MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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NB: PUBLICATION OF THE NAME OF THE DOCTOR AND ANY DETAILS WHICH MAY IDENTIFY THE DOCTOR AS A XX PRACTITIONER IS PROHIBITED IN THE INTERIM. PUBLICATION OF THE NAME AND DETAILS OF THE COMPLAINANT IS PROHIBITED	**DECISION NO:**	227/02/97C
	IN THE MATTER	of the Medical Practitioners Act 1995
		-AND-
	IN THE MATTER	of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **D** medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL:	Dr D B Collins QC (Chair)
	Mrs J Courtney, Dr R S J Gellatly, Dr U Manukulasuriya,
	Dr J L Virtue (Members)
	Ms G J Fraser (Secretary)
	Mrs G Rogers (Stenographer)

Hearing held at Napier on Monday 14 and Tuesday 15 April 2003

APPEARANCES: Ms K P McDonald QC for the Complaints Assessment Committee ("the CAC")

Mr H Waalkens and Ms C Garvie for Dr D.

CONTENTS

The Charge

1. On 19 November 2002 a Complaints Assessment Committee ("CAC")[1] charged Dr D with "conduct unbecoming a medical practitioner".[2]

2. On 5 February 2003 counsel for the CAC filed and served a proposed new notice of charge. The proposed new notice of charge alleged Dr D's conduct constituted disgraceful conduct in a professional respect.[3] The particulars of the proposed new charge were identical to the particulars set out in the first notice of charge filed by the CAC. On 10 February 2003 the Tribunal issued a decision concerning the procedure to be followed before the proposed new charge could be considered by the Tribunal. The CAC was required to apply for leave to amend the charge. The CAC duly applied to amend the charge. In a decision delivered on 7 March 2003 the Tribunal granted the CAC's application to amend the charge by substituting the allegation Dr D's conduct constituted "conduct unbecoming a medical practitioner" with an allegation that his conduct amounted to "disgraceful conduct in a professional respect".

3. The particulars of the amended charge allege:

> *"… Dr D, a registered medical practitioner of xx over the period 22 February 1995 and 28 March 1995 in the course of his management and treatment of his patient [V]:*
>
> *1. Asked questions and made comments of an inappropriate and sexual nature;*
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> *2. Performed five internal vaginal examinations in the course of six consultations which was[sic] inappropriate and not medically justified; and*
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> *3. Performed one or more of the internal vaginal examinations in an inappropriate sexual manner; and*
>
> *4. First discussed and then suggested to his patient that he should use on her a "perineometer" which he had made himself which was inappropriate and for which there was no medical justification; and*

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1 Established under s.88 Medical Practitioners Act 1995

2 Section 109(1)(c) Medical Practitioners Act 1995. The statutory description of the charge is "… conduct unbecoming a medical practitioner, and that conduct reflects adversely on the practitioners fitness to practice medicine"

3 Section 109(1)(a) Medical Practitioners Act 1995.

5. When confronted by his patient on or about 28 March 1995 destroyed or sought to destroy her medical notes; …"

Name Suppression

4. On 11 December 2002 Dr D applied for name suppression. The Tribunal's decision granting Dr D interim name suppression could not be delivered until 7 March 2003 because the Tribunal sought information from Dr D and his counsel concerning that application. The information sought from Dr D concerning name suppression was received by the Tribunal on 26 February 2002. No application was made by the complainant for suppression of her name. Nevertheless the Tribunal exercised its discretion to grant her interim name suppression because it was concerned that the evidence relating to "V" was likely to be intensely private and intimate. Having now heard the evidence the Tribunal has no hesitation in granting "V" permanent name suppression. The evidence heard by the Tribunal was very intimate and private and it would be totally inappropriate for "V's" name to be published.

5. When the hearing of the case commenced on 14 April "V" was advised of the provisions in s.107 Medical Practitioners Act 1995 which are for the benefit of complainants giving evidence where the charge relates to or involves:

- any matter of a sexual nature;
- any matter that may require or result in the complainant giving evidence of an intimate or distressing nature.

6. The complainant properly sought the protections afforded by s.107 Medical Practitioners Act 1995. Accordingly "V" effectively gave her evidence in private. The Tribunal's decision to grant "V" permanent name suppression dovetails with her request for her evidence to be given "in private".

7. One of the many troubling features of this case concerns the issue of whether or not Dr D's name should continue to be suppressed. That issue has not yet been determined by the Tribunal. The interim name suppression order will continue pending the Tribunal reaching its final decision on this issue.

Summary of Tribunal's Decision

8. At the conclusion of the hearing of evidence and submissions on 15 April 2003 the Tribunal retired to consider its decision. Later that day it advised Dr D that it found two of the particulars namely, particulars 1 and 4 established, but not at the level of disgraceful conduct. The Tribunal found those particulars were proven and amounted to professional misconduct.[4] The Tribunal advised Dr D that in reaching its conclusion it was satisfied his conduct was not sexually motivated.

9. The Tribunal now explains the reasons for the decision it announced on 15 April and the penalties it imposes on Dr D.

Summary of the CAC's case

10. The complainant was the principal witness for the CAC. She told the Tribunal that she first consulted Dr D in February 1995 and that she saw Dr D on approximately six occasions during the course of February and March of that year.

11. After reading her medical notes "V" concluded that she first saw Dr D on 22 February 1995 for four matters, namely,

- eczema on her shoulder;
- two moles;
- suspected thrush;
- concern about her weight.

When he gave evidence Dr D also said he first saw "V" on 22 February 1995. Whilst it is not crucial, the Tribunal notes that the records kept by Dr D suggest Dr D may have first seen "V" on 15 February 1995 when a record of her previous significant medical history[5] was noted.

