatment Mrs Short had the right to be properly informed about:

(a) The proposed treatment, and how such therapy was to be carried out.

(b) Such treatment was non-conventional

(c) The extent to which PMRT had been scientifically evaluated for its efficacy in management and treatment.

(d) The options for treatment that were available (including conventional options).

(e) The risks, benefits and efficacy of the various treatment options.

581. At the first consultation on 19 March 1998, Dr Gorringe diagnosed Mrs Short as suffering from paraquat poisoning. By way of management and treatment he prescribed homeopathic injections and other non-conventional treatments. His diagnosis was not conventional and the treatments he prescribed are not recognised as having proven efficacy. He failed to explain to her either that his diagnosis was not conventional or what were its risks, benefits or efficacy. The Tribunal is satisfied he gave Mrs Short no conventional treatment options. Necessarily, it follows she had no means of assessing the comparative worth of the treatments which Dr Gorringe prescribed for her as against conventional treatment.

582. The Tribunal has already found that Dr Gorringe required Mrs Short to cease using the topical steroids prescribed to her by Dr Joe. The charge also alleges Dr Gorringe required her to forego the use of Histafen. (Dr Joe had also prescribed Histafen for Mrs Short) There was insufficient evidence to establish whether Dr Gorringe knew Mrs Short was on Histafen at the first consultation and required her to discontinue its use at that time.

583. At the consultation of 15 June 1998, Dr Gorringe diagnosed Mrs Short as suffering from CMV. For this he prescribed a number of homeopathic drops.

584. He also lasered her ear, a procedure he undertook first on 21 May (the fifth consultation). This was said to be to remove the remaining paraquat from out of an energy spot in Mrs Short's ear.

585. Dr Rademaker was asked by the Tribunal to comment on this procedure. Dr Rademaker replied that it was *"nonsense"*. When asked if he wanted to add to that he repeated that it was *"nonsense"*.

586. Dr Doehring, when asked by the Director to comment on the procedure, replied that he did not believe there was either a theoretical or empirical reason to believe it would work.

587. In cross-examination, Dr Doehring stated that from basic scientific principles it seemed to him an implausible technique and that he would very much like to see any properly controlled studies of its efficacy.

588. CMV as Dr Gorringe described it, is not a recognised diagnosis. The treatment he prescribed is not recognised as having any efficacy. The lasering of the ear is likewise without recognition or foundation. The Tribunal is satisfied he did not inform Mrs Short that his diagnosis was not a recognised one.

589. Again, he did not explain the risks, benefits and efficacy of the treatments he prescribed. Accordingly, she had no means of assessing the value of his diagnosis or the worth of the treatments.

590. It is apparent Dr Gorringe recognised Mrs Short's condition had deteriorated and in consequence he prescribed an oral steroid (Betnesol) and an antihistamine (Zyrtec) both of which are conventional forms of treatment.

591. At the consultation of 3 September 1998, Dr Gorringe diagnosed Mrs Short as suffering from Legionella infection. Legionella infection, as Dr Gorringe described it, is not a recognised diagnosis. On this occasion he again prescribed homeopathic treatment and also required Mrs Short to join him in prayer as part of her treatment. Neither form of treatment is recognised in conventional medicine as having any efficacy. Although Dr Gorringe prescribed Advantan (a topical steroid), its use would appear to have no direct relevance to his Legionella infection diagnosis. Again, Dr Gorringe did not adequately inform Mrs Short of the true nature of his diagnosis or any conventional options which might have been open to her. Accordingly, on that occasion she could not have appreciated either the risks, benefits or efficacy of the treatment he was proposing or of the comparative benefits or disadvantages of conventional treatment.

592. At the consultation of 22 September 1998, Dr Gorringe diagnosed Mrs Short as suffering from EMR. As treatment, he prescribed homeopathic drops, further prayer and a course of vitamin B12 tablets. On the evidence, the prescription of the vitamin B12 tablets was unnecessary as the Tribunal has already found. EMR as Dr Gorringe described it, is not a recognised diagnosis. The treatment he prescribed likewise was unconventional. No conventional treatment was offered. Again, he failed to explain adequately to Mrs Short the nature of his diagnosis or the risks, benefits and efficacy of the treatment he proposed, or how these compared with conventional treatment.

593. At one of the September consultations Mrs Short said that after prayer Dr Gorringe told her that God had told him she needed to take only six more Histafen pills and thereafter she would not need them. He denied that but her evidence is corroborated by Mrs McMahon and the Tribunal accepts it.

594. That evidence is further corroborated by the fact that Dr Gorringe in September did not write any repeat script for Histafen by which time the supply he had prescribed for her in June would have run out.

595. The Tribunal is satisfied, therefore, that between 19 March 1998 and 1 October 1998, Dr Gorringe did prescribe treatment for Mrs Short in the form of homeopathic paraquat injections, homeopathic drops, laser management and spiritual healing without explaining to her conventional options and without advising her of the risks, benefits and efficacy of his non-conventional treatment compared with conventional treatment. Between 19 March 1998 and 15 June 1998, he required Mrs Short to forego conventional medical treatment specifically the use of topical steroid creams. In September 1998 he again required her to forgo conventional medical treatment by telling her she no longer needed to take Histafen beyond six more pills.

596. Despite the fact that by 15 June 1998 Dr Gorringe did belatedly prescribe some conventional treatment, throughout the whole of the period Mrs Short consulted him he failed to advise her adequately of the risks, benefits and efficacy of his non-conventional treatments and accordingly failed to obtain her informed consent. To that extent the Tribunal finds this charge proved.

Particular 4 – Documentation – Mrs Short

597. Particular 4 alleges that Dr Gorringe failed to adequately document any explanations given by him to Mrs Short or her consent to his proposed treatment. Particular 4 is expressed as an alternative to particulars 2 and 3. As the Tribunal has found particulars 2 and 3 proved, it is not necessary for the Tribunal to come to any finding on this particular.

Particular 5 – Exploitation - Mrs Short

598. Particular 5 alleges that Dr Gorringe knew or ought to have known that the various diagnoses (paraquat poisoning, cytomegalovirus, Legionella infection and electromagnetic radiation sensitivity) were not supported by Mrs Short's clinical presentation and that he exploited Mrs Short for financial gain by continually advising and/or reassuring her that her condition was improving, and/or by advising her to purchase homeopathic treatment from him, and/or by advising her to attend follow up appointments for the monitoring of her condition and/or treatment.

599. Between 19 March and 1 October 1998 Mrs Short paid Dr Gorringe a total of $1,294.45. He has subsequently refunded that money to her.

600. The Director did not contend that Dr Gorringe exploited Mrs Short by charging an excessive fee but rather he engaged in exploitative practices and was remunerated in consequence.

601. Dr Gorringe made a series of definitive diagnoses. None of his diagnoses is recognised by conventional medicine, none of the treatments he prescribed is recognised by conventional medicine, and none of his diagnoses was supported by Mrs Short's clinical presentation. On no occasion did he explain to her the unconventional nature of his diagnoses or the risks, benefits and efficacy of his proposed treatment. He offered no options for conventional treatment.

602. Mrs Short's health deteriorated seriously after the first consultation. Despite that, Dr Gorringe and his staff gave Mrs Short continued reassurances her health was improving when plainly it was in fact getting worse.

603. The Tribunal is satisfied Dr Gorringe was aware of Mrs Short's deteriorating condition and his persistence with his unconventional treatment and his failure to alleviate her condition by conventional means was, in the circumstances, unconscionable and exploitative.

604. Having regard to all the evidence, the Tribunal is satisfied Dr Gorringe must have known his successive diagnoses were unsustainable.

605. Dr Gorringe's continued use of pseudo scientific and pseudo medical language exploited an anxious and vulnerable patient.

606. The Tribunal accepts the evidence of Dr Rademaker that eczema cannot be cured, although it can be managed.

607. Dr Gorringe assured Mrs Short that she would be cured of her eczema within twelve weeks when there was no foundation whatsoever for that assurance. He was irresponsible to give it.

608. On 5 August Dr Gorringe advised Mrs Short that she should not attend her own GP as she may be *"put out of balance"*. The Tribunal is satisfied that Dr Gorringe said this because he apprehended that Mrs Short's GP would have been critical of the actions which Dr Gorringe had taken.

609. Having regard to all the findings the Tribunal has made in respect of each of the particulars, the Tribunal is satisfied that Dr Gorringe's conduct individually and cumulatively amounted to professional misconduct.

