Medical Practitioners Disciplinary Tribunal

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DECISION NO: 57/97/15C

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 **DALUWATUMULLE GAMAGE RAVINDRA RAMYASIRI** medical practitioner of Levin

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr F E Bennett, Ms S Cole, Dr J C Cullen, Dr D C Williams (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Palmerston North on Thursday 16 April 1998

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

Mr C J Hodson QC for Dr D G R Ramyasiri ("the respondent").

SUPPLEMENTARY DECISION:

THIS supplementary decision should be read in conjunction with Decision No. 35/97/15C (the primary Decision) which issued on 14 May 1998.

1. BACKGROUND:

1.1 **IN** the primary Decision a number of interim penalty orders were made. One of those orders imposed suspension of Dr Ramyasiri's registration as a medical practitioner for a period of eight months from 16 April 1998.

1.2 **IN** the primary Decision it was further ordered that Dr Ramyasiri may, for a period not exceeding three years, practice medicine only in accordance with such conditions as to employment, supervision or otherwise, to be specified by the Tribunal in a final order to issue prior to 16 December 1998.

1.3 **IT** was noted in the primary Decision (paragraph 8.9) that the Tribunal had postponed imposition of actual conditions of practice following expiry of suspension on 16 December 1998, pending receipt and consideration of a report from the Medical Council's Assessment and Rehabilitation Programme ("the report"). The report is now to hand. The parties having

been given an opportunity to comment on the report, the Tribunal is now in a position to formulate conditions on Dr Ramyasiri's right of future medical practice.

2. THE REPORT:

2.1 **UNFORTUNATELY** the assessment process took longer than expected. Dr Ramyasiri made prompt payment of the requisite fee towards the assessment and consented to release of documents so that the referral to Dr Peter Johnston, Registered Clinical Psychologist, was able to be made early in June. However, Mr Hodson apparently had certain misgivings about the form Dr Ramyasiri was asked to sign to consent to participate in the process, and this caused a delay.

2.2 **FROM** the report it is clear that Dr Johnston, and the Psychiatrist selected to assist with the assessment, Dr Bill Gordon of Christchurch, had difficulty adequately assessing the case. The report writers noted the difficulty arose as a result of Dr Ramyasiri's unwillingness or inability to disclose the details of his offending behaviour. Earlier in their report they had explained:

"With regard to the allegations of sexual misconduct, Dr Ramyasiri acknowledges only that he breached certain of the boundaries appropriate to his role in relation to complainant TH. He accepts that his feelings towards her were "more than they should have been", and that he was too informal and relaxed in his manner towards her. He accepts that he ought not to have kept her on as his patient given her employee status, nor should he have examined her medically while alone in the surgery and without her mother's presence or knowledge. Beyond this, Dr Ramyasiri maintains a position of more or less complete denial in relation to the various charges that have been brought against him. He denies having had sexual interest in any of the complainants, or of behaving in a sexually abusive or exploitative manner. He believes that his plight has to an extent been the result of conspiracy involving sexual abuse counsellors who put false ideas into client's heads, former patients (some disgruntled over unrelated matters, some who placed an untoward interpretation of medically appropriate actions), overly zealous Police officers, and even a former staff member with an axe to grind.

Perhaps inevitably then, given his view of matters, there were no signs of remorse for the offending, nor was there any indications of empathic concern for the victims. Notable instead were expressions of extreme shame and mortification surrounding his very public exposure. This theme of shame arose repeatedly during the course of the assessment as he described how utterly humiliating had been the various stages of the process, through Police investigation, the Court proceedings and eventual imprisonment."

2.3 **IN** evaluating the options open to the Tribunal in dealing with Dr Ramyasiri the report noted:

- Given that a return to general practice "*inevitably will carry some level of risk to patient safety"*, professional practice in a setting which involves no contact with pre-menopausal female patients, may be favoured.
- Dr Ramyasiri's stated preference for a return to a sole general practitioner arrangement, but with involvement and support from certain colleagues.