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4 Section 109(1)(b) Medical Practitioners Act 1995

5 A miscarriage and a surgical termination of pregnancy

12. The complainant explained that during the consultation on 22 February Dr D made inappropriate and sensitive remarks during the course of her vaginal examination. She told the Tribunal:

> *"I was told to lie on the table and open my legs, he made sensitive comments about the fact that I had shaven pubic hair and I recall very clearly that he pulled my genitals apart. I remembered thinking to myself what on earth is he doing? It was very uncomfortable. I don't think he had gloves on at this stage"*.

13. During the course of her evidence in chief "V" elaborated further on the matters referred to in paragraph 12 of this decision. She said Dr D told her that her shaven pubic hair "*looked quite appealing for a woman*".

14. The complainant also explained that during the course of a vaginal examination Dr D discussed:

> "*…the use of vibrators with me. He asked me whether I had one and how often I used one. He was continually talking about sex and related matters. He wanted to know if I was satisfied with my sex life"*.

15. During the course of her evidence in chief "V" said that she thought Dr D's references to vibrators:

> *"… was really personal and he really had no right to ask me"*,

and that she:

> *"…tried to change the subject because that was not why I was there. I didn't go to talk to him about vibrators"*.

16. The complainant's evidence was that during the course of another visit Dr D:

> *"… talked about sex again. Dr D started talking about the smell of a female and how I should use vaginal fluids as a perfume on my neck as he thought the smell 'delicious'. I recall these were the words that he used. I don't know [why] he told me to try this. He even told me how to do this, although it was self explanatory. I thought it was disgusting and changed the subject."*

17. The complainant's evidence before the Tribunal included a reference to Dr D explaining how a prostitute patient achieved three orgasms a day. In her evidence in chief "V"

explained how Dr D told her how the lady in question achieved this. It is not necessary to elaborate on that evidence in this decision.

18. The complainant did confide to Dr D that she was anorgasmic. She also said that during the course of consulting Dr D he referred to sexual topics and that he *" … kept trying to talk about these sexual matters all the time"*. According to "V" the sexual topics traversed by Dr D included his questioning the size of her partner's penis. The complainant also told the Tribunal:

> *"Dr D also asked me how often my partner and I had sexual intercourse. Dr D asked this of me on more than one occasion. Dr D urged me to get my partner to perform oral sex on me and went into great detail to describe how it would feel. I did not believe this was relevant to anything I was seeing Dr D about. I specifically remember him referring to a "soft tongue" in this context. He said it was good and the tongue is really soft. I didn't talk about it with him. I said nothing as I didn't want to carry on the conversation. I was very embarrassed."*

19. The complainant told the Tribunal that during one consultation Dr D asked her to hold a speculum after it had been inserted and that he also used the speculum to try to sexually stimulate "V".

20. The medical notes record that on 1 March 1995 "V" consulted Dr D about her left ovary which was very painful. In her evidence "V" said that she suggested her painful ovary *"… did not seem to be a priority at the consultation. Dr D didn't seem at all interested in my ovary"*.

21. During the course of the consultation on 1 March 1995 Dr D applied nylon ties to the two moles which "V" had brought to Dr D's attention during an earlier consultation. It would also appear he provided "V" with Pimafucort cream for her suspected thrush.

22. The next consultation recorded in the notes occurred on 6 March 1995. Again "V" complained of her sore left ovary. A vaginal swab was taken to test for chlamydia.[6] The issue of the sore left ovary was raised again during the course of a consultation she had with Dr D on 10 March. It was on this occasion that "V" said Dr D gave her an ointment (Xylocaine gel). When referring to the Xylocaine "V" said:

> *"He told me to 'massage' my clitoris and to see what happened. He gave me something that caused numbness. He wanted me to masturbate with it. He didn't come right out and say I want you to have an orgasm, but that was the whole idea and what he meant. My ovary felt like it was going to explode. It was really painful. I remember he pushed it. He knew exactly where it was. I nearly went through the roof so he knew it was sore but then after I was dressed again he went straight back to talking about sex. I went home with nothing for my pain. I was worried about it. I rang him the next day to say it was still very sore. He asked if I had used the Xylocaine and if I had used it where he had told me to. I said yes. I think he wanted to hear results but I didn't have any".*

23. During her evidence in chief "V" reiterated that Dr D provided her with Xylocaine to use when massaging her clitoris in order to try to produce an orgasm.

24. In her evidence "V" told the Tribunal that she was convinced:

> *"Dr D had an absolute obsession/fascination with sexual matters".*

She said that during one consultation she noticed Dr D:

> *"… rubbing his penis through his trousers"*

and that:

> *"…he was definitely aroused when he was talking to me about these matters. I could tell that he was aroused and that he had his hand down there. He appeared to be masturbating".*

25. The complainant also told the Tribunal that during the course of a consultation Dr D produced from a box stored under the examination table a "gadget" which looked like a vibrator. It transpired that this device was made by Dr D and that it is called a

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[6] When Dr D gave evidence he explained he took the swab from the vaginal wall and not the cervix. Although it is not relevant to the particulars of the charge the Tribunal was concerned Dr D's knowledge about how to take a swab for Chlamydia was deficient.

perineometer and is designed to test the strength of a woman's pelvic floor muscles. The complainant referred to this incident in the following way:

> *" Dr D showed me a vibrator that he made himself and I noticed some old used condoms in the same box as the vibrator item. He tried to encourage me to let him try the vibrator but I said I was not interested. He had made some sort of thing (gadget) that was supposed to be used for testing the strength of pelvic muscle. He said he would test mine some time. Nothing else was said."*

In her oral evidence in chief "V" said that Dr D referred to the perineometer as a vibrator[7].

26. The complainant's evidence was that on the last day she consulted Dr D (28 March 1995) she telephoned Dr D and raised with him her concerns about the way he conducted his consultations. She said that she:

> *"… explained to him that the reason [she went] to [Dr D] was for a few prescriptions and not to learn about sex or hear about other people's sexual problems".*

27. The complainant said that on this occasion she again asked Dr D for a prescription for diet tablets and that he agreed to prescribe Tenuate Dospan. Later that day "V" went to the surgery to uplift this prescription. Dr D saw "V" in the waiting room and handed her the prescription.