Disgraceful Conduct - Mrs Short

610. With regard to Mrs Short, Dr Gorringe was also charged with disgraceful conduct in that between 19 March 1998 and 1 October 1998 in his management of Mrs Short, whom he knew had been previously diagnosed with chronic eczema, and having diagnosed her variously with paraquat poisoning, cytomegalovirus, Legionella infection and EMR:

(i) he required her to cease her then current medication (including Histafen and topical steroid creams which he knew, or ought to have known, were essential to the ongoing management of her condition) and/or

(ii) in his management of Mrs Short when he knew, or ought to have known, of her severe continuing physical and psychological deterioration he continued to advise and/or reassure her that her condition was improving and would continue to improve when he knew, or ought to have known, that this was not correct and/or

(iii) when he knew, or ought to have known, that Mrs Short's physical and psychological condition had deteriorated, and was continuing to deteriorate he failed:

(a) to reinstate her former medication in a timely manner and/or

(b) to prescribe other medication appropriate for her condition in a timely manner and/or

(c) to advise her to seek further medical care or advice and/or to refer and/or consult with an appropriate specialist regarding her clinical condition at any time during this period.

Particular 1.1 – Requirement to cease medication

611. The Tribunal has already found that Dr Gorringe was aware that Mrs Short was on topical steroids at the time of the first consultation and that he required her to cease such medication during the twelve week period of the *"detoxification"*.

612. The Tribunal has also found that Dr Gorringe was aware of Mrs Short's longstanding requirement to take Histafen as treatment for chronic urticaria but nevertheless either at the consultation of 3 September or 22 September, after prayer, told her she needed to take only six more Histafen pills but would not need to take any more thereafter because God had told him.

613. The Tribunal accepts Dr Rademaker's evidence that topical steroids and oral steroids were necessary for the ongoing management of Mrs Short's chronic eczema. He confirmed at the time he saw Mrs Short on 30 October 1998 the severity of her endogenous eczema was such that she had difficulty walking into his clinic and that he treated her with the most potent of the topical steroid creams available. It was his opinion that Mrs Short's worsening symptoms were consistent with her stopping the topical steroid creams which had, prior to her consultations with Dr Gorringe, largely kept her eczema under control.

614. Dr Joe, in his evidence, confirmed that as at the 10 February 1998 consultation he considered both topical and oral steroids necessary for Mrs Short's management.

615. The Tribunal has already found that Mrs Short's condition was appropriately managed with topical and oral steroids.

616. Dr Gorringe himself prescribed an oral steroid on 15 June. The Tribunal is entitled to draw the reasonable inference that he must have considered it necessary in order to manage Mrs Short's skin condition. The only reason he prescribed an oral steroid at this time was because the twelve week period of the *"detoxification"* had passed.

617. The Director has submitted that as a conventionally trained practitioner faced with such dramatic deterioration, Dr Gorringe ought to have known that it was steroids (both oral and topical) which had previously kept Mrs Short's eczema under control and was therefore essential to her ongoing management. She referred to a concession by him in cross-examination that if a patient needed steroids and they had been shown to be efficacious then there was the possibility that symptoms would worsen if taken off them.

618. The Director further submitted that requiring Mrs Short to desist from applying steroid creams in the first twelve weeks and persisting with his management notwithstanding her deterioration showed Dr Gorringe's significant indifference to Mrs Short's physical and emotional wellbeing, and reached the disciplinary threshold for disgraceful conduct.

619. With regard to the topical steroid creams, Mr Knowsley has submitted that Dr Gorringe prescribed these as required and that he did not require Mrs Short to cease taking any medication of which he was aware was current. The Tribunal has already made a finding to the contrary. We have found that he was aware, and that the first occasion on which he prescribed a topical steroid was approximately three months after she first consulted him.

620. The Director submitted it was predictable, given Mrs Short's continuation of antihistamine historically that the stopping of it would result in a resumption of her urticaria. Dr Rademaker gave an opinion to that effect. The Director submitted that when Dr Gorringe advised Mrs Short to stop taking Histafen she was still having ongoing difficulties with her skin. She contended that requiring Mrs Short to stop Histafen in the face of her ongoing skin condition again portrayed indifference to Mrs Short's clinical condition and that the manner

in which he determined its discontinuation (a prayer to God) was totally unacceptable and a gross abrogation of his duties as a medical practitioner.

621. In his submissions, Mr Knowsley claimed that Dr Gorringe did not require Mrs Short to stop Histafen and gave her a prescription for it on several occasions as required and that it was also made available by his nurse upon request on 14 October 1998.

622. He rejected the submission that Dr Gorringe was indifferent. He maintained that he did not display indifference to Mrs Short's condition but was giving her a full range of medication.

623. He submitted that the Director was seeking to attribute to Dr Gorringe all the bad times and the natural cycle of eczema to all the good times. He asserted that Dr Gorringe was trying the hardest he knew how to get rid of the underlying problem of Mrs Short's eczema. He maintained that steroids had not worked in the past and that he did not wish to repeat suppressive treatments which had already been shown to have failed. He submitted that Dr Gorringe was expecting some deterioration but he was not expecting the problems caused by other factors such as the EMR/sun sensitivity and infection and that he responded to each of those issues as they arose and on the signs and symptoms that presented.

624. The Tribunal rejects Mr Knowsley's submissions and accepts the Director's submissions. The Tribunal has already made findings of fact regarding the various matters contrary to Dr Gorringe's assertions and has also found that Mrs Short's eczema was appropriately managed in the past by the use of steroids, also contrary to Dr Gorringe's assertion.

625. The Tribunal finds this particular proved.

Particular 1.2 – Reassurances when physical and psychological condition deteriorating

626. In the earlier part of its decision, the Tribunal has set out in some detail Mrs Short's evidence (which it has accepted) describing her physical and psychological health covering the period 19 March 1998 to 1 October 1998 (and beyond).

627. It accepts that once Dr Gorringe prescribed some conventional treatment on 15 June onwards Mrs Short experienced some improvement in her condition but that it was inadequate and that she continued to experience ongoing problems to the extent that by the

time she consulted Dr Joe (whose evidence the Tribunal accepts) on 15 October 1998 her eczema was the worst he had seen it.

628. Dr Gorringe did not challenge Mrs Short's (and Mrs McMahon's) evidence that he continued to reassure Mrs Short her condition was improving. He sought to convince the Tribunal in his evidence that he believed her condition was improving and both throughout the hearing and in his counsel's submissions continued to assert that Mrs Short received benefit from his treatment.

629. The Director has submitted that from the standpoints of both conventional and homeopathic practice, Dr Gorringe's assertions and beliefs of such improvement is untenable, and that as a conventionally trained medical practitioner he was under an obligation to consider her symptoms from the conventional standpoint.

630. The Director has contended that from the conventional perspective Mrs Short's deterioration was obvious and consistent with worsening, infected eczema which was likely as a result of the discontinuation of, and failure to apply, conventional treatment; the evidence was that untreated or under-treated eczema can worsen and is more difficult to treat once over a certain threshold.

631. She further submitted that from a homeopathic perspective Mrs Short's symptoms were not consistent with an *"aggravation"* (as contended by Dr Gorringe). In this regard she referred to the evidence of Dr Isbell whose opinion it was that aggravations should only last between one or two days at most and that she would not have been looking to homeopathy to explain Mrs Short's symptoms by the second consultation on 9 April. In this regard the Director also referred to the written materials attributed to Dr Gibb in which he stated that in relation to *"detoxification"* that *"the maximum crisis that a patient should get is some fatigue!"* (exhibit 43 p.75)

632. The Director referred to the evidence that the paraquat injection packaging specifically required medical advice to be sought if symptoms persisted. She stated that Dr Gorringe provided no evidence, apart from his own assertions, that such deterioration was acceptable in unorthodox practice.

633. The Director concluded that there was ample proof that Dr Gorringe knew or ought to have known Mrs Short's condition was not improving and, therefore, should not have reassured her to that effect. She contended that such reassurance was cruel, exploitative and was deserving of opprobrium from his peers and the community.

634. Mr Knowsley, in his submissions, submitted that Dr Gorringe's reassurance was based on the expected course and condition as presented to him at the time and not as subsequently stated by the patient to support her complaint. He stated reassurance was a normal part of encouragement to continue with a course of treatment and that mental attitude towards beating illness was an important aspect.

635. He stated that it was not accepted that there was a steady clear deterioration but that Mrs Short's condition was up and down; and that in Dr Gorringe's experience one could expect aggravation as part of a homeopathic drainage course and that he was genuinely reassuring Mrs Short within the context of an expected course complicated by unrelated flares, infections and aggravations.

636. He also referred to Mrs Short's diary which he contended confirmed she was not in a steady decline but rather that she went up and down and at times was markedly improved over what she had been when she first saw Dr Gorringe.

637. He submitted that reassurance was therefore a normal part of the process and was justified on the presentation at the time; and that aggravations caused by factors outside of Dr Gorringe's control were dealt with as they arose and appropriately; and that encouragement to overcome new hurdles as they arose was appropriate.