2.4 **THE** report writers listed a number of factors which they considered both militated against and at the same time mitigated the level of risk of the sole general practice option.

2.5 **IN** the event of a decision being made permitting a return to general practice, the following conditions were recommended:

- *"That he be encouraged to consider the option of group practice (with the other practitioners and the non-medical staff being informed of his difficulties); at the very least, there ought be a requirement of regular scheduled meetings with another doctor functioning in the role of mentor, and/or attendance at some form of support group which provides peer scrutiny of his attitudes and practice style; his work level and management of stress ought also be monitored in such a context.*
- *That conducting examinations of female patients without a chaperone be forbidden.*
- *That he undertake a refresher course on medical ethics, and in particular the issues and considerations that apply to professional boundaries.*
- *That hiring employees (including casuals) from amongst his patients also be forbidden.*

- *That he be encouraged to further review his attitudes and view of the patient-doctor relationship (the support and guidance of a reputable doctor from his own cultural background could be ideal in this regard."*

3. SUBMISSIONS:

3.1 **DR** Ramyasiri explained in his letter of 4 November 1998 to the Tribunal that he is strongly motivated to resume work in his own practice,

".... which has been kept running throughout. The fact that my patients have continued to use the practice (there are 11 other GPs in Levin) and the feedback I get from my practice staff, also from the patients themselves, strongly suggests that they would be comfortable with me and accept me as their GP. A good number of them are in families I have known for over 20 years. My patients' support was also evident in the 750-strong petition that they had prepared for the MPDT hearing.

My practice has about 2500 patients at present with a female receptionist on duty from 8.00 am to 6.30 pm and a practice nurse from 9 am to 3.30 pm. I intend to employ my wife, a Registered General Nurse, with post-Graduate Nursing qualifications, to cover from 8.00 am to 9.00 am and after 3.30 pm, if I am allowed to return to my practice.

I am also strongly motivated to put in place measures, to avoid all the factors that led to the complaints and my conviction."

3.2 **AND:**

"A semi-retired female GP, Dr Marie Sewell, who currently does some sessions at the local hospital, has indicated her availability to become a part-time associate in my Practice (thus avoiding the solo practice situation) and do 2-3 sessions per week. She is also willing to act as a mentor. Dr Sewell was a GP in Levin for over 20 years and semi-retired a few years ago, since when she has been in hospital practice. She is well known and respected in the Levin community and could regularly furnish the MPDT with a report."

3.3 **FOR** the CAC Ms McDonald indicated its view is that essentially imposition of conditions of practice is a matter for the Tribunal. Reiterating views expressed by Ms McDonald at the hearing, the CAC is concerned if Dr Ramyasiri is to be permitted to return to sole general practice, and is also concerned that Dr Sewell would be doing only three sessions which *"would not provide sufficient protection"*.

4. TRIBUNAL'S POSITION:

4.1 **A** re-reading of the primary Decision reminds us:

- "It is his longer-term aim to resume general practice, but he would not wish to be in sole practice again" (paragraph 4.8 on p8)
- "Noted at this stage is Dr Ramyasiri's current wish not to return to private practice, and the existence of possible non-private practice options such as his employment in a War Veterans Home" (paragraph 8.10 on p15)

4.2 **INSTITUTIONAL** employment, such as at a local retirement home, or at the Kimberley Centre, although possible options which would best ensure protection of the public, would probably serve little purpose in rehabilitating Dr Ramyasiri. We are mindful that general practice is Dr Ramyasiri's strength.

4.3 **CONTRARY** to what Dr Ramyasiri led us to believe at the hearing, his plans propose what in effect is a return to sole general practice. While intending no disrespect to Dr Sewell, we view Dr Ramyasiri's proposal that she become a part-time associate in his practice, as little more than window dressing.

4.4 **IN** reading the report, particularly we note Dr Ramyasiri's admission that cultural differences may affect his attitude to patients and his lack of awareness of the dangers (for patients and himself) of seeing female patients alone. This combination, amongst others possibly not identified, no doubt contributed to his boundary breaches, in a classic situation where he himself was vulnerable because of his own personal health. Another, again not uncommon feature of his offending, was that it involved patients who were also employees, who were young and who had been known to him over a long period in a social context, which could lead to breach of professional boundaries. Finally the patients concerned were vulnerable and had been harmed.

4.5 **DR** Ramyasiri's conduct is well known in the community, which is relying on the medical regulatory process to ensure that he does not again have the opportunity to exploit vulnerable patients to satisfy his own needs. There is concern among some members of the community that Dr Ramyasiri was not struck off the Register. Imposition of robust conditions on Dr Ramyasiri's right of future practice will, in our view, certainly not be unexpected.

5. CONDITIONS ON PRACTICE:

5.1 **5.1.1** **PURSUANT** to Section 110(1)(c) of the Act Dr Ramyasiri may, for the period of three years commencing 16 December 1998, practise medicine only in a position approved by the Medical Council of New Zealand which meets the following criteria:

a) In a group or team environment where Dr Ramyasiri is not at any time practising alone, without the on-site presence of another registered medical practitioner, preferably holding vocational registration in the branch of medicine in which Dr Ramyasiri is practising.

b) Clinical supervision is provided on site at all times, and the supervisor is willing to provide regular progress reports to the Medical Council at stated intervals, one month, three months and six months, with frequency of reporting reviewed by the Council after six months.

c) The supervisor (or supervisors) confirm to the Council in writing that they have informed current permanent staff and will inform all future permanent staff in the team or group about the nature and content of the conditions imposed by the Tribunal following the expiry of the suspension of Dr Ramyasiri's name from the Register. Practice staff shall be given permission by Dr Ramyasiri to inform the Council if they have any concerns about Dr Ramyasiri's practice or conduct.

d) No other member of Dr Ramyasiri's family is involved as a member of the team, e.g. practice nurse in general practice.

e) Employees (paid or voluntary, including casuals) are not employed from amongst his patients.

5.1.2 **DR** Ramyasiri must have a chaperone present during physical examinations of women. A chaperone must be present during after hours work, including night calls to women patients. This chaperone might be an adult companion of the patient, or a nurse or receptionist of the practice. A notice to this effect must be displayed in the waiting room for the information of the patients. Any patient who does not wish to comply with this order must be informed that she should seek medical services from another practitioner.

5.1.3 **DR** Ramyasiri does not undertake any long-term counselling of patients without the appointment of a supervisor for such counselling practice.

5.1.4 **DR** Ramyasiri must have a mentor arranged through the Medical Council's mentoring co-ordinator. Dr Ramyasiri must make arrangements to contribute financially to the cost of providing a mentor and agree to sign a separate agreement with the Council for this purpose. The mentoring co-ordinator will report to the Council about Dr Ramyasiri's progress in the mentoring programme. The mentor will be asked to meet with Dr Ramyasiri monthly for the first six months. The frequency of mentoring contact will be reviewed after six months. A report to the Tribunal at six monthly intervals is requested, to ensure the Tribunal is aware of progress and that the programme is being undertaken.

5.1.5 **DR** Ramyasiri must enter an education programme designed to fulfil the re-accreditation requirements of the Royal New Zealand College of General Practitioners and attend regular meetings of his peer group.

5.1.6 **DR** Ramyasiri must not provide general oversight for any other doctor requiring such oversight, in any branch of medicine, nor is he to be appointed as a supervisor for any probationary registrant.

5.1.7 **DR** Ramyasiri must submit a "safety plan" to the Council, developing specific detail about the following matters - having his own named personal physician, limiting hours of work and developing a lifestyle which reduces stress. The safety plan is to be submitted by Dr Ramyasiri to the Medical Council not later than 16 February 1999.

5.2 **THE** Tribunal makes no apology for the robust nature of the above practice conditions. They reflect the Tribunal's total opposition to the conditions of sole general practice promoted by Dr Ramyasiri on his own behalf. The practice conditions imposed by the Tribunal are designed for both the protection of the public and Dr Ramyasiri's rehabilitation.

DATED at Auckland this 8th day of December 1998

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal