MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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PUBLICATION OF THE NAME OF THE DOCTOR IS PROHIBITED	**DECISION NO:**	287/04/118D
	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 M medical practitioner of xx.

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Dr L Henneveld, Dr M G Laney, Dr J M McKenzie,

Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Wednesday 26, Thursday 27 and Friday 28 May 2004

APPEARANCES: Ms T Baker and Ms L Curtis for the Director of Proceedings

Ms H Winkelmann for Dr M.

Introduction

1. Doctor M practises as an xx in xx. On 19 December 2003 the Director of Proceedings[1] laid a disciplinary charge with the Tribunal alleging Dr M failed to obtain a patient's informed consent before performing an abdominoplasty procedure and/or failed to inform the anaesthetist and/or other theatre staff of the proposed procedure prior to the commencement of anaesthesia. The charge alleged M's shortcomings constituted professional misconduct[2], or, in the alternative, conduct unbecoming a medical practitioner which reflected adversely on her fitness to practice[3].

2. The charge was heard in Auckland on 26, 27 and 28 May 2004. At the conclusion of the hearing the Tribunal advised that by a majority, it was satisfied that one of the particulars of the charge had been proven to the requisite standard and justified a disciplinary finding against Dr M. The Tribunal reserved its decision on whether or not the adverse finding against Dr M was one of professional misconduct, or conduct unbecoming a medical practitioner which reflected adversely on her fitness to practise. The Tribunal also advised the parties on 28 May that submissions in relation to penalty should focus on costs, rather than other penalty options because the Tribunal was of the view that an adverse finding was, in the circumstances of the case, a serious punishment in its own right. The Tribunal

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1 Section 15 Health and Disability Commissioner Act 1994
2 Section 109(1)(b) Medical Practitioners Act 1995
3 Section 109(1)(c) Medical Practitioners Act 1995

also signalled its desire to receive submissions on whether or not its interim orders granting Dr M name suppression should continue.

3. In this decision the Tribunal explains its reasons for the decision it announced on 28 May and requests the Director of Proceedings to file submissions on penalty within 14 days of the date of the decision. Doctor M should file her submissions and evidence in support of her application to continue name suppression within the same 14 day period. Each party will then have 7 days to respond to each other's submissions.

The Charge

4. For convenience the Tribunal now sets out the details of the charge:

> *"1. Before performing an abdominoplasty procedure [Dr M] failed to obtain Mrs Morrison's informed consent in that [she] failed to inform her adequately and/or in appropriate circumstances of the extent and/or costs of the proposed surgery;*
>
> *and/or*
>
> *2. Failed to adequately advise the anaesthetist and/or other theatre staff of the proposed procedure prior to the commencement of the anaesthesia;*
>
> *The conduct alleged in paragraphs 1 and 2 separately or cumulatively amounts to professional misconduct or to conduct unbecoming and that conduct reflects on [Dr M's] fitness to practise medicine."*

Facts

5. On 18 October 2000 Mrs Morrison consulted Dr M in relation to prolonged and heavy vaginal bleeding.

6. On 26 October 2000 Mrs Morrison returned to see Dr M to discuss the results of tests carried out the previous week. At the consultation on 26 October Dr M discussed three options available to Mrs Morrison, namely:

6.1 Insertion of a Mirena intrauterine device; or

6.2 Endometrial ablation; or

6.3 Total hysterectomy.

At the consultation on 26 October 2000 Mrs Morrison chose the option of total hysterectomy. Arrangements were made for that operation to be performed at the xx Hospital on 18 December 2000. Doctor M recommended the hysterectomy be performed abdominally because Mrs Morrison had previously undergone three Caesarian sections.

7. During the consultation on 26 October 2000 Mrs Morrison asked Dr M if liposuction could be performed on her lower abdomen at the same time as the hysterectomy. A discussion then took place about a procedure that could be performed to address Mrs Morrison's concerns about the visual appearance of her lower abdomen. There are differences of view between Dr M and Mrs Morrison about what was said about the additional procedure.

8. Mrs Morrison believes she was told the procedure involved removing fat and taking skin on either side of her hips and pulling it across and down, followed by the removal of a pouch of skin. Mrs Morrison recalls she was told the cost of the procedure was approximately $5,000 to $6,000. Mrs Morrison is certain that the term "abdominoplasty" was not used during the consultation and that she was not told the procedure involved the relocation of her umbilicus, or about Dr M's expertise in performing the procedure.