638. Based on the findings of fact which the Tribunal has already made, the Tribunal does not accept or agree with Mr Knowsley's submissions, and nor do they reflect with any accuracy the actual evidence.

639. The Tribunal considers that the references to certain parts of the evidence in the Director's submissions are accurately portrayed and it agrees with the thrust of her submissions.

640. The Tribunal finds this particular proved.

Particular 1.3 – Failure to reinstate former medication etc.

641. This particular relates to the failure to reinstate former medication in a timely manner; to prescribe other medication appropriate for Mrs Short's condition in a timely manner; to advise her to seek further medical care or advice; and/or to refer and/or consult with an appropriate specialist regarding her clinical condition at any time during this period.

642. The evidence is undisputed that between 19 March 1998 and 22 September 1998 Dr Gorringe did not consult with or refer Mrs Short to another specialist. On 5 August 1998 Mrs Short telephoned Dr Gorringe to see if she should consult her usual general practitioner regarding her cold. Dr Gorringe advised her to see himself that afternoon, which she did. At no time did Dr Gorringe suggest to Mrs Short that she consult any other medical practitioner or specialist.

643. Dr Isbell gave evidence that with Mrs Short's history she would be wanting the help of a dermatologist because as a general practitioner she would not be expert in dealing with severe skin problems. With regard to Mrs Short's presenting symptoms at the second consultation on 9 April, Dr Isbell stated that she would be considering whether there was infection for which she would prescribe oral antibiotics or intravenous ones if the infection were sufficiently severe. She would also consider prescribing an antihistamine for urticaria and whether there was a need for oral steroids. With regard to Mrs Short's aggravation, she would not have looked to homeopathy or homeopathic treatment to explain what was happening to her but rather thought that the most likely cause of Mrs Short's deterioration in her skin was having had her conventional medical treatment stopped.

644. When asked about Mrs Short's presenting symptoms at the third consultation on 23 April 1998, Dr Isbell said she would have, among other things, taken a further history, made an examination of the skin, assessed whether there was urticaria or infection and treated Mrs Short appropriately. She added *"The fact that I am doing homeopathy in my practice doesn't in any way mean I don't also practise adequate conventional medicine"*.

645. When asked about Mrs Short's presenting symptoms at the fourth consultation on 7 May 1998, Dr Isbell stated that she would certainly be wanting to refer her to an expert in the field. She said that in her practice she would have done so at an earlier stage, and added that most doctors who were observing a marked worsening in the patient's functioning and

clinical condition would want extra help in the management of that patient and would seek the help of a relevant specialist.

646. With regard to Mrs Short's presenting symptoms at the sixth consultation on 15 June (when Dr Gorringe prescribed Zyrtec (an antihistamine) and Betnesol (an oral steroid)), Dr Isbell was of the opinion that skin infection was likely and when that severe she would have given consideration as to whether the patient should be given intravenous antibiotics or possibly admitted to hospital for further management.

647. Dr Rademaker was asked his opinion given the symptoms with which Mrs Short had presented during the first three month period she had been consulting Dr Gorringe. In his view, during that period Mrs Short was exhibiting worsening eczema which had become infected. He stated that with the extent of the infection one would treat it with systemic antibiotics and then one would want to give symptomatic relief with a preparation such as antihistamines but that the two main treatments would be steroids and antibiotics. He added that from the description of the symptoms one may want to admit Mrs Short to hospital because she would find it very difficult to cope at home with that extent of eczema.

648. Dr Gorringe maintained throughout that steroids had not worked for Mrs Short in the past and that was why she had consulted him and he therefore should not have been expected to institute a treatment which had previously failed.

649. However, the Tribunal has already made a finding in this regard. The evidence was clear that in the past, Mrs Short's chronic eczema had been appropriately managed with steroids. She told the Tribunal that while steroids could not cure her condition (as confirmed by Dr Rademaker) they provided relief and made her hands feel a lot better and she was accordingly able to function. She said that the oral steroid (Prednisone) had always worked and Dr Joe confirmed that Mrs Short's control was fairly good in that in 1996 and 1997 he saw her only once as she had a flare.

650. When asked for his opinion about this, Dr Rademaker stated that if someone says something has not worked in the past it is very important to determine what is meant by that. Prednisone is not a cure. Its effectiveness depends on the dose, the length of time it is used

and the co-factors which can play an important role as to whether or not a system steroid has or has not worked.

651. Dr Gorringe made no such enquiries. Notwithstanding, Dr Gorringe himself did prescribe an oral steroid (Betnesol) on 15 June. Mrs Short told the Tribunal that following this there was an improvement in her condition.

652. Dr Gorringe maintained that Mrs Short's skin was not infected and that as he was the clinician observing her, his evidence should be preferred to that of Drs Rademaker and Isbell. However, having heard all of the evidence, and having accepted Mrs Short's evidence regarding the description of her health and symptoms as accurate, the Tribunal is satisfied that during the twelve week period of *"detoxification"* Mrs Short's skin condition substantially deteriorated and became infected. At the very least, Dr Gorringe should have prescribed antibiotics at an earlier time. He did not do so until 29 June 1998 when he prescribed Klacid which was far too late.

653. In his evidence, Dr Gorringe maintained that skin applications which he prescribed for Mrs Short during the *"detoxification"* period such as BK Lotion and Pinetarsal were appropriate substitutes for atopical steroids.

654. However, again, having heard all the evidence, the Tribunal does not accept this claim. Dr Rademaker (whose evidence the Tribunal accepts) told the Tribunal that while moisturisers and soap substitutes such as these are key treatment in the management of eczema they are not actually a treatment of active eczema itself as they have very little anti-inflammatory effect and do make the condition worse because they occlude the skin and make it hot and more itchy. He said that it was a very important distinction to recognise that while moisturisers are one of the most important long term treatments of eczema they are of little value in acute situations.

655. Dr Isbell did not consider either BK Lotion or Pinetarsal a reasonable substitute as they do not contain any steroid component but rather are used as an emollient.

656. With regard to the period 19 March to 15 June 1998, the Director submitted, in reliance on the evidence of Drs Rademaker and Isbell, that as early as the second consultation on 9 April, Dr Gorringe should have been reassessing his diagnoses and responding to Mrs

Short's deteriorating condition; that he should have either reinstated Mrs Short's former medication (oral/topical steroids), prescribed other appropriate medication (including antibiotics), advised her to seek further medical care, or referred and/or consulted an appropriate specialist. She further submitted that the return to conventional medication on 15 June was too little, too late. The fact that Mrs Short actually improved following the administration of conventional medication at that time and with antibiotics on 29 June, was, in the Director's submission, more good luck than good management. She contended that for Dr Gorringe to suggest (as he did in cross-examination) that Paracetamol was an adequate allopathic response, was also indicative of his absolute indifference to Mrs Short's suffering; and that to allow Mrs Short to deteriorate in this manner was grossly negligent and of significant risk to his patient's wellbeing.

657. With regard to these matters, we refer to the earlier submissions made by Mr Knowsley.

658. Additionally, he submitted that recognition of suffering was appropriate but that it was not appropriate to link it to cause or culpability. He maintained that Dr Gorringe was not showing indifference to Mrs Short's condition and that Paracetamol was a very good pain reliever.

659. With regard to referral, the Director submitted that referral or consultation is not difficult or onerous. She referred to Dr Rademaker's evidence who stated that he consulted on an informal basis by telephone with general practitioners generally once or twice a day.

660. Mr Knowsley submitted that general practitioners refer due to their own lack of expertise in treating some conditions and that was what Mrs Short consulted Dr Gorringe for, not for referral. He stated that she went to him because of his expertise in treating her condition with which her usual general practitioner had not been able to deal with effectively and that she chose not to be referred by her GP to another specialist but went to Dr Gorringe.

661. Mr Knowsley further submitted that Dr Gorringe added to his allopathic methods and training to achieve results where patients are other doctors' failures. He maintains that Dr Gorringe was not going to be successful with every patient but that each patient he helped who had not been able to be helped by other doctors is very grateful for what he has done for them; and that it was a plus for the patient when no-one else could offer help.

662. While the Tribunal accepts the patients Dr Gorringe called may have been satisfied with his treatment of them, that is not the issue in this case. Necessarily, his treatment of those patients was not the subject of critical scrutiny. The charges he faced related to his treatment of Mrs Short and Ms Ghaemmaghamy. The other evidence is irrelevant or of negligible worth.

663. We turn now to the period between 29 June and 22 September 1998.

664. At the seventh consultation on 29 June, Dr Gorringe, after using PMRT, told Mrs Short that all the paraquat had gone from her system but that she had now developed another infection that was affecting her leg and face and prescribed antibiotics as well as homeopathic remedies to rid her of the glandular fever (which he had diagnosed at the previous consultation). At this consultation he diagnosed cellulitis.