The complainant told the Tribunal that she said to Dr D she *"… would not be coming back to him"* and that she remonstrated over what had happened. The complainant said she *"was very angry and told [Dr D she] wouldn't be coming back so he could destroy [her] notes as she wouldn't be needing them again. Dr D then cut up my medical file in front of [her]".*

28. The complainant also explained to the Tribunal that approximately three years ago she telephoned Dr D following publicity about Dr Morgan Fahey in Christchurch who was convicted of serious offences relating to the sexual abuse of patients. The complainant said that when she telephoned Dr D she told him he was no better than Dr Fahey and that she should report Dr D to the Medical Council. The complainant said that during the course of

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[7] Transcript p.12 line 11

this telephone conversation Dr D told her a number of doctors were concerned about his fascination with the clitoris and that he wanted to write a book about the clitoris and sex organs.

29. The complainant told the Tribunal that the reason she refrained from lodging a complaint with the Medical Council for approximately five years after the consultations with Dr D was because she wanted to put the matters of concern behind her. However when "V" saw publicity about Dr Fahey's exploits the events which occurred in Dr D's surgery "*preyed on [her] mind"* so she lodged her complaint.

30. The CAC called one other witness. That person was a former partner of "V". His evidence was that the complainant told him what had occurred in Dr D's surgery approximately two months after the alleged incidents. The complainant's former partner said that after the consultations "V" was very concerned and stressed. The Tribunal heard that when "V" spoke to this witness she told him how her doctor had told her he would help her have an orgasm and that her doctor had talked to "V" about a vibrator.

Summary of Dr D's case

31. Dr D is now xx years old. He retired from medical practice in xx. Dr D practised as a GP in xx for slightly over 40 years. Dr D vehemently denies the allegations made against him by "V" and explained that he was deeply distressed and horrified by her claims.

32. During the course of his evidence Dr D explained that during his career he developed an interest in sexual education, and in particular, female sexual function and dysfunction. Dr D's interest in these areas developed because of the paucity of information available about these topics.

33. The Tribunal was told by Dr D that his interest in the pelvic floor of women related to the problems which he observed patients suffering with bladder incontinence and vaginal prolapse. Dr D explained that he developed the perineometer for legitimate health purposes, namely as a device to measure pelvic floor strength.

34. Dr D ardently denied making any comments of an inappropriate sexual nature to "V".

More specifically, Dr D said he did not comment on "V's" shaven pubic hair. Dr D also told the Tribunal that "V's" allegations that he discussed vibrators with her were false. Other allegations made by "V" concerning the way internal examinations were conducted were also flatly denied by Dr D. Dr D responded to the claims he talked to "V" about sex and related matters and asked her whether she was satisfied with her sex life by saying:

> *"I deny asking questions of this nature. [The complainant] acknowledges … that she confided in me that she had never had an orgasm. I do not recall her saying that, however it is most likely that any discussion of a sexual nature was in the context of that comment".*

35. In response to "V's" claims that Dr D spoke to her about using vaginal fluids as a perfume Dr D told the Tribunal:

> *"I certainly did not discuss vaginal fluids nor advise [V] to use them as a perfume, or use the word 'delicious' in this context".*

To this evidence Dr D added:

> *"Although I cannot recall, it is possible that I discussed pheromones during the course of a discussion with [V], but not in the terms or the manner she describes."*

36. Dr D told the Tribunal he did not speak to "V" about a prostitute who reportedly had three orgasms per day.

37. Similarly Dr D's evidence before the Tribunal was that he did not question "V" about her sexual experiences, or the size of her partner's penis. His evidence was:

> *"I deny asking or discussing these matters. I would have no reason to ask such questions, or any interest in this. As I have said, if there was any discussion around sexual intercourse that would only have arisen from the admission made by [V] that she had never had an orgasm and her complaint about painful intercourse. It is not a topic I asked questions about."*

38. In response to "V's" claims Dr D discussed oral sex with her, Dr D denied any such discussion and told the Tribunal that he had not heard the expression "soft tongue" and that it was not a phrase he used.

39. In relation to the claim Dr D gave "V" Xylocaine to assist with masturbation Dr D told the

Tribunal:

> *"I did give [V] Xylocaine because of her complaints of soreness in the vaginal area during intercourse, as it has the effect of inducing numbness. I would have advised [V] to apply it externally to the area that was sore. I most certainly did not tell her to apply it to her clitoris. Her suggestion that I wanted her to masturbate with it is nonsense."*

40. Dr D told the Tribunal that the allegations he was sexually aroused and that he may have been masturbating himself when "V" was in his surgery were completely false. Dr D told the Tribunal he suffered erectile dysfunction and provided the Tribunal with documentary evidence that showed he sought assistance for this condition long before he saw "V".

41. In his evidence Dr D addressed the allegations in the second particular of the charge by explaining he performed four vaginal examinations, namely, on 22 February, 6 March, 10 March and 22 March. Dr D told the Tribunal each vaginal examination was clinically justified and conducted in an appropriate manner. Dr D stressed there was no sexual motives for the examinations. Dr D was certain he always wore gloves when conducting internal examinations but also said he did not wear gloves when taking a swab[8].

42. There appeared to be some agreement between "V" and Dr D that Dr D requested "V" to tighten her pelvic floor muscles whilst he conducted an internal examination. Dr D said that he would have done this for the sole purpose of assessing the strength of "V's" pelvic floor muscles.

43. Dr D responded to the suggestion from "V" that he inserted a speculum into her in a way which was meant to sexually stimulate her by saying that the allegation was untrue.

44. Dr D summarised his responses to the allegations in the second and third particulars of the charge by saying that none of the four vaginal examinations he performed were conducted in an inappropriate manner.