9. Doctor M was certain she fully described the procedure, and that she referred to it as being an abdominoplasty. In particular, Dr M believes she explained the procedure involved relocation of the umbilicus, and that the performance of an abdominoplasty would make Mrs Morrison's convalescence less comfortable. Doctor M told Mrs Morrison that she had arranged for an abdominoplasty for another patient and that she would normally involve a general surgeon in performing the procedure. Doctor M said she told Mrs Morrison the procedure would involve an additional cost of $4,000 to $5,000.

10. It is agreed by both parties that when the costs of the additional procedure were explained Mrs Morrison stated she could not afford the additional operation. Accordingly, a second additional procedure was discussed which involved a wide abdominal excision of the previous Caesarian scars. The procedure was described as either a "nip and tuck" or a "tummy tuck". Doctor M said the procedure would take 10 to 15 minutes and would cost something in the vicinity of $200 to $300. Mrs Morrison agreed to this procedure.

11. Mrs Morrison signed a standard consent form on 26 October. The document was filled in both by Mrs Morrison and Dr M. That consent form referred to a hysterectomy only. No reference was made to the minor additional cosmetic procedure as the form was to be submitted to Mrs Morrison's health insurer and neither Dr M nor Mrs Morrison thought it necessary to concern the insurer about the additional procedure which Mrs Morrison was going to pay for herself.

12. On 15 December 2000 Dr M's secretary telephoned Mrs Morrison to confirm the surgery scheduled for 18 December. Mrs Morrison mentioned the "tummy tuck" procedure and was told by the secretary to remind Dr M of this on the morning of 18 December.

13. Mrs Morrison was admitted to the ward early on the morning of 18 December. The anaesthetist, Dr Gray, saw Mrs Morrison at 7.15am. An anaesthetic plan for a hysterectomy was discussed. Doctor Gray charted pre medication in the form of midazolam. Midazolam is a benzodiazepine. Doctor Gray told the Tribunal that it is a relaxant which can have a variety of effects upon patients. In some patients they can fall asleep from the effects of midazolam, others can appear lucid and awake. Midazolam frequently has an amnesic effect in that patients often cannot remember anything after taking midazolam. When asked about the effects of midazolam on a patient's ability to make decisions Dr Gray said:

> *"Patients appear to make rational decisions but may well make more frivolous statements, may become less inhibited, and might perhaps say things they don't really mean … Patients that have …*

> *midazolam …are advised after taking it not to make important decisions and not to sign important documents or drive or drink."*[4]

14. The surgery was scheduled to commence at 8am on 18 December. Midazolam was administered to Mrs Morrison prior to that time.

15. Doctor M was unable to get to the xx Hospital until about 8.45am because of traffic delays. Unbeknown to Dr M Mrs Morrison was taken from the ward to the surgical suite. Doctor M saw Mrs Morrison in a corridor outside the theatre at about 8.50am. Doctor M did not know Mrs Morrison had been administered midazolam about an hour beforehand.

16. Mrs Morrison has no recollection of the discussion she had with Dr M in the corridor outside the theatre. According to Dr M and Kate Leggatt, a member of the theatre staff, Mrs Morrison appeared lucid. Doctor M told the Tribunal that during the course of the discussions she had with Mrs Morrison she was told to "cut away as much as she could" and that she "didn't care how low her navel was". Doctor M's evidence was that she explained to Mrs Morrison that Mrs Morrison's request involved a full abdominoplasty (including relocation of the umbilicus). The issue of cost was again raised. Doctor M offered to perform the operation for nothing provided Mrs Morrison paid for the additional theatre time, and the additional costs of the anaesthetist. Doctor M believed Mrs Morrison directed Dr M undertake a full abdominoplasty on the condition that Mrs Morrison would only be liable to pay for the additional costs of theatre time and the anaesthetist.

17. A theatre nurse (Ms Willmott) explained that when she was scrubbing Dr M told her a full abdominoplasty would be performed in addition to the hysterectomy. When Nurse Willmott questioned Dr M she said she had spoken to Mrs Morrison and had obtained her verbal consent.