665. Dr Isbell stated that at this consultation she would have sought another opinion either from a dermatologist or, failing that, from the dermatology registrar at the hospital. She said it was possible to make a telephone request for an urgent out-patient consultation that day at most hospitals.

666. At the eighth consultation on 9 July Mrs Short's situation had improved. Having heard all the evidence, the Tribunal is satisfied that any improvement was attributable to the conventional medication which Dr Gorringe had prescribed at the consultations of 15 and 29 June. At this consultation Dr Gorringe prescribed an atopical steroid (Elocon). Notwithstanding, Mrs Short continued to experience health problems.

667. By 30 July, her deterioration was such that she telephoned Dr Gorringe's surgery with the intention of speaking to Dr Gorringe but was told by his receptionist he was unavailable but would call back. He did not do so. The following day, 31 July, she asked her mother to telephone his surgery. The receptionist told Mrs McMahon that there was a lot wrong with her daughter when she started with Dr Gorringe and that her cure would take some time. Eventually the nurse telephoned Mrs Short and told her that Dr Gorringe would send two new kinds of homeopathic drops.

668. In the Tribunal's view, this was a most inappropriate response to the requests for help by and on behalf of Mrs Short. It is apparent to the Tribunal that both the receptionist and the

nurse were authorised by Dr Gorringe to make the responses which they did. It is noteworthy that Mrs Short was not given an appointment with Dr Gorringe; that no referral was made to any other practitioner or specialist; that there was no review of Mrs Short's condition at that time; that no conventional medication was prescribed; and that the only *"treatment"* which Mrs Short was given were some homeopathic drops which arrived in the mail to treat conditions such as *"hopelessness"* and *"depression"*.

669. In the Tribunal's view the response was inadequate and inappropriate.

670. Mrs Short told the Tribunal that by 23 August she was *"fed up"* and spoke to Dr Gorringe by telephone the following day. She said he seemed perplexed by her ongoing problems and prescribed her some more Advantan (an atopical steroid).

671. The Tribunal is satisfied that Mrs Short's ongoing skin problems were due to the inadequate management and treatment by Dr Gorringe. Following her telephone call, at the very least, he should have reassessed her condition in view of her clinical history. He did not do so.

672. On 3 September Mrs Short consulted Dr Gorringe for the tenth time, when he diagnosed her with Legionella infection, said a prayer and gave her homeopathic treatment. Again, the Tribunal considers the treatment and management inadequate and inappropriate.

673. On 22 September Mrs Short consulted Dr Gorringe for the eleventh time. She initiated this consultation due to her ongoing and deteriorating health problems. It was at this consultation that Dr Gorringe diagnosed electromagnetic radiation sensitivity following PMRT. He prescribed a repeat of an atopical steroid (Advantan cream) but again his principal treatment was homeopathic remedies. As already found by the Tribunal, it was either at this consultation or the previous one that Dr Gorringe told Mrs Short that God had told him (following prayer) she need take only six more Histafen pills and would not need to take them thereafter.

674. The Tribunal is satisfied that it was abundantly apparent that Dr Gorringe's treatment and management was not working in the face of Mrs Short's continuing and deteriorating health problems.

675. Mrs Short told the Tribunal that on 6, 8, 9, 10, 11 and 12 October 1998 she took oral Prednisone which she had left from a previous prescription. She confirmed there was an improvement at that time in her skin condition.

676. In summary, the Tribunal finds each and every particular of this charge proved.

677. The Director has submitted that over the six month period Dr Gorringe's management consisted of a catalogue of diagnoses and various homeopathic remedies and that the conventional treatment he did prescribe was inadequate and not done so in a timely manner. She contended that Dr Gorringe's failure to reassess adequately Mrs Short from a conventional perspective during her continued deterioration and the experiencing of skin problems highlighted a significant public safety issue, gross negligence and indifference to patient welfare. She submitted that his failure to manage adequately must also be assessed in relation to his failure to obtain informed consent to such management, and in the context of what she alleged was exploitative practice. She submitted that both separately and cumulatively the particulars amounted to disgraceful conduct in a professional respect.

678. Mr Knowsley, in his submissions, has submitted that in no way did Dr Gorringe act disgracefully in relation to Mrs Short. He maintained that she suffered from eczema aggravated by paraquat poisoning and her course of treatment was complicated by several unrelated flares or aggravations. He maintained that Dr Gorringe responded correctly to each situation as it presented itself using all of the techniques available, both conventional and complementary. He contended that in between the flares Dr Gorringe achieved some marked improvements in Mrs Short's condition and that her diary records as well as Dr Gorringe's notes together with other contemporaneous records such as Dr Joe's notes and letters and the interview with the Health and Disability Commissioner gave the true picture of what occurred rather than what he referred to as *"the revisionist history given by the patient at a later time"*.

679. In view of the findings already made and for the reasons already given, the Tribunal does not accept Mr Knowsley's submissions. It has carefully perused all of the written documents presented to it and carefully observed and listened to all of the witnesses. It is satisfied Mrs Short did not give a *"revisionist history"*. If there was any impression of *"revision"* it emerged from Dr Gorringe's explanations.

680. While Dr Gorringe was aware from the very first consultation that Mrs Short had been diagnosed from an early age with chronic eczema, he never acknowledged to Mrs Short she had chronic eczema, and the Tribunal rejects his evidence that he did.

681. Dr Gorringe led Mrs Short and her mother to believe that her skin problems and deteriorating state of health were successively attributable to Paraquat poisoning, cytomegalovirus/cytomegalovirus toxin, Legionella infection (they understood him to say Legionnaires' Disease) and electromagnetic radiation sensitivity.

682. None of these diagnoses was conventional but he made them as a medical practitioner, and presented them to Mrs Short and her mother with unquestionable authority.

683. Mrs Short was an anxious and vulnerable patient of which Dr Gorringe was aware. He took advantage of that and made his worrisome and obscure diagnoses without any credible evidence or foundation.

684. It is readily apparent that he knew, or ought to have known, that his treatment could seriously compromise her wellbeing and he persisted with it despite its manifest lack of success. That was grossly irresponsible and unconscionable. The Tribunal is satisfied it constituted disgraceful conduct.

685. The Tribunal finds the particulars either separately or cumulatively amount to disgraceful conduct in a professional respect.

Professional Misconduct – Ravaano Ghaemmaghamy

686. In relation to Ms Ghaemmaghamy , the Director of Proceedings laid charges against Dr Gorringe relating to the period 21 March 1998 to 5 May 1998.

Particular 1

687. The first particular alleges that in diagnosing brucellosis, Dr Gorringe failed to undertake an adequate clinical examination; relied unduly on PMRT; failed to carry out any other diagnostic tests to confirm his diagnosis; and reached the diagnosis when it was not supported by Ms Ghaemmaghamy's clinical presentation.

688. The first issue under this particular is whether Dr Gorringe failed to undertake an adequate clinical examination of Ms Ghaemmaghamy when he diagnosed brucellosis.

Particular 1.1(a) Failed to undertake an adequate clinical examination

689. Dr Isbell stated it would have been appropriate for Dr Gorringe to have asked for some information about her presenting complaints. She stated that one would want to find out a little more about whether her increased insulin requirements were a common thing for her, whether there had been any reason for it, to ask about her dizziness and nausea and to think about any other causes for them. With regard to the aches and pains, Dr Isbell stated one would ask the patient what she meant by it and ask her to describe it and then one would want more information whether the aches and pains were associated to joints and muscles.

690. Dr Isbell explained that brucellosis is a bacterial infection transmitted to humans from animals. Taking a history will reveal that a person with brucellosis will have consumed affected (unpasteurised) cheese, have recently been abroad, or had occupational contact with infected animals. The incubation period is about one to three weeks but may be as long as several months.

691. She commented that Dr Gorringe's medical record showed scant history taking and examination findings.

692. Dr Doehring stated that brucellosis is not an easy diagnosis either to make or exclude, as its clinical presentation is highly variable. He stated that diagnosis relies on clues from both history and physical examination, and on confirmation by laboratory testing.

693. It was his view that an adequate assessment would have comprised a full occupational, travel and dietary history, comprehensive physical examination, and most importantly, blood marrow culture and serological tests for brucellosis. He expressed the view that from the notes Dr Gorringe appeared to have done none of those.

694. With regard to history taking, he stated the first thing to be sought should be a history of contact with infected animals or unpasteurised milk or milk products.

695. He noted that no mention was made in Dr Gorringe's notes whether Ms Ghaemmaghamy had travelled in enzootic areas abroad, or consumed imported dairy products made of unpasteurised milk, nor whether those crucial questions were even asked by him.