45. In relation to "V's" allegations about the perineometer Dr D told the Tribunal that he did not suggest he could use this gadget on "V". Dr D said:

> *"I cannot recall whether I did show the perineometer to [V], but if I did I*

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[8] Transcript p.70 line 17

would not have considered this inappropriate. Nor did [V] say anything at the time to give me the impression that she was offended, but I apologise if she was. I would have explained to her its purpose – namely for measuring the strength of the pelvic floor and surrounding muscles, to be used in conjunction with instruction for the strengthening of the same. I asked her if she wished to use it. I certainly did not use it at the surgery."

46. In relation to the fifth particular of the charge, Dr D told the Tribunal that he left a prescription at the front desk for Tenuate Dospan which "V" was to collect. Dr D explained what happened thereafter in the following way:

"Later that day [V] called at the surgery. She did not have an appointment and as far as I was aware was calling to pick up the prescription for the diet tablets which I had left for her.

Evidently [V] had caused something of a scene at the front desk although I was not there. I was called by the front desk receptionist who asked if I would see [V]. I saw her in my consulting room.

[V] was very worked up. She seemed irrational and quite different from the person who prior to that day, I had known as a patient. She did not say what she was upset about and certainly did not tell me that she considered I had acted in a sexually inappropriate manner in previous consultations. I can be quite certain about that.

[V] demanded that I give her the notes. I said I would post them to her new doctor but she said she did not have one. She wanted to take the notes there and then. I said I would photocopy them in the event of an enquiry (she had previously in the telephone call said she might make a complaint). She told me an enquiry /complaint would not occur but she wanted to destroy the notes. I would not allow her to take the notes to be destroyed, and I could not understand why she wanted to do so. To placate [V], I said that I would cut them up in her presence. She agreed and I had a guillotine in my room, and I used that to cut the notes, then placed them in a rubbish bin in front of her.

She also wanted to know how much she owed. I told her it was $15 (not $20 as she refers to in her statement). She then said that this account should be written off. I thought that must be what she was on about – namely to not have to pay the account and to save any argument I did write off this balance.

As soon as she left my surgery I then retrieved the notes from the rubbish bin and placed them in an envelope.

> *In hindsight, I regret cutting the notes. I realise that the better approach would have been to photocopy them and give [V] the records but retain a copy. My concern was not to destroy the notes, and also to avoid a confrontation with her, and I thought by cutting the notes and placing them in the waste bin, as I did, would prevent [V] from destroying them. I did not destroy her notes, but as I have said, above, I retained them. However her behaviour was such that I have no doubt she would have reacted angrily to this. I was trying to placate her behaviour.*
>
> *I regret any inference that I attempted to destroy the notes because I was concerned at the manner in which I had conducted the consultations with [V]. I was completely puzzled by [V's] behaviour, and why she would want the notes destroyed, so for that reason made sure the notes were retained."*

47. Dr D made a note in his diary after "V" left the consulting room. A copy of his diary note was produced for the Tribunal. Dr D also provided the Tribunal with a copy of the notes he made in his diary when "V" telephoned him prior to lodging her complaint.

48. Dr D's summarised his case by emphasizing to the Tribunal that "V's" complaint was the first he had in relation to his 44 years practice of medicine. He expressed regret that "V" had *"misinterpreted things that occurred or were said during her consultations with [him]. However [he] reiterate[d] that many of the comments and actions "V" … alleged, [he] completely denied and … [was] disturbed by the allegations"*.

49. Dr D called one witness, namely, Dr Bernard Brenner, a gynaecologist with a particular interest in urogynaecology. Dr Brenner's evidence was presented to the Tribunal by way of video link. The essence of Dr Brenner's evidence was that it was appropriate to use a perinoemeter to assess pelvic floor strength. Dr Brenner told the Tribunal that "*perinoemetry has been available for several decades and was designed to improve the assessment of and provide a semi quantitative assessment of pelvic muscle tone*". Dr Brenner also said that in his expert opinion it is reasonable to advise patients in a general practice setting of the purpose and benefits of developing or maintaining pelvic floor muscle strength.

Evaluation of Evidence

50. The Tribunal has very carefully evaluated the evidence presented to it and taken into account the submissions made by counsel for the respective parties.

51. In assessing the evidence the Tribunal has generally accepted that the contemporaneous records accurately reflect the events recorded in those documents. In particular, the Tribunal accepts the medical records made by Dr D and the diary notes he made are substantially accurate.

52. When assessing the accuracy of "V" and Dr D's respective recollections of events the Tribunal has been very mindful of two matters, namely:

52.1 The events complained of occurred in February and March 1995. It is natural that with the passage of time memories fade and recollections become distorted. This concern was highlighted in very forceful terms by the Supreme Court of New South Wales in *Herron v McGregor*.[9]

52.2 Dr D is now xx years old. His ability to accurately recall events has been affected by his age. Dr D alluded to this concern during the course of his cross examination when he suggested that in relation to some contentious matters his memory may not be as accurate he would like.[10] The Tribunal fully understands Dr D's difficulty.

53. In assessing the credibility of "V" and Dr D the Tribunal has carefully focused upon their demeanour and the way in which they have responded to careful and thorough cross examination from experienced counsel, as well as their responses to the questions put by members of the Tribunal. As is often the case where issues of credibility are pivotal the Tribunal has concluded that both "V" and Dr D's recollections of events were partially correct, but some of their recollections are distorted and not accurate.

54. In those instances where the Tribunal has rejected the evidence of a witness it has done so on the basis that the witnesses' recollection is inaccurate and not because the witness concerned has deliberately tried to mislead the Tribunal.

55. The evidence the Tribunal has relied upon is examined in detail when considering the particulars of the charge. It is however convenient to summarise in general terms the Tribunal's assessment of the evidence given by the witnesses.

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9 (1986) 6 NSWLR 246 at 254

10 See for example, Transcript p.99 line 1 and p.111 line 8.

The Complainant

56. The Tribunal thought "V" presented as an honest and generally reliable witness. It was apparent however that "V" misconstrued and misunderstood some of Dr D's comments and actions. For example the Tribunal was totally satisfied "V" mistook Dr D's actions when she thought he may have been aroused and possibly masturbating himself. That suggestion was not compatible with the evidence the Tribunal heard and accepted about Dr D's erectile dysfunction. The Tribunal also thought "V" misunderstood the suggestions which Dr D made about use of the perinoemeter. The Tribunal can understand "V's" error in assuming Dr D's gadget was a sexual device. In fact it was a medical implement.