18. It is difficult to ascertain precisely when all theatre staff appreciated that a full abdominoplasty was to be carried out on 18 December. Doctor M said she announced

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[4] Transcript p.47

her intentions when she arrived in the theatre. Nurse Leggatt indicated she learned about the additional procedure from Nurse Willmott and that Nurse Leggatt went and spoke to the theatre manager because of her concern that there was no record of an abdominoplasty being performed that day. When Nurse Leggatt was out of the theatre speaking to the theatre manager Nurse Willmott says she spoke to the anaesthetist who, until then, was unaware of the additional surgery.

19. When Nurse Leggatt returned to the theatre she added the words "abdominoplasty" to Mrs Morrison's consent form. Mrs Morrison was still awake at the time and indicated she was content with the change. At that stage Dr Gray assumed the reference to an abdominoplasty was to a minor cosmetic procedure. She said she only appreciated that a full abdominoplasty was to be undertaken after Mrs Morrison had been anaesthetised.

20. It is apparent that none of the theatre staff raised concerns about the appropriateness of Mrs Morrison's apparent consent to undergoing an abdominoplasty. They all assumed the procedure had been discussed in Dr M's rooms and that Dr M would not undertake such an extensive operation without obtaining proper consent. None of the theatre staff told Dr M that Mrs Morrison had been administered midazolam.

21. Surgery commenced at 9.20am. Difficulties were encountered with the hysterectomy which necessitated a change of plan. A sub total hysterectomy was undertaken which entailed leaving the cervix intact.

22. Doctor M had estimated that the abdominoplasty would take about 45 minutes. In fact it took approximately 1½ hours. The total surgery took 3 hours 20 minutes. By the time the operation was completed another scheduled operation had been seriously delayed.

23. Doctor Gray saw Mrs Morrison on the ward later on 18 December and explained about the length of time the surgery had taken. Mrs Morrison was concerned about the financial implications of the extra time taken to perform the second surgical procedure.

24. On 19 December Dr M explained what had occurred to Mrs Morrison. The following day they examined the surgical scar. Doctor M thought Mrs Morrison was happy with the outcome. Mrs Morrison reiterated her concerns about costs.

25. On 21 December 2000 Mrs Morrison complained to hospital management about the abdominoplasty having been performed without her informed consent. Soon after Dr M became aware that she had obtained Mrs Morrison's consent to the abdominoplasty after her patient had been administered midazolam. Mrs Morrison discharged herself from hospital earlier than scheduled, partly to save costs and partly to avoid further direct contact with Dr M.

26. Mrs Morrison was very concerned that she had been subjected to an abdominoplasty in circumstances where she had not given informed consent. Mrs Morrison was distressed that her ability to determine what medical procedure should be carried out on her had been by-passed. In addition to this fundamental concern Mrs Morrison was particularly distressed that:

    26.1 Her umbilicus had been relocated. Mrs Morrison described her umbilicus as being a particularly sensitive part of her body and that at no time had she been told that it might be relocated.

    26.2 She had been exposed to the risks of additional costs because of the abdominoplasty.

27. It has not been possible to determine what, if any, additional costs Mrs Morrison has incurred as a result of the abdominoplasty. The additional costs of the anaesthetist came to $450 which Mrs Morrison paid Dr Gray. There were also additional theatre and sundry costs. However offsetting these expenses is the fact an account was not rendered for either the hysterectomy or the abdominoplasty. By one calculation Mrs Morrison may have paid $600 more than she had anticipated as a consequence of undergoing the abdominoplasty. However, it is possible Mrs Morrison may have paid significantly less than she originally anticipated. The reason why it has not been possible to calculate the true financial implications of the additional surgery is due to the fact the Tribunal has not

been told what portion of the surgical/anaesthetic costs Mrs Morrison's health insurer agreed to pay.

28. Ultimately the Tribunal has approached its task by putting to one side questions about what, if any, additional costs were incurred by Mrs Morrison. Although there is reference to the costs of the abdominoplasty in the first particular of the charge the Tribunal has assessed Dr M's culpability on the basis that the abdominoplasty was performed in circumstances where Mrs Morrison had not validly consented to the procedure and that in the final analysis, the cost associated with the surgery is not in itself, a determining factor.