696. Dr Marcus was asked if he were considering the possibility of brucellosis what examination he would undertake. He said he would check temperature, problems with the joints, liver, spleen, and enlarged glands and would undertake blood tests. In terms of history taking, he would ask about travelling and exposure to unpasteurised milk and the type of pains and weakness and the duration of the problems and how they related to possible exposure to brucellosis.

697. When it was put to Dr Gorringe by the Director that he did not enquire of Ms Ghaemmaghamy as to her contact with raw meat or farm animals he confirmed that this was so because it was not a case of *"acute"* brucellosis. When it was put to him that he did not enquire as to her contact with unpasteurised dairy products he agreed and added *"because in most cases you can't trace them"*. He gave a similar answer when it was put to him that he did not enquire into her travel abroad either.

698. He added that he agreed with Drs Doehring and Isbell that such enquiries were appropriate but only if one were considering a diagnosis of *"acute*" brucellosis. He added that this was not a case of *"acute"* brucellosis as it had been declared extinct in New Zealand for 10 years.

699. He confirmed that he did not physically examine Ms Ghaemmaghamy's lymph nodes because they were *"not up in chronic brucellosis"*.

700. With regard to checking her liver and spleen, he confirmed that he had not done so because Ms Ghaemmaghamy "had only just come from medical outpatients where she had had full examinations from her doctor, she had had a reassessment in medical outpatients, and she specifically did not want to spend her money with my time doing all that routine stuff that had just been done well".

701. Dr Gorringe insisted that the presentation for *"acute"* brucellosis and *"chronic"* brucellosis are entirely different presentations and that while he respected the opinions of Drs Doehring

and Isbell with regard to acute brucellosis that was not the situation in Ms Ghaemmaghamy's case.

702. The Tribunal does not accept Dr Gorringe's answers or explanations as either accurate or credible. For example, he referred to Ms Ghaemmaghamy's full examinations by her doctor and the reassessments she had in medical outpatients (at Waikato Hospital). However, at the time Ms Ghaemmaghamy first attended Dr Gorringe on 21 March 1998, though Dr Marcus had referred her to Waikato Hospital, the hospital had not acted on that referral.

703. As Dr Isbell stated, if Dr Gorringe were taking responsibility for diagnosing and treating Ms Ghaemmaghamy, then he was obliged to go through his own procedures to ascertain what was going on and, as a responsible doctor that meant he needed to go beyond what the patient requested.

704. Mr Douglas Lush is a Senior Adviser in Communicable Diseases for the Ministry of Health. His evidence was that brucellosis is a notifiable disease under the Health Act 1956 and that in 2002 he was involved in an investigation into the first case of locally acquired brucellosis in New Zealand since 1989. He did not have any knowledge of a notification of brucellosis made by Dr Gorringe in relation to Ms Ghaemmaghamy or any other patient of his since 1989. He also stated it was recommended in the Communicable Diseases Control Manual that the diagnosing doctor contact an infectious disease physician before the case is classified as confirmed.

705. Brucellosis is a serious disease. It is both contagious and life threatening. The reasons for notification are obvious.

706. In view of his diagnosis of Ms Ghaemmaghamy as having brucellosis, be it *"acute"* or *"chronic"*, Dr Gorringe had a clear responsibility and duty of care to undertake a proper clinical examination of Ms Ghaemmaghamy.

707. We accept and agree with the expert evidence of Dr Isbell and Dr Doehring and also the evidence of Dr Marcus.

708. What Dr Gorringe should have done but did not do was seek a full occupational, travel and dietary history (as described above) and a comprehensive physical examination which would

have included such things as checking temperature, examination of lymph nodes, liver and spleen, and seek full information about Ms Ghaemmaghamy's aches and pains and whether or not they were associated to joints and muscles; and to assess Ms Ghaemmaghamy's presenting symptoms at the time of the consultation including such matters as her increased insulin requirements and the reasons for it.

709. Dr Gorringe's clinical examination was undoubtedly inadequate. The Tribunal finds this particular proved.

Particular 1.1(b) – Dr Gorringe relied unduly on the results of PMRT to reach the diagnosis of brucellosis.

710. After some initial discussion with Ms Ghaemmaghamy and carrying out some *"basic doctor things"* such as taking her blood pressure and pulse, Dr Gorringe proceeded to *"test"* Ms Ghaemmaghamy with PMRT following which he reached his diagnosis of brucellosis. Following PMRT he did not seek any clinical information from Ms Ghaemmaghamy to support his diagnosis.

711. Dr Gorringe stated in his own evidence that brucellosis *"of the intracellular kind"* can only be diagnosed by PMRT.

712. In view of the Tribunal's findings regarding PMRT, it cannot be relied upon and, indeed, should not have been relied upon to diagnose brucellosis, particularly in the absence of an indicative clinical history and other confirmatory tests. Dr Gorringe unduly relied on it to reach his diagnosis. The Tribunal finds this particular proved.

Particular 1.1(c) – Dr Gorringe failed to carry out any other diagnostic tests to confirm his diagnosis.

713. Dr Doehring stated that "Laboratory investigations are the key to diagnosis. The most specific indicator is culture of "brucella" organisms from blood or bone marrow". He added that modern enzyme-linked immunosorbent assays are highly reliable.

714. While he acknowledged that Dr Gorringe was correct in saying that brucella tends to be located intracellularly, this was not a cause of negative serology, and indeed antibody levels may be very high.

715. He explained that "The negative serology, when taken in conjunction with the lack of a suggestive history, virtually rules out a diagnosis of brucellosis."

716. Dr Doehring referred to Dr Gorringe's evidence when he spoke of a *"resonance"* remaining after the elimination of brucellae from the patient. Dr Doehring explained that brucellosis is sometimes characterised by a prolonged period of convalescence, with ongoing malaise and depression. Such post-infectious malaise is not unique to brucellosis. He stated it was also characteristic of viral infections. In the case of viral infections the post infectious malaise has been ascribed to the interleukins, a group of non-specific components of the immune response. He explained the use of the term *"remaining resonance"* by Dr Gorringe at best metaphorical. In Dr Doehring's opinion *"There is no scientific reason to believe that any brucella bacteria or their components remain in the patient."*

717. The only blood test results available to Dr Gorringe at this consultation were those taken in December 1997 (arranged by Dr Marcus) but which were not tested for brucella.

718. Dr Isbell also gave evidence in this regard. She stated that brucellosis can readily be confirmed by blood tests, that formal blood tests would be standard and necessary in order to make the diagnosis and also to exclude any other causes for the symptoms. She stated that the investigation of brucellosis needed to be done in association with the clinical microbiology laboratory. Cultures of blood, body fluid or tissues may be positive.

719. She expressed the opinion that Dr Gorringe's failure to arrange for confirmatory blood tests was *"extraordinary, given the nature of the diagnosis"*.

720. Dr Gorringe claimed that the brucellosis which he had diagnosed was the intracellular kind which he also described as *"chronic"* brucellosis as distinct from *"acute"* brucellosis and that blood tests would be unable to confirm it.

721. The Tribunal accepts the evidence of Drs Doehring and Isbell that laboratory investigations are the key to the diagnosis.

722. At the very least, Dr Gorringe had a clear responsibility to refer Ms Ghaemmaghamy for full diagnostic tests (as described by Dr Doehring) and at the very least should have ensured that she underwent a blood test to confirm or exclude the diagnosis. He did not do so.

723. It is worthy of note that when Ms Ghaemmaghamy did undergo a brucella screen test some four days later (through her GP Dr Marcus), it was shown to be negative. The Tribunal is satisfied Ms Ghaemmaghamy did not have brucellosis, *"acute"* or *"chronic"*.

724. The Tribunal finds this particular proved.

Particular 1.1(d) – Dr Gorringe reached the diagnosis of brucellosis which was not supported by Ms Ghaemmaghamy's clinical presentation

725. Dr Isbell stated that the most common symptoms are fever, chills, sweating, headaches, muscle aches, fatigue, anorexia (lack of appetite), joint and low-back pain, weight loss, constipation, sore throat and dry cough. She stated some patients are acutely ill with pallor, lymphadenopathy (enlarged glands), enlarged liver and spleen, arthritis, spinal tenderness, acute rash (not eczema or urticaria), meningitis and spinal osteomylitis. Complications include abscesses in the cardiovascular system, brain or spleen, and meningitis and spinal osteomylitis. In mild cases, physical examination may be normal and the patient may be deceptively well. In more ill patients there will be fever, enlarged lymph nodes, enlarged liver and spleen, spinal tenderness or evidence of abscesses at varying sites.

726. Dr Isbell referred to Ms Ghaemmaghamy's presenting symptoms which, in her view, *"[did] not support, or even suggest the diagnosis of brucellosis"*. She also referred in this regard to the fact that Dr Gorringe had not made the appropriate enquiries nor undertaken the appropriate physical examination.