Dr D

57. The Tribunal thought Dr D genuinely tried to recall the events which occurred in his surgery in February and March 1995. The Tribunal concluded however that in relation to some aspects of his responses to "V's" allegations Dr D's recollections were inaccurate.

58. The Tribunal believes this case relates primarily to poor communication on the part of Dr D. It is the Tribunal's conclusion that when "V" presented to Dr D he made assumptions about her sexual experiences and her willingness to listen to some of his well intended advice and information about sexual matters. Dr D failed to appreciate that she did not share his enthusiasm for exploring and discussing issues of a sexual nature. The doctor/patient relationship was, in this case, flawed from the outset because of Dr D's lack of insight in not appreciating what "V" wanted from Dr D. Dr D's failure to recognise that "V" did not want to learn about the sexual issues which Dr D wanted to explain generated distrust and suspicion in the mind of "V" to the point where comments and actions by Dr D were easily misconstrued by "V".

Complainant's former partner

59. The Tribunal thought "V's" former partner was an honest and generally reliable witness.

Dr Brenner

60. The Tribunal accepted Dr Brenner's expert opinions and is grateful for his having made time available to provide his testimony to the Tribunal.

Standard of Proof

61. The allegations leveled against Dr D are very serious. Accordingly the onus placed upon the CAC to establish the charge requires a high standard of proof.

62. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[11] where the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[12]

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy.*[13] *Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

63. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[14] where it was emphasised that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*[15]:

> *"The onus and standard of proof is upon the accused but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge".*

In *Cullen v The Medical Council of New Zealand*[16] Blanchard J adopted the directions given by the Legal Assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall œrrectly described it in the directions which he gave the Committee:*
>
> *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious*

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11 (1984) 4 NZAR 369
12 (1967) 1 NSWLR 609
13 [1966] ALR 270
14 [1989] 1 NZLR 139 at 163
15 Unreported HC Wellington M 239/87 11 October 1990
16 Unreported HC Auckland 68/95, 20 March 1996

> *charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts.'"*

64. Where the Tribunal has made findings adverse to Dr D it has done so because the evidence satisfies the test as to the onus of proof set out in paragraphs 61 to 63 of this decision. Indeed, in relation to the two particulars where the Tribunal finds Dr D's conduct constitutes professional misconduct the Tribunal believes the evidence against Dr D is compelling.

Disgraceful Conduct in a Professional Respect

65. In its interlocutory decision of 7 March 2003 granting the CAC leave to amend the charge the Tribunal explained the essential ingredients of a charge of disgraceful conduct in a professional respect. It was noted in that decision that a charge of disgraceful conduct in a professional respect is reserved for the most serious instances of professional disciplinary offending. Doctors found guilty of disgraceful conduct in a professional respect are at risk of having their name removed from the register of medical practitioners. In *Duncan v Medical Practitioners Disciplinary Committee*[17] the Court of Appeal said:

> *"A charge of disgraceful conduct in a professional respect has been described by the Privy Council as alleging conduct deserving of the most serious reprobation.*[18]

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

66. In relation to the two particulars which the Tribunal finds proven the Tribunal believes Dr D's conduct does not amount to disgraceful conduct in a professional respect. The reasons for this are explained when the Tribunal sets out its conclusions in relation to each particular of the charge. Suffice to say at this juncture that the Tribunal does not believe Dr D's errors and shortcomings were sexually motivated. Had the Tribunal concluded there were any sinister motives behind Dr D's conduct then it is likely the charge of disgraceful

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[17] [1986] 1 NZLR 513

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

conduct in a professional respect would have been upheld. This observation is consistent with the judgment of the full bench of the High Court in *Brake v PPC*[19] where it was said that where it is established that a doctor has engaged in sexual misconduct with a patient the doctor will usually be found guilty of disgraceful conduct in a professional respect.

Professional Misconduct

67. In recent years, those attempting to define professional misconduct have invariably commenced their analysis by reference to the judgment of Jefferies J in *Ongley v Medical Council of New Zealand*[20]. In that case his Honour formulated the test as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … 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 position of the Tribunal which examined the conduct."*

68. In *Pillai v Messiter* [No.2][21] the New South Wales Court of Appeal signalled a slightly different approach to judging professional misconduct from the test articulated in *Ongley*. In that case the President of the New South Wales Court of Appeal considered the use of the word "misconduct" in the context of the phrase "misconduct in a professional respect". In his view, the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

> *"The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure 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."*

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19 [1997] 1 NZLR 71 at 79

20 supra.

21 (1989) 16 NSWLR 197.

69. In *B v The Medical Council*[22] Elias J said in relation to a charge of "conduct unbecoming" that:

> *"… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the 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."*

70. In *Staite v Psychologists Board*[23] Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

71. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care*

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22 Unreported HC Auckland , HC11/96, 8 July 1996

23 (1998) 18 FRNZ 18

> *that would reasonably be expected of the practitioner in the circumstances – that is in relation to the preparation of Family Court reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of Section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances …".*

72. In *Tan v Accident Rehabilitation Insurance Commission*[24] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

73. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

74. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J. delivered his judgment in *Ongley*. In the Tribunal's view the following are the crucial considerations when determining whether or not conduct constitutes professional misconduct:

- The first portion of the test involves answering the following question:

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

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[24] (1999) NZAR 369

- If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public?

75. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his seminal decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the communities' expectations may require the Tribunal to be critical of the usual standards of the profession.[25]

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

77. The Tribunal has assessed Dr D's conduct by answering the questions posed in paragraph 74 in relation to each particular allegation in the amended notice of charge.

Tribunal's Findings in relation to each particularised allegation of the charge

78. Ms McDonald QC advised the Tribunal during the course of her closing submissions that the second alleged particular was effectively covered by the allegations set out in the third particular of the charge. Accordingly Ms McDonald sought leave to delete the second particularised allegation from the charge. That request was granted.

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[25] *B v Medical Practitioners Disciplinary Tribunal* (supra); *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) In which it was said: "If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in *B* goes beyond usual practice to take into account patient interests and community expectations".

First Particularised Allegation: Dr D "Asked questions and made comments of an inappropriate and sexual nature".

79. Dr D's notes accurately record the basis upon which he was consulted by "V". As previously mentioned, the notes show that he was consulted on 22 February 1995 in relation to four concerns, namely:

- eczema
- two moles
- suspected thrush
- concerns about weight

The medical notes for 1 March record that "V" returned to see Dr D because of her painful left ovary. The consultation on 6 March 1995 related to removal of "V's" two moles, her concerns about post coital bleeding, dysuria and dyspareunia. The notes for the consultation on 10 March refer again to "V's" painful left ovary and an itchy dry vulva. On 14 March "V" saw Dr D for injuries suffered after falling from a horse. The final consultation occurred on 22 March 1995 when "V" saw Dr D in relation to suspected thrush and the injuries suffered when she fell from a horse.

80. It is to be noted that none of the consultation notes record any suggestion "V" was consulting Dr D about issues relating to possible sexual dysfunction.

81. The Tribunal is in no doubt that when "V" first saw Dr D he made assumptions about her sexual experience. He assumed that because she had shaven pubic hair that she was a prostitute and that she would be a willing listener to some of his views and theories about sex. The Tribunal is also in no doubt that the complainant did tell Dr D that she was anorgasmic and that this fuelled his willingness to talk about sexual issues with the complainant.

82. When Dr D was cross examined it became very apparent that his recollection of what he said to "V" during the consultations of February and March 1995 had become blurred. The following examples illustrate why the Tribunal has reached this conclusion:

82.1 In his evidence in chief Dr D told the Tribunal:

> *"[The complainant] acknowledges at paragraph 9 of her statement that she confided in me she never had an orgasm. I do not recall her saying that, however it is most likely that any discussion of a sexual nature was in the context of that comment."*[26]

Later in his evidence in chief Dr D said:

> *"As I have said, if there was any discussion around sexual intercourse that would only have arisen from the admission made by [V] that she had never had an orgasm and her complaint of painful intercourse. It is not a topic I asked questions about".*[27]

When cross examined Dr D told the Tribunal that "V" never talked to him about being anorgasmic.[28] The Tribunal was concerned this statement was not consistent with the paragraphs in Dr D's evidence in chief referred to above. When cross examined about the apparent inconsistencies between his oral evidence and his written brief on the topic of whether or not she had explained she was anorgasmic Dr D tried to explain his evidence in chief by saying that he had "*… been very negligent in what [he had] written down*"[29] and that he could not understand why he had said what was recorded in his written brief of evidence in relation to this topic.[30] Dr D also said in relation to this topic he was "*confused*"[31] and that his memory was failing him.[32] When cross examined further Dr D said he had "*…no idea at this stage, after all these years… of things that could be discussed if matters [relating to a patient being anorgasmic] arose*".

82.2 In his evidence in chief Dr D told the Tribunal:

> *"At paragraph 8 [V] states that I talked about the use of vaginal fluids as a perfume, and further that I described the smell of the same as 'delicious'. I certainly did not discuss vaginal fluids nor advise [V] to use them as a perfume or use the word 'delicious' in this context.*

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26 Paragraph 21 evidence in chief.
27 Paragraph 25 evidence in chief.
28 Transcript p.97 line 22.
29 Transcript p.99 line 4.
30 Transcript p.99 line 15.
31 Transcript p.98 line 12
32 Transcript p.99 line 1

> *… Although I cannot recall, it is possible that I discussed pheromones during the course of a discussion with [V], but not in the terms or the manner she describes*".[33]

When cross examined Dr D said:

> *"…it appears that pheromones were mentioned because of the possibility, because of the interest we hear of pheromones in nature, traps to catch insects, and the significance of pheromones in the animal kingdom and as we are members of the living – not quite animals, but pheromones are common to all living life*".[34]

The Tribunal was perplexed by these comments, and by Dr D's subsequent acknowledgement that he accepted he could have discussed pheromones with "V" but he had no recollection why he had discussed sexual scents with the complainant.[35]

83. After carefully assessing "V" and Dr D's evidence and the manner in which they gave their evidence, the Tribunal concluded Dr D assumed "V" was a prostitute and that she would be interested in hearing about sexual issues. Dr D's willingness to discuss sexual matters with "V" was reinforced when he learned she was anorgasmic. Dr D thought he was assisting "V" by explaining sexual issues with her. It was for this reason he raised issues relating to "V's" sexual compatibility with her partner, her sexual history, her ability to achieve orgasm, and the effects of pheromones as a sexual scent. The Tribunal is satisfied Dr D no longer has an accurate recollection of what he said to "V" when he discussed these issues with her. The Tribunal is equally satisfied that "V's" recall of these matters was generally accurate.

84. In reality "V" did not consult Dr D about the way she might enhance her sexual life. The complainant consulted Dr D about specific clinical issues. It was Dr D who pursued issues of a sexual nature with "V" believing she was interested in learning about his views and theories concerning sexual dysfunction. Dr D appears to have been unaware of the fact that "V" was not interested in his questions and comments concerning sexual dysfunction. It was Dr D's responsibility to appreciate "V" did not welcome his raising the sexual issues

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[33] Paragraphs 22 and 23 evidence in chief.
[34] Transcript p.101 line 20.
[35] Transcript p.103 line 6

which Dr D appeared to be intent in pursuing. Dr D lacked insight and was therefore inappropriate and confused in his role as the complainant's general practitioner.

85. The Tribunal reiterates that although Dr D did ask questions and make comments of an inappropriate sexual nature during the course of these consultations with him, he did so in the mistaken belief that "V" wanted to hear about these issues. The Tribunal is confident Dr D pursued these topics out of a genuine interest for the welfare of his patient and that he was not motivated by personal sexual gratification.

86. The Tribunal is satisfied Dr D's raising of sexual issues with "V" in the circumstances of this case breached the standards which the profession and the community expect of a general practitioner in Dr D's position. Furthermore the Tribunal believes Dr D's serious breaches of standards warrants a disciplinary finding against him. Accordingly the Tribunal has found that in relation to the first alleged particular of the charge Dr D's conduct amounts to professional misconduct.

Third particularised allegation: Dr D "performed one or more of the vaginal examinations in an inappropriate sexual manner".

87. The Tribunal is satisfied Dr D performed four vaginal examinations, and that each of those examinations was clinically justified in order to:

- take a swab for chlamydia;
- assess "V's" painful left ovary;
- assess "V's" dyspareunia;
- assess "V's" post coital bleeding;
- assess "V's" dysuria.

88. The CAC's case is that one or more of the vaginal examinations was performed in an inappropriate sexual manner.

89. The Tribunal can readily understand "V's" suspicions and concerns about the way she believes Dr D performed one or more of the vaginal examinations on her. Dr D's raising

of sexual topics in circumstances which caused concern and distress to "V" may easily have led her to believe that Dr D was acting in an inappropriate way during the course of conducting vaginal examinations.

90. The Tribunal is not satisfied to the requisite standard that Dr D attempted to sexually stimulate "V" during the course of any of the vaginal examinations, or that he acted in a sexually inappropriate manner when conducting any vaginal examination.

91. The Tribunal believes that Dr D may well have asked "V" to hold a speculum in place during the course of a vaginal examination but that nothing sinister can be deduced from that.

92. This case illustrates the importance for all doctors to offer their patient the opportunity to have either a support person or chaperone present during the course of vaginal examinations, and that the patient be given privacy to undress and dress and a sheet for cover during the examination. Dr D was not in the habit of having a third person in his room when conducting vaginal examinations. His reluctance to have a third person present when conducting vaginal examinations was not consistent with best medical practice. However, Dr D's shortcomings in this respect are not relevant to the charge before the Tribunal and accordingly are not taken into account by the Tribunal.

Fourth particularised allegation: Dr D "… discussed and then suggested to his patient that he should use on her a "perinoemeter", which he had made himself which was inappropriate and for which there was no medical justification".

93. The Tribunal accepts Dr D constructed the "perinoemeter" for the purpose of either using it himself or allowing patients to use it to assess the strength of their pelvic floor muscles. The perinoemeter was not a vibrator. The complainant produced a very accurate diagram of the perinoemeter during the investigative stages of this case. The diagram drawn by "V" included the gauge which Dr D intended to use to quantitatively assess pelvic muscle strength.

94. In his evidence in chief Dr D told the Tribunal:

> *"I did not suggest that I use the perinoemeter on [V]. That never happened. Although I do not recall precisely what was said, I can be absolutely sure of that*.
>
> *…I would have explained to her its purpose – namely for measuring the strength of the pelvic floor and surrounding muscles, to be used in conjunction with the instruction for the strengthening of the same. I asked her if she wished to use it. I certainly did not suggest she use it at the surgery".*[36]

95. Dr D accepted "V" did not present with any clinical issues concerning the strength of her pelvic floor muscles. The complainant showed no signs of incontinence or vaginal prolapse.

96. When Dr D was questioned why he showed the perinoemeter to "V" he could provide no satisfactory explanation and stated he could not remember why he raised the issue of the perinoemeter with the complainant.[37]

97. The Tribunal readily understands why "V" was concerned and confused when Dr D produced the perinoemeter. In the context of consultations in which Dr D raised a number of sexual issues, "V" could be excused for thinking the perinoemeter was some form of home made sexual device. In fact, Dr D again completely misread his patient's concerns and failed to realise that she was not interested in his home made "gadget". There was no obvious clinical justification for Dr D to show "V" the perinoemeter. This was another example of Dr D pursuing issues which interested him but which were not relevant to the reasons why he was being consulted by his patient. The Tribunal accepts Dr Brenner's opinion that there is merit in general practitioners explaining to patients the need to improve pelvic floor muscle strength and that a perinoemeter may be a useful device in this regard. However in this case Dr D should have appreciated that he was again pursuing matters which were causing concern and embarrassment to his patient when he presented her with the perinoemeter.

98. While the Tribunal has again given Dr D the benefit of the doubt and concluded there was no sinister motives behind his showing "V" the perinometer, and suggesting it be used, the Tribunal is nevertheless confident there was no clinical justification for Dr D's actions in the

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[36] Evidence in chief paragraphs 47 and 48.

[37] Transcript p.85 line 20

circumstances of this case and that it was inappropriate for him to show the device to the complainant in circumstances which caused her distress and concern.

99. In relation to the fourth particular the Tribunal concludes Dr D's acts fell well below the standards expected of a medical practitioner by the profession and the community. The Tribunal also concludes that Dr D's lack of insight was so significant that a disciplinary finding is warranted against him.

Fifth particularised allegation: When confronted by his patient on or about 28 March 1995 [Dr D] destroyed or sought to destroy her medical notes.

100. The Tribunal accepts Dr D's explanation as to what occurred when confronted by the complainant in his surgery on the 28th March 1995. The Tribunal accepts that "V" told Dr D that he could destroy her notes and in order to placate her he proceeded to cut her medical notes up in her presence using a guillotine. The Tribunal also accepts that as soon as the complainant left Dr D retrieved the notes from a rubbish bin and placed them in an envelope for safe keeping.

101. The Tribunal accepts that even though Dr D cut up the medical notes he had no intention of destroying or disposing of them. His actions immediately after the complainant left the surgery show that he had no intention of disposing of the complainant's medical notes.

102. It was not appropriate for Dr D to cut up "V's" medical notes. Dr D's actions in cutting up the notes constituted a failure to adhere to the standards expected of a medical practitioner by the New Zealand profession and members of the community. Dr D should have photocopied the records and handed a copy to "V". To his credit, Dr D acknowledges this is the course of action he should have followed. However, the charge alleges Dr D 'destroyed or sought to destroy' "V's" medical notes. Dr D did not destroy the notes. Nor did he seek to destroy them. He ensured they were salvaged and stored safely after "V" left the surgery. The circumstances of this case are such that no disciplinary finding is justified in relation to Dr D's breaches of his duty when he cut the medical notes with his guillotine.

103. During the course of the hearing an issue was raised as to whether or not there was jurisdiction for the Tribunal to consider this particular of the charge because it was not a

matter which "V" complained of when she wrote her letter of complaint to the Medical Council. This issue was raised in light of the Court of Appeal's judgment in *Complaints Assessment Committee v R.*[38]

104. The Tribunal declines the invitation extended to it by Ms McDonald QC to rule on whether or not there was jurisdiction for the Tribunal to consider the fifth particular of the charge. The Tribunal has reached its conclusions on the assumption that it does have jurisdiction but has nevertheless found that the fifth particular has not been proven.

Penalties

105. When the Tribunal announced its decision on 15 April it sought submissions from Mr Waalkens on the issue of penalty. In seeking submissions from Mr Waalkens the Tribunal indicated that in the circumstances of this case it thought it would be appropriate to punish Dr D by:

105.1 censuring him;

105.2 ordering him to make a contribution to the costs of and incidental to the hearing.

106. The reasons why the Tribunal believes a lenient penalty can be imposed upon Dr D in the circumstances of this case are as follows:

106.1 Dr D has practised medicine for approximately 44 years without any other complaints of a disciplinary nature being brought against him. He deserves full credit for his career and for the fact that no complaint of any disciplinary kind has ever been brought against him.

106.2 The events complained of occurred a considerable time ago. There was a delay of approximately five years from the matters that took place in Dr D's surgery in February/March 1995 and the laying of the complaint by "V". Thereafter further delays occurred which were not attributable to either the complainant or Dr D. The antiquity of the matters complained of, and the delays which have occurred

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38 CA 282/01, 10 June 2002

in bringing this matter to the attention of the Tribunal are factors that the Tribunal takes into account in determining the level of penalty to be imposed upon Dr D.

107. Dr D no longer practises medicine. He retired from medical practice in xx. One of the purposes of punishment in a disciplinary forum is to discourage further offending. The fact that Dr D has not practised medicine for xx years and is never likely to practise again, is another reason why the Tribunal believes leniency is justified.

108. Mr Waalkens, in his submissions concerning penalty advised the Tribunal that Dr D and his wife had been the victim of failed investments of funds they had set aside for their retirement. The Tribunal accepts that Dr D and his wife are not in a position to pay a substantial sum by way of costs and accordingly the Tribunal will direct that Dr D be required to pay $10,000 as a contribution towards the costs of and incidental to the hearing of the charge. A further factor that the Tribunal takes into account in assessing the level of costs is the fact that Dr D has successfully defended a charge of disgraceful conduct and has been found guilty in relation to two particulars of the five particulars which were initially laid against him.

Name Suppression Issues

109. The Tribunal has already delivered a full decision in this case concerning the principles it takes into account when determining whether or not a medical practitioner should be given the benefit of anonymity in a disciplinary hearing. It is not necessary to reiterate those principles in this decision. The Tribunal's decision on interim name suppression should be read in conjunction with this decision.

110. When granting Dr D interim name suppression the Tribunal (by a majority of three to two) was persuaded to grant his application because of concerns about the effects of publication on Dr D's health. The Tribunal was concerned that if Dr D's name was published his ability to defend the charge may be compromised because of the "severe depression" and "related insomnia" which the Tribunal was told Dr D suffered from. In a letter supplied to the Tribunal on 24 February from Dr D's general practitioner the Tribunal was told:

> *"In the past 2 years, as a result of a Court case hanging over his head [Dr D] has had bouts of severe depression with associated insomnia".*

111. The Tribunal was concerned to learn during the course of the hearing that in fact Dr D is not receiving any medication or treatment for depression. The only "medication" he is currently taking is a herbal remedy to prevent cramp at night. He also has a prescription for Mestinon tablets for myasthemia gravis. When specifically questioned as to whether or not Dr D was receiving any other treatment he responded "none whatsoever". He also advised the Tribunal that he had not received treatment for any other condition during the course of this year.[39]

112. The Tribunal is very concerned that when it granted interim name suppression to Dr D it did so in the belief that he was suffering from "severe depression" and "related insomnia". The Tribunal believes it reasonable to conclude that if a patient is suffering from "severe depression" and "related insomnia" then those conditions would be the subject of medication and/or treatment.

113. The Tribunal wishes to afford Dr D one final opportunity to explain whether or not he is indeed suffering from "severe depression" and "related insomnia". If he is suffering from these conditions the Tribunal wishes to know precisely what treatment and medication he is receiving for these conditions (if any). Dr D, through his counsel, is given ten days from the date of this decision to provide further information concerning the question of Dr D's medical condition to the Tribunal before a decision is made on whether or not the interim name suppression order should be lifted.

Conclusions

114. The Tribunal finds Dr D's conduct as alleged in the first and fourth particulars of the charge have been proven and that his acts and omissions constituted professional misconduct.

115. Dr D is censured and ordered to pay costs in the sum of $10,000.

116. The Tribunal will deliver its decision on whether or not to continue the interim orders made suppressing Dr D's name, and the fact that he was a former practitioner in xx until it has received further submissions and/or evidence from Dr D concerning his medical condition.

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[39] Transcript p.123, line 1.

DATED at Wellington this 14th day of May 2003

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D B Collins QC
Chair
Medical Practitioners Disciplinary Tribunal