Expert Evidence

29. The Tribunal was assisted by expert opinions called by both parties.

30. The Director of Proceedings relied on the expert testimony of Dr John Hutton, a senior and very experienced gynaecologist from Wellington. Dr Hutton was formerly a professor of Obstetrics and Gynaecology. Since 1994 he has practised primarily in the private sector in Wellington.

31. Doctor Hutton was certain Dr M should not have proceeded with the abdominoplasty. The circumstances under which consent for the procedure concerned Dr Hutton. He was of the view Mrs Morrison could not provide informed consent to the abdominoplasty because:

31.1 She was under the influence of midazolam; and

31.2 The environment in which consent was purportedly given (in the theatre corridor) was not a place for a patient to reflect on and give consent to a significant surgical procedure.

32. Doctor Keith Allenby gave expert evidence for Dr M. He is an obstetrician and gynaecologist practising in Auckland. Doctor Allenby provided the Tribunal with the benefit of his very carefully considered analysis of the evidence and concluded that although Mrs Morrison's consent was "*… invalid due to the pre-medication*",

nevertheless, he believed "*… that Dr M did not depart from the relevant standards observed by her peers or, if she did that, having regard to the circumstances, that departure was minor".* [5]

33. Doctor Allenby acknowledged that his evaluation of Dr M's conduct involved measurement of her conduct against the standards of her peers. He appreciated that approach was consistent with the standard articulated by the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital*. Doctor Allenby also appreciated that the "doctor peers" approach to assessing the adequacy of informed consent is not the test for assessing whether or not a New Zealand doctor has complied with their obligations to obtain informed consent. The directions of the Medical Council on informed consent first issued in 1990, and Right 6 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996 place a clear emphasis on assessing the adequacy of informed consent from the standpoint of a reasonable patient.

Dr M

34. Doctor M obtained a **(not for publication by order of the Tribunal)**. Prior to 18 December 2000 Dr M had assisted other surgeons performing a total of 6 abdominoplasty procedures.

35. The Tribunal carefully assessed Dr M when she gave evidence. The Tribunal believed Dr M empathised with Mrs Morrison and decided to undertake the abdominoplasty because she genuinely believed that is what her patient wanted. Doctor M performed extensive additional surgery without appreciating that her patient had not provided valid consent for the surgery in question.

Mrs Morrison

36. The Tribunal can understand Mrs Morrison's anger and distress at having undergone an extensive surgical procedure without her knowledge or consent. The Tribunal fully

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5 [1985] AC871

appreciates Mrs Morrison's evidence when she said that she had no knowledge of the discussions which occurred in the corridor of the theatre on 18 December 2000 and that any consent she purportedly gave was invalid. Doctor M's decision to proceed with the abdominoplasty breached Mrs Morrison's fundamental right to determine for herself what medical procedures she should have been subjected to on 18 December 2000.

Theatre Staff

37. Doctor M and Dr Allenby were concerned theatre staff and Dr Gray did not raise concerns about the validity of Mrs Morrison's consent to the abdominoplasty performed on 18 December.

38. The Tribunal is surprised and concerned no-one in the theatre thought it appropriate to question Dr M's decision to proceed with the abdominoplasty in a way which might have alerted Dr M to the fact her patient had been given midazolam. The Tribunals concerns were enhanced when it learnt Mrs Morrison was asked if she was comfortable with her written consent form being amended when she was lying on the operating table in the presence of the theatre team. Ultimately however, Dr M should have discussed the proposed procedure in a way which would have encouraged others to think about the issue of consent. Instead, assumptions were made by all concerned about the validity of Mrs Morrison's consent. Regrettably, everyone's assumptions were wrong.

Legal Principles

<u>Onus and standard of proof</u>

39. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[6] where the High Court adopted the

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[6] (1984) 4 NZAR 369

following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[7]

> *"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.*[8] *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".*

40. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[9] where it was emphasized that the civil standard of proof must be tempered "having regard to the gravity of the allegations". The point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*[10]:

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

41. In *Cullen v The Medical Council of New Zealand*[11] 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 correctly described it in the directions which he gave the Committee:*
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> *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious 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".*

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7 (1967) 1 NSWLR 609
8 [1966] ALR 270

9 [1989] 1 NZLR 139 at 163
10 Unreported HC Wellington M 239/87 11 October 1990
11 Unreported HC Auckland 68/95, 20 March 1996

42. Where the Tribunal has made a finding adverse to Dr M it has done so because the evidence satisfies the tests as to the onus and standard of proof set out in paragraphs 39 to 41 of this decision. The allegations against Dr M are at the lower end of the spectrum of charges heard by the Tribunal. Where the Tribunal has made a finding against Dr M it has done so because it is very satisfied that the Director of Proceedings has discharged the onus placed upon her.

Professional Misconduct

43. Doctor M has been charged with professional misconduct, or in the alternative, conduct unbecoming a medical practitioner which reflects adversely on her fitness to practise.

44. 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*[12]. 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 her 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."*

45. In *Pillai v Messiter* [No.2][13] 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*

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12 supra.

13 (1989) 16 NSWLR 197.

> *such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

46. In *B v The Medical Council*[14] 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."*

47. In *Staite v Psychologists Board*[15] 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.

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[14] Unreported HC Auckland , HC11/96, 8 July 1996

[15] (1998) 18 FRNZ 18.

48. 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 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 …".*

49. In *Tan v Accident Rehabilitation Insurance Commission*[16] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to a 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.*

50. 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".*

51. 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:

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[16] (1999) NZAR 369

51.1 The first portion of the test involves an objective evaluation of the evidence and answer to 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?

51.2 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 and/or maintaining professional standards and/or punishing the doctor?

52. 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.[17]

53. The 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.

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[17] *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 her conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and the 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".

54. In *McKenzie v MPDT*[18] Venning J endorsed the two question approach taken by the Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. The same judgment of the High Court cautioned against reliance in this country upon the judgment of the Privy Council in *Silver v General Medical Council*[19] In that judgment it was said the general Medical Council could take into account subjective factors relating to the circumstances in which a doctor practised when assessing whether or not the doctor should be held liable in respect of a disciplinary charge.

Conduct Unbecoming a Medical Practitioner

55. Ms Winkelmann argued that if the Tribunal was minded to find Dr M liable then she should be found "guilty" of "conduct unbecoming" pursuant to s.109(1)(c) Medical Practitioner's Act 1995. Section 109(1)(c) of the Act refers to the offence of conduct unbecoming a medical practitioner which reflects adversely on their fitness to practise medicine.

56. The Tribunal is divided on whether or not it is appropriate to find Dr M guilty of professional misconduct as opposed to conduct unbecoming a medical practitioner which reflects adversely on her fitness to practise. The Chairman, Dr Laney, and Dr McKenzie believe the appropriate finding is one of professional misconduct. Mr Searancke believes the appropriate finding is one of "conduct unbecoming". Doctor Henneveld has reached the conclusion no disciplinary finding is justified.

57. The Chairman, Dr Laney and Dr McKenzie will now endeavour to explain why they depart from the approach taken by Mr Searancke.

58. The Chairman, Dr Laney and Dr McKenzie acknowledge that conduct unbecoming was a "lesser form" of professional misconduct under the Medical Practitioners Act 1968.

59. The origins of the view that "conduct unbecoming" was a less serious version of "professional misconduct" under the 1968 Act can be traced back to comments made in Parliament when the Medical Practitioners Act 1968 was amended in 1979 to provide for

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[18] Unreported, High Court Auckland, CIV 2002-404-153-02, 12 June 2003, see also *F v MPDT* High Court Auckland, AP113/02, 20 November 2003, Frater J

[19] [2003] UK, PC33

the new disciplinary offence of conduct unbecoming a medical practitioner. The then Minister of Health, the Hon. E S F Holland said:

> *"The new clause 15B introduces a new charge of conduct unbecoming a medical practitioner, representing a complaint or charge of lesser seriousness than that of professional misconduct".*[20]

60. The view that "conduct unbecoming" was a less serious charge than "professional misconduct" also has its origins in the fact that when the Medical Practitioners Act 1968 was amended in 1979, Divisional Disciplinary Committees were empowered to hear charges of "conduct unbecoming a medical practitioner". The penalties which Divisional Disciplinary Committees could impose were confined to censure and costs. However, under the 1968 Act the Medical Practitioners Disciplinary Committee could hear charges of "conduct unbecoming a medical practitioner" as well as charges of "professional misconduct". As McGechan J pointed out in *Cullen v The Preliminary Proceedings Committee*[21] when the Medical Practitioners Disciplinary Committee heard a charge of conduct unbecoming a medical practitioner:

> *"The penalties for conduct unbecoming a practitioner and professional misconduct [were] exactly the same … [and that] Parliament by the terms of the statute it passed envisaged the possibility of cases of 'conduct unbecoming a practitioner' so grave that the penalty imposed could equal the most serious available for professional misconduct".*

61. Aspects of the observations of McGechan J in *Cullen* are highly relevant to the current statutory regime. Section 110 of the Act confers on the Tribunal exactly the same powers to penalise a doctor found guilty of "professional misconduct" as one who is found guilty of conduct unbecoming a medical practitioner.

62. The legislative regime now in place portrays "conduct unbecoming a medical practitioner" as a disciplinary offence which parallels "professional misconduct". The language employed to describe the offence of "conduct unbecoming a medical practitioner" suggests that offence encompasses conduct by a doctor which falls outside the scope of a doctor's "professional" conduct. This interpretation is reinforced when account is taken of the way

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[20] New Zealand Parliamentary Debates Vol. 426 p.3524

[21] Unreported High Court Wellington AP 225/92, 15 August 1994

Parliament has now framed the charge of "conduct unbecoming a medical practitioner" to include the requirement the conduct must also "reflect adversely on the practitioner's fitness to practise medicine"[22] which, when viewed objectively, conveys a considerable "sting". Indeed, the charge conduct unbecoming a medical practitioner which reflects adversely on their fitness to practise may involve allegations of graver culpability than a charge of professional misconduct. For example, a doctor who habitually attends their clinic under the influence of alcohol may face a charge of conduct unbecoming a medical practitioner which reflects adversely on their fitness to practise. Such behaviour may be considered more grave and deserving of punishment than a doctor who negligently performs an operation in circumstances that gives rise to a charge of professional misconduct.

63. It is axiomatic that there must be a distinction between "professional misconduct" and "conduct unbecoming a medical practitioner". If there were no distinction s.109(1)(c) Medical Practitioners Act 1995 would be otiose. The distinction which does exist between "conduct unbecoming" and "professional misconduct" can be maintained by ensuring charges of "conduct unbecoming a medical practitioner" focus on allegations that extend beyond a doctor's "professional conduct".

64. Mr Searancke has been persuaded by Ms Winkelmann that the gradation of charges in the Medical Practitioners Act 1968 has been adopted in the Medical Practitioners Act 1995, and that the cases decided under the earlier legislation provide compelling precedent for finding Dr M guilty of the "lesser charge" of conduct unbecoming a medical practitioner.

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[22] The words "reflect adversely on the practitioner's fitness to practise medicine" have been commented upon in two District Court decisions: In *Complaints Assessment Committee v Mantell* (District Court Auckland, NP 4533/98, 7 May 1999) the Court said: "*The text of the rider in my view makes it clear that all that the prosecution need to establish in a charge of conduct unbecoming is that the conduct reflects adversely on the practitioner's fitness to practise medicine. It does not require the prosecution to establish that the conduct establishes that the practitioner is unfit to practise medicine. The focus of the enquiry is whether the conduct is of such a kind that it puts in issue whether or not the practitioner whose conduct it is, is a fit person to practise medicine… The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree*".
In *W v Complaints Assessment Committee* (District Court Wellington, CMA 182/98, 5 May 1999) the Court said: "*It is to be borne in mind that what the Tribunal is to assess is whether the circumstances of the offence "reflect adversely" on fitness to practice. That is a phrase permitting of a scale of seriousness. At one end the reflection may be so adverse as to lead to a view that the practitioner should not practice at all. At the other end a relatively minor indiscretion may call for no more than an expression of disapproval by censure or by an order for costs*".

Dr M's Duty to Obtain her patient's Informed Consent to the Abdominoplasty

65. The first particular of the charge focuses on Dr M's failure to obtain Mrs Morrison's informed consent to undertaking an abdominoplasty. All acknowledged that the consent Mrs Morrison purportedly gave to that procedure on the morning of 18 December was invalid and not truly informed because of the effects of the midazolam which had been administered to Mrs Morrison approximately 1 hour earlier. The Director of the Proceedings also submitted Mrs Morrison's purported consent was invalidated by the circumstances in which it was given, namely, in the corridor of the theatre suite. The Director of Proceedings submitted consent to a significant medical procedure such as an abdominoplasty should have been obtained either in Dr M's rooms on the 26th October or in the ward prior to the administration of midazolam.

The Code

66. 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."*

67. The Code of Health and Disability Services Consumers Rights Regulations 1996 describes in detail the duties of health professionals to inform patients and obtain informed consent to medical procedures. The provisions of the Code relevant to the case before the Tribunal are:

67.1 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".*

67.2 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 …"

67.3 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."

67.4 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 the Code provides otherwise".

Medical Ethics

68. 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"[23]

and the duty of doctors to:

"Exchange such information with patients as is necessary for them to make informed choices where alternatives exist" [24]

The current 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".[25]

Medical Council Statements

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[23] Paragraph 7 1994 NZMA Code of Ethics
[24] Paragraph 11 1994 NZMA Code of Ethics
[25] Paragraph 10 2002 NZMA Code of Ethics

69. 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.

70. The first comprehensive statement for the New Zealand medical profession on information for patients and consent was issued in June 1990.[26] That report was issued in response to the *Cartwright Inquiry*.[27] In describing the duty of New Zealand doctors to inform patients, the Medical Council said at page 1 of its 1990 statement:

> *"Information must be conveyed to the patient in such detail and in such manner, using appropriate language, as to ensure that an informed decision can be made by that particular patient. The necessary standard for the requirement (that is the extent, specificity and mode of offering the information) should be that which would reflect the existing knowledge of the actual patient and the practitioner. More generally, it should also reflect what a prudent patient in similar circumstances might expect."*

71. In 1995 the Medical Council published a pamphlet summarising its 1990 guideline on information and consent. In its 1995 pamphlet the Medical Council reiterated the standards expected of New Zealand doctors in relation to informing and obtaining consent set out in paragraph 70 of this decision.

72. 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:

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

72.2 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.

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[26] A statement for the Medical Profession on Information and Consent, Medical Council of New Zealand, June 1990.

[27] The Report of the Cervical Cancer Inquiry into allegations concerning the treatment of Cervical Cancer at National Women's Hospital and into other related matters, 1988.

72.3 The assessment of whether or not a doctor has discharged their 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.

73. In both the 1990 and 1995 statements the Medical Council stated:

> *"If it can be shown that a doctor has failed to provide adequate information and thereby failed to ensure that the patient comprehends, so far as is possible, the factors required to make decisions about medical procedures, such failure could be considered professional misconduct and could be the subject of disciplinary proceedings."*

74. For the sake of completeness the Tribunal records that in April 2002 the Medical Council issued a further statement on "Information and Consent". The updated statement reflects the Code and recent case law. That statement post dates the events under consideration by the Tribunal. Nevertheless, the Tribunal notes that in all respects relevant to its decision the 2002 Medical Council statement is similar to the Medical Council's 1990 and 1995 statements on "Information and Consent".

Common Law

75. The common law also provides some guidance when assessing a doctor's duty to inform a patient and obtain their consent to proposed medical procedures. The authorities referred to below illustrate the main components of the doctrine of informed consent and also demonstrate there are divergent approaches to the topic within common law jurisdictions.

75.1 A convenient starting point is *Canterbury v Spence*[28] in which the US Court of Appeals, District of Columbia said:

> *"1. To determine what should be done with her or her body, a patient is entitled to make an informed choice which entails knowing the options and risks attendant upon the proposed treatment.*
>
> *2. The scope of the doctor's duty to communicate with the patient is measured by the patient's need for information that is material in*

[28] (1972) 464 F(2d) 772

enabling the patient to make a decision about consenting to proposed treatment.

3. A risk is … material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk … in deciding whether or not to forego the proposed therapy."

75.2 In *Sidaway v Board of Governors of the Bethlem Royal Hospital*[29] the House of Lords rejected the doctrine of "informed consent" as it had developed in North American jurisdictions. In that case the House of Lords held that whether or not a particular risk should be explained to a patient depended on whether a reasonable body of the medical profession would have disclosed the information in question.[30]

75.3 In *Rogers v Whittaker*[31] the High Court of Australia endorsed the patient orientated North American approach when it determined a doctor had failed to discharge his professional obligations by failing to disclose to a patient a rare but known risk of surgery. The High Court of Australia held:

> *"…that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment: a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, warned of the risk, would be likely to attach significance to it."*

In their judgments the High Court of Australia did not refer to the New Zealand Medical Council 1990 statement on information and consent. Nevertheless, the approach taken by the High Court of Australia was strikingly similar to the standards which the New Zealand Medical Council had enunciated two years earlier.

75.4 The final case the Tribunal refers to is *B v The Medical Council of New Zealand*[32] an unreported but nevertheless important judgment in New Zealand medical law.

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[29] supra

[30] That is to say, the House of Lords applied the test articulated in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 in determining whether or not the doctor had breached the duty of care to inform their patient of risks associated with surgery.

[31] (1992) CLR 175

[32] supra

As mentioned earlier, that case concerned a charge of conduct unbecoming a medical practitioner brought under the Medical Practitioners Act 1968. The case concerned several allegations including a claim that a doctor failed to properly inform his patient about the risks associated with not excising a lump found in the patient's breast. In *B v The Medical Council of New Zealand* the High Court adopted the reasoning of the High Court of Australia in *Rogers v Whittaker*. The High Court in New Zealand stressed the importance of assessing the adequacy of information conveyed by a doctor to a patient from the viewpoint of the patient, rather than the doctor. Poignantly the learned High Court Judge opined:

> *"In my view, the provision of inadequate information in a situation where the patient needs that information for her decisions affecting treatment or investigation, will almost always be professional misconduct or conduct unbecoming"*.

76. In the Tribunal's view:

76.1 Rights 5(2), 6(1), 6(2), and 7(1) of the Code; and

76.2 The ethical obligations set out in paragraph 34 of the decision; and

76.3 The statements on information and consent issued by the Medical Council; and

76.4 The judgment of Elias J. (as she then was) in *B v The Medical Council of New Zealand* can be distilled to the following three elementary propositions.

<u>One</u>

77. Mrs Morrison had the right to be informed in circumstances which ensured she fully and properly understood what an abdominoplasty entailed, and in particular that when undergoing an abdominoplasty her umbilicus would be relocated.

She was also entitled to be properly appraised of the potential costs associated with an abdominoplasty.

Two

78. When informing Mrs Morrison about the matters referred to in paragraph 77 of this decision, Dr M needed to have regard to Mrs Morrison's circumstances, her existing knowledge and her understanding of the matters referred to in paragraph 77.

Three

79. An assessment of whether or not Doctor M discharged her duty to properly inform Mrs Morrison is to be measured from the standpoint of a reasonable patient in Mrs Morrison's circumstances.

Tribunal's Finding in Relation to the First Particular of the Charge

80. The Tribunal is unanimously of the view that the Director of Proceedings has established Dr M failed to adhere to the standards expected of a xx practising in New Zealand when she failed to obtain Mrs Morrison's informed consent to the abdominoplasty performed on 18 December 2000.

81. The consent which Mrs Morrison purportedly gave to Dr M for the abdominoplasty was not valid. Mrs Morrison was unable to consent because of the effects of midazolam which had been administered approximately one hour earlier. Furthermore, it was not appropriate for Dr M to attempt to get her patient's consent for such a significant procedure in the corridor of the theatre suite. Mrs Morrison had no time to consider and reflect on the information given to her by Dr M in the short space of time before she was taken into the operating theatre.

82. While the Tribunal is unanimous in its view Dr M's actions when endeavouring to obtain Mrs Morrison's informed consent to the abdominoplasty breached the standards expected of a xx, the Tribunal is not unanimous in its conclusion that a disciplinary finding is justified.

83. Dr Henneveld believes that, although the part of the consent process that took place in the corridor on the morning of the surgery was below a standard expected, because of mitigating circumstances, it would be unreasonable to impose a disciplinary finding against Dr M. The mitigating circumstances include:

83.1. The express wish of the patient to undergo surgery at that time.

83.2. The delays that had occurred.

83.3. The transportation of the patient to the corridor outside