727. Dr Doehring was of the opinion that "The negative serology, when taken in conjunction with the lack of a suggestive history, virtually rule[d] out a diagnosis of brucellosis".

728. When it was put to Dr Isbell during cross-examination that Ms Ghaemmaghamy's muscle and unusual back pain were consistent with brucellosis, Dr Isbell replied that:

> "*There are many causes of aches/pains that you would consider before even thinking of resorting to testing for brucellosis … I think aches/pains are consistent with so many other things, there might be a list of 100 that it might be consistent with that wouldn't lead me to the differential diagnosis*."

729. Dr Gorringe emphasised Ms Ghaemmaghamy's level of muscle pain, her weakness and fatigue and her fluctuating low grade temperatures which he stated were the commonest signs

and symptoms that can appear in the chronic case of brucellosis. He maintained that Ms Ghaemmaghamy had the unusual brucellosis like pain reasonably readably recognised by an experienced rural GP such as himself, having been in rural practice from 1980 to 1989.

730. The Tribunal does not accept Dr Gorringe's evidence in this regard as credible. He did not take Ms Ghaemmaghamy's temperature and was relying on temperatures taken by another doctor in the previous December and January. Further, the Tribunal has already found that Dr Gorringe did not question Ms Ghaemmaghamy about the nature of her pains or whether they were associated to joints or muscles.

731. The Tribunal finds that in the absence of a suggestive history, in the absence of the taking of a clinical history, in the absence of an appropriate clinical examination, and taking into account the general nature of Ms Ghaemmaghamy's symptoms at the time of her presentation, the diagnosis of brucellosis was not supported by Ms Ghaemmaghamy's clinical presentation on 21 March 1998 nor on 5 May 1998 by which latter time Dr Gorringe had the results of the negative serology undertaken by Dr Marcus.

732. In summary, the Tribunal finds each of the allegations in Particular 1 proved.

Particular 2 Informed Consent – Diagnostic Technique - Ms Ghaemmaghamy

733. Particular 2 charges Dr Gorringe with failing to obtain Ms Ghaemmaghamy's informed consent to his diagnostic technique.

734. Ms Ghaemmaghamy stated that Dr Gorringe did not provide an explanation about the muscle testing procedure nor any choice about its use as a diagnostic tool prior to commencement of the testing. As he commenced performing the muscle testing procedure, she began to ask him questions about what was happening. She said she was getting somewhat confused about which vials to touch in accordance with his instructions. She said he offered her very brief and insubstantial answers, he was abrupt and kept insisting that she pay attention. She stated she had a sense that she should stop bothering him. She said the brief explanations he did offer gave her the impression that somehow the energy in the vials transferred to her body. She stated she found the whole procedure both weird and emotionally uncomfortable and that this was unusual for her as, due to her occupation, she

was quite accustomed to dealing with medical people on both professional and personal matters.

735. She stated that if she had known that Dr Gorringe would be relying on a muscle testing procedure she would have been more wary about consulting him but at the time she did not know he would be relying on it as his diagnostic technique until it happened.

736. She added that he did impart some level of understanding to her at the outset of the actual testing process that he was checking for whether she was sensitive to any of the contents in the vials and that what they were looking for was weakness in her muscles, hence the name muscle testing but she could not recall whether he used that term or not. Ms Ghaemmaghamy was adamant that Dr Gorringe did not explain to her the philosophy of his practice and nor did he advise her that he would be confining himself to non-conventional practice.

737. Ms Ghaemmaghamy was cross-examined carefully on this issue.

738. She stated that she knew that he was testing the weakness of her muscles because she had experienced a type of muscle testing prior to this occasion, that during the actual testing he offered some level of explanation about where her hand was and how he was going to pull her fingers apart and that it was implicit in a sense that that was what he was doing.

739. When asked whether he explained to her what the advantages or shortcomings to the technique were Ms Ghaemmaghamy replied that he certainly did not state any shortcomings. She added, but she could not be sure, that he may have, commented about the safety or lack of invasiveness of the technique. She believed there was some attempt at some kind of description of how it worked but she was not able to recall the detail. She was clear that he did not compare it at all with any other diagnostic techniques and that he did not tell her that there were any shortcomings relating to it.

740. Dr Gorringe conceded in cross-examination that he did not tell Ms Ghaemmaghamy the extent to which PMRT had been scientifically evaluated compared to a conventional diagnostic technique.

741. He also conceded in cross-examination that Ms Ghaemmaghamy "wanted a great deal more explanation timewise than was consistent with her wanting to ring areas that she wanted me to be looking at …".

742. Dr Gorringe stated that in accordance with Ms Ghaemmaghamy's wishes he explained that he would like to proceed and use a complementary technique called muscle testing or PMRT according to the Vega test method. He said he asked her if she had heard of it and she informed him that the Anglican vicar (who had recommended her) had told her about it. He said he listened to her description of what she had been told and it seemed adequate as a background. He said he filled in the gaps sufficient to be able to progress to the mechanics of doing the tests while stating the obvious that this was not a standard regular allopathic medical test.

743. Dr Gorringe stated that with regard to Ms Ghaemmaghamy he felt that what he had explained, given the time, was appropriate but that she proved from the outset an unusually challenging patient to work with, not because of lack of explanation on his part but because, as he put it, she had difficulty in carrying out simple directions and she insisted on continuing to ask him questions not essential to the testing while he was testing and demanded immediate answers. He said that twice he stopped everything and explained that he could not carry out the test accurately and answer her questions in a meaningful way at the same time. He explained that was because if the tester was not concentrating at the time what comes up was a null test. He said he offered that she come back in a week when he had staff to assist him (this being a Saturday) but she insisted on continuing which he said was her decision.

744. Dr Isbell was asked how she would ensure that a patient was given a chance for informed consent. She replied that she would describe to the patient what was proposed to be done before starting with it; there would be written material available which the patient could read at the time or come back to it. If the patient were not sure whether to proceed or not Dr Isbell said she would not proceed unless she was sure the patient wanted her to. She stated that justifications in terms of time and money are not sufficient to limit the requirement for informed consent. She added that in her case she also uses a written consent form. She said that if there were any doubt or if the patient did not want to proceed she would not proceed

because she did not want to coerce the patient into something with which the patient was not happy.

745. With regard to her own practice, when asked what steps she took to ensure that the patient was happy to proceed, she stated that she had a number of stages during the consultation where she would stop and ask if it made sense to the patient, if it was what the patient wanted, if the handout made sense to the patient, and if the patient had any questions. She said she did not consider that was a waste of time or money for her to be doing that.

746. Dr Isbell referred to Ms Ghaemmaghamy's evidence regarding the second appointment where she had attended with the intention to challenge Dr Gorringe but said she did not have the courage to do so when she got there. Dr Isbell commented that *"no doctor's perfect"* but that there was an inherent power differential between the doctor and patient.

747. Dr Isbell explained that what they now talk about is "concordance which is the agreement between the doctor and the patient about what is going to be done in treatment".

748. The Director has submitted that Ms Ghaemmaghamy was a patient who was *"desperate"* for a diagnosis, who had waited two months for a consultation, and who had undertaken the onerous pre-consultation requirements. She has submitted that Dr Gorringe's evidence that *"it [had] to be one or the other"*, that is, that he be permitted to proceed with the testing uninterrupted or that he answer Ms Ghaemmaghamy's questions, did not permit a choice about continuing with the consultation. She added that it was not acceptable to expect a patient to make her choice between receiving information on the one hand or undergoing consultation for diagnosis and management on the other.

749. She also referred to and relied on Dr Isbell's evidence in this regard.

750. Mr Knowsley submitted that Dr Gorringe did give some explanation on PMRT, that Ms Ghaemmaghamy did have some prior knowledge of it and that she chose to proceed of her own free will. He also referred to Ms Ghaemmaghamy's evidence where she stated that Dr Gorringe had given her some explanation of PMRT but that she could not remember the details of it. He submitted that her answers amounted to an awareness of some details and a hazy memory; and that there was no evidence that Dr Gorringe did not give an explanation

sufficient for Ms Ghaemmaghamy to consent to proceed and that she agreed it was her own free will to proceed following his explanation.

751. The Tribunal finds that Ms Ghaemmaghamy was *"desperate for a diagnosis"* and vulnerable.

752. While the Tribunal accepts there was some attempt by Dr Gorringe at some kind of description as to how PMRT worked the details of which Ms Ghaemmaghamy could not remember, and while he did impart some level of understanding that he was checking for whether Ms Ghaemmaghamy was sensitive to any of the contents of the vials and that he was looking for weakness in her muscles after the procedure had commenced, he did not explain to Ms Ghaemmaghamy the philosophy of his practice nor did he advise her he would be confining himself to non conventional practice. The Tribunal finds that Dr Gorringe did provide only brief and insubstantial answers and that he did not advise Ms Ghaemmaghamy of the disadvantages of PMRT when compared to conventional and generally recognised diagnostic/investigatory techniques and he did not advise her of the degree to which PMRT had been scientifically evaluated for its efficacy as a diagnostic tool.

753. The Tribunal accepts Ms Ghaemmaghamy's evidence that there was no discussion about PMRT prior to the commencement of the testing but that during it, and that following Ms Ghaemmaghamy's questions, Dr Gorringe did give some explanation regarding his checking for whether Ms Ghaemmaghamy was sensitive to any of the contents of the vials and that he was looking for weakness in muscles.

754. Having carefully observed Dr Gorringe giving evidence over a lengthy period, the Tribunal accepts Ms Ghaemmaghamy's evidence that Dr Gorringe was in a hurry, kept cutting off her questions for explanations, and was not really listening to her.

755. While the Tribunal accepts that Ms Ghaemmaghamy did agree to proceed with the muscle testing rather than return at another time when Dr Gorringe could more fully answer her questions, in reality it presented Ms Ghaemmaghamy with a most difficult situation. She had already waited two months for a consultation with Dr Gorringe, she had gone to considerable lengths to write out a very detailed medical history from memory in accordance with Dr Gorringe's requirements, and she was desperate for a diagnosis. In those

circumstances, it was understandable that she felt she had little option but to proceed. The Tribunal is satisfied that it would have been awkward and difficult for Ms Ghaemmaghamy to have terminated the consultation.

756. Taking into account all of the circumstances, the Tribunal finds Dr Gorringe failed to give Ms Ghaemmaghamy an adequate explanation regarding PMRT so as to enable her to make an informed choice and therefore failed to obtain her informed consent to this so-called diagnostic technique.

757. The Tribunal finds the allegations in particular 2 proved.

Particular 3 – Informed Consent – treatment/management – Ms Ghaemmaghamy

Particular 3.1(a) – Spiritual healing

758. The Director submitted that the right of a consumer to make an informed choice about the treatment they receive imposes a concomitant duty upon the doctor to ensure that the patient is given the information that the patient would expect to receive in those circumstances. If a practitioner is intent on spiritual healing, since spiritual healing is a non conventional mode of treatment, full information should be provided before the prayer is commenced. In Ms Ghaemmaghamy's case, the Director submitted it was not.

759. Mr Knowsley submitted that Ms Ghaemmaghamy had gone to Dr Gorringe on the recommendation of an Anglican Minister whom she knew, she did bow her head without raising any objection or letting Dr Gorringe know that he was proceeding under a misunderstanding as to her beliefs, and that on being asked about her receptiveness to spiritual healing, her conduct would have indicated to a practitioner that she was taking part of her own free will.

760. Mr Knowsley referred to an answer from Ms Ghaemmaghamy "And I now in retrospect understand that he was offering that as a second option, I answered honestly and said yes, and he quite mistakenly took that as my consent and proceeded with his second option."

761. He submitted there was a misunderstanding as to her being a Christian but that this did not amount to professional misconduct.

762. The Tribunal does not accept Mr Knowsley's submission is an adequate answer. Dr Gorringe did not ascertain from Ms Ghaemmaghamy beforehand what, if any, religion she ascribed to. If he were going to offer spiritual healing then he should have done so. He was not entitled to assume that Ms Ghaemmaghamy was making the choice of a preferred option of treatment by obtaining an affirmative answer from her to his general question that she was open to spiritual healing. It was incumbent on him to advise Ms Ghaemmaghamy the manner in which spiritual healing, as a treatment modality, would be conducted. He did not do so.

763. In the circumstances, he did not have Ms Ghaemmaghamy's consent and there was little she could do once Dr Gorringe *"launched"* into his charismatic prayer. What is worse, at the end of the prayer Dr Gorringe required Ms Ghaemmaghamy to *"thank the Lord"* and when she did not do so he repeated his requirement as a reprimand which was quite unacceptable.

764. The Tribunal finds particular 3.1(a) proved.

Particular 3.1(b) - Antibiotics

765. Dr Gorringe denied that he had failed to advise Ms Ghaemmaghamy whether antibiotics were available in conjunction with or as an alternative to homeopathic medication and/or spiritual healing.

766. He stated that he did inform her about her options with antibiotics and that all he needed to tell her was that "this particular form [brucellosis] was sensitive to sulphur drugs only … Was she sulphur sensitive? – No? Then end of story …".

767. With regard to the spiritual healing component, Dr Gorringe said he explained to Ms Ghaemmaghamy that the reason he offered both (prayer and antibiotics) was that:

> *"it is a lot cheaper and safer praying and it saved a $15 antibiotic script and avoided the risk with her diabetes of 18 days of a sulphur drug at the high doses necessary to kill brucellosis."*

He said that she asked if they could do both to which he replied it was possible but that she would need to make a decision on what she wanted him to do. He said that Ms Ghaemmaghamy:

> *"equivocated to the degree that I made a suggestion "Why don't we pray and see if it works and go from there?" She agreed and we prayed."*

768. Ms Ghaemmaghamy stated that prior to leaving the first consultation Dr Gorringe *"required"* her to purchase some homeopathic medication from him. She stated that he did not advise her what the medication was for and nor did he give her any option of purchasing the medication from anywhere else other than his office. She stated she was not given the opportunity at that time of having antibiotics prescribed and was completely unaware that in receiving spiritual healing she had somehow given up her option of having antibiotics.

769. When Ms Ghaemmaghamy was asked to comment on Dr Gorringe's written evidence she stated he told her there was only one antibiotic that worked for brucellosis, that there were options and he told her how antibiotics worked and that a powerful or strong one would be accompanied by the usual complications, especially for diabetics such as herself. She said he then paused and then asked her whether she was open to spiritual healing. She stated she thought he was opening a conversation and did not realise that prayer was supposed to be an option. Following the prayer, she could not be sure but did not think there was any further discussion of antibiotics. She explained that she *"was pretty shocked"* and *"was really quite anxious to get going"*. When asked further whether there was any discussion about prayer being used as an alternative to the antibiotics Ms Ghaemmaghamy replied that by the time she left Dr Gorringe's rooms she understood that prayer was the other option he was talking about and that he had done it and that *"It was a really dramatic – we're not talking an ordinary prayer here, it was full of drama and pageantry"*.

770. When pressed in cross-examination about this issue, Ms Ghaemmaghamy thought that she had not given up the option of antibiotics because of the prayer. However, she discussed it with others afterwards and resolved on her next visit to him to ask about antibiotics. She did not think she asked about antibiotics at the first consultation after the prayer. When it was put to her by Mr Knowsley that she did not say to Dr Gorringe *"what about those other options you were telling me about?"* she responded that she did not remember but she *"certainly was stunned"*.

771. She explained that she "found Dr Gorringe fairly foreboding in the way that he, you know, sort of barked at me to concentrate during the muscle testing, his general manner, the bizarre

prayer, the nature and way in which he prayed – the whole thing – I was quite nervous to go to the next consultation but resolved to ask him about the possibility of antibiotics".

772. While the Tribunal accepts that Ms Ghaemmaghamy could not be precise about all details of the discussion relating to antibiotics, it accepts her description of Dr Gorringe as being *"fairly foreboding"* and that following his recitation of the prayer in dramatic terms she was *"stunned"*.

773. The Tribunal prefers Ms Ghaemmaghamy's description of events to that of Dr Gorringe.

774. It finds that Dr Gorringe did not advise Ms Ghaemmaghamy in any coherent way whether antibiotics were available in conjunction with, or as an alternative to, homeopathic medication and/or spiritual healing.

775. The Tribunal finds that he conducted the consultation in an overbearing manner which confused and stunned her and which created an atmosphere which was not conducive to making an informed choice and thereby giving informed consent.

776. The Tribunal finds particular 3.1(b) proved.

Particular 3.1(c) – Purpose of risks, benefits, efficacy

777. Ms Ghaemmaghamy stated that Dr Gorringe did not advise of the purpose of, risks, benefits and efficacy of the non conventional treatment options of prayer and homeopathic medication.

778. Dr Gorringe stated that he did and that from the moment he begins any examination he has "a running commentary going constantly to inform people about what I would like to do, how I would like to do it, and I then invite them to participate". He stated he did this with Ms Ghaemmaghamy.

779. However, the Tribunal is satisfied on the evidence before it that Dr Gorringe did not so advise Ms Ghaemmaghamy at either consultation.

780. Further, the document which he forwarded in advance of the first consultation to Ms Ghaemmaghamy entitled *"Taking Homeopathic Medicine (Naturopharm)"* does not advise of the purpose of, risks, benefits and efficacy of the homeopathic treatment option.

781. The Tribunal finds particular 3.1(c) proved.

782. The Tribunal further finds that in failing to give Ms Ghaemmaghamy adequate information regarding his management and treatment, Dr Gorringe failed to enable her to make an informed choice and therefore failed to obtain her informed consent to his management and treatment.

Particular 4 - Documentation

783. This particular which relates to a charge of failure to adequately document any explanations was laid in the alternative to particular 2 and 3.

784. As the Tribunal has found particulars 2 and 3 proved it did not consider it necessary to address particular 4.

Particular 5 - Exploitation

785. The Tribunal makes the following findings of fact which are relevant to this particular:

(a) At the first consultation, Dr Gorringe charged Ms Ghaemmaghamy $172.30 being $98 for the consultation fee and $74.30 for the homeopathic medication.

(b) At the second consultation Dr Gorringe charged $242.30 being $165 for the consultation and $77.30 for the homeopathic medication.

(c) While Ms Ghaemmaghamy was aware that she could purchase homeopathics remedies elsewhere, Dr Gorringe did advise her at the end of each consultation to purchase homeopathic treatment from him.

(d) Ms Ghaemmaghamy was desperate for a diagnosis and was vulnerable. Dr Gorringe was aware of this.

(e) At the conclusion of the muscle testing procedure at the first consultation, having told Ms Ghaemmaghamy she had brucellosis, he told her that with treatment she would be feeling better in about a week and that the brucellosis was the kind that could not be diagnosed by other doctors.

(f) Following the prayer at the first consultation, Dr Gorringe did not muscle test Ms Ghaemmaghamy again.

(g) Dr Gorringe told Ms Ghaemmaghamy she would feel an *"improvement"* in seven days.

(h) On 25 March 1998, four days after the first consultation, Ms Ghaemmaghamy underwent a brucella screen test (initiated by her GP Dr Marcus) which was negative.

(i) These results were sent by facsimile to Dr Gorringe making him aware of the negative serology.

(j) When Ms Ghaemmaghamy consulted Dr Gorringe again on 5 May 1998 she was still desperate for a diagnosis of which he was aware.

(k) At the 5 May consultation Ms Ghaemmaghamy told Dr Gorringe that she understood that the prayer did not exclude antibiotics or other medical treatments for the brucellosis.

(l) Dr Gorringe advised Ms Ghaemmaghamy that there was no need for her to undergo antibiotic treatment as *"the prayer had killed the brucellosis bug"*.

(m) Dr Gorringe then conducted a muscle test in order to demonstrate to Ms Ghaemmaghamy that the brucellosis was *"as dead as a doornail"*.

(n) At the conclusion of the second consultation Dr Gorringe prescribed further homeopathic remedies which he advised Ms Ghaemmaghamy to purchase from him.

786. The Director relied on certain aspects of the evidence (many of which are the subject of the Tribunal's findings set out above).

787. Dr Gorringe submitted that even though the brucellosis bug was found to be dead it was still necessary for it to be removed from Ms Ghaemmaghamy's system and hence the need for homeopathic remedies. His counsel submitted they were to detoxify and were believed by Dr Gorringe to be a necessary part of the process and that offering a course of homeopathics to carry out that detoxification process was not exploitation but rather merely a necessary part of the treatment.

788. The Director submitted that in determining whether Dr Gorringe exploited Ms Ghaemmaghamy the following contextual factors were relevant:

(a) That Ms Ghaemmaghamy had given clear evidence she felt extremely vulnerable at the time she saw Dr Gorringe and was desperate for a diagnosis.

(b) That Dr Gorringe had given her a timeframe for cure of 7 to 10 days and that she had called the surgery after the lapse of that time as she had not been feeling any

improvement in her symptoms.

(c) It was notable that the brucellosis diagnosis was of a form that could not be diagnosed by other doctors.

(d) Ms Ghaemmaghamy had described a sense of drama and build up to the consultations which could be regarded as an attempt to enhance his credibility for his patients.

(e) Ms Ghaemmaghamy felt exploited by Dr Gorringe's practice.

(f) As in her earlier submission regarding Mrs Short, Dr Gorringe *"medicalises"* his alternative practice to give it scientific validity.

789. The Director considered it relevant that Dr Gorringe did not muscle test Ms Ghaemmaghamy immediately after the prayer (at the first consultation) which Dr Gorringe disputed. However, she stated, that Ms Ghaemmaghamy was clear that muscle testing was conducted at the second consultation in order to show that the brucellosis bug was dead and that antibiotics were no longer necessary. She submitted that this begs the question – how could Dr Gorringe have known the brucellosis bug was dead? Upon what basis did he require her to purchase medication at the first consultation?

790. She submitted that taking into account all of the above factors there was exploitation by Dr Gorringe for financial gain, amounting to professional misconduct.

791. The Tribunal is satisfied that Dr Gorringe's conduct towards Ms Ghaemmaghamy was exploitative.

792. At the first consultation, as the Tribunal has already found, Dr Gorringe failed to undertake an adequate clinical examination, failed to carry out any other diagnostic tests to confirm his diagnosis (other than PMRT which has not been scientifically validated), and reached a diagnosis of brucellosis which was not supported by Ms Ghaemmaghamy's clinical presentation.

793. He made a diagnosis of a rare, extreme, and obscure kind. It was a worrisome and frightening diagnosis.

794. Bearing in mind Dr Gorringe's own training and qualifications and taking into account his failure to undertake an adequate clinical examination, his failure to carry out any other diagnostic tests to confirm his diagnosis, and to reach a diagnosis which was not supported by Ms Ghaemmaghamy's clinical presentation, there was no credible basis on which he could have reached such a diagnosis.

795. When Ms Ghaemmaghamy returned to the second consultation, he knew by then, as a result of the laboratory tests, that she did not have brucellosis. He then claimed that the prayer which he had recited at the first consultation *"had killed the bug"* and then muscle tested her to *"prove"* it. Nonetheless he again advised her to purchase homeopathic treatment from him.

796. Before the Tribunal he claimed that this was still necessary for the *"bug"* to be *"removed"* from Ms Ghaemmaghamy's system.

797. Mr Knowsley submitted that Ms Ghaemmaghamy was not required to purchase the homeopathic treatment from Dr Gorringe, knew she could buy them elsewhere and would still have had to pay elsewhere for them at greater cost, agreed to the course, and would need to buy them from somewhere. The Tribunal rejects this submission.

798. In the Tribunal's view, the evidence is overwhelming that there was no credible basis upon which Dr Gorringe could have made a diagnosis of brucellosis; and there was no credible basis upon which he could claim that the prayer which he recited *"killed it"*.

799. His initial prescription was unnecessary and his action in prescribing further homeopathic treatment when the *"bug"* was *"as dead as a doornail"* is indicative of his exploitation of a vulnerable patient.

800. The Tribunal finds particular 5 proved.

801. In view of the Tribunal's findings, and for the reasons already given, the Tribunal finds that Dr Gorringe's conduct as alleged in particulars 1 to 5 (including the sub-particulars contained within those particulars) either separately or cumulatively amount to professional misconduct.

NAME SUPPRESSION DISCHARGED – MS GHAEMMAGHAMY

802. On 19 August 2002, following an application from the Director, the Tribunal made an interim order suppressing Ms Ghaemmaghamy's name. More recently the Tribunal has received an application from the Director that the order be discharged as Ms Ghaemmaghamy no longer requires it. The Tribunal grants the application.

CONCLUSION AND ORDERS

Mrs Short

803. The Tribunal is satisfied that the charge of professional misconduct laid against Dr Gorringe in respect of Mrs Short in all its particulars, both separately and cumulatively, is established. Dr Gorringe is guilty of professional misconduct.

804. The Tribunal is satisfied that the charge of disgraceful conduct in a professional respect laid against Dr Gorringe in respect of Mrs Short in all its particulars, both separately and cumulatively, is established. Dr Gorringe is guilty of disgraceful conduct in a professional respect.

Ms Ghaemmaghamy

805. The Tribunal is satisfied that the charge of professional misconduct laid against Dr Gorringe in respect of Ms Ghaemmaghamy in all its particulars, both separately and cumulatively, is established. Dr Gorringe is guilty of professional misconduct.

806. The interim order which was made on 19 August 2002 suppressing the name of Ms Ghaemmaghamy is hereby discharged.

PENALTY

807. The Tribunal invites the Director of Proceedings to file submissions as to penalty within 14 days from the date of receipt of this decision.

808. The submissions are to be served on counsel for Dr Gorringe. Mr Knowsley shall have a further 14 days from the date of service to make submissions in reply.

DATED at Wellington this 5th day of August 2003

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S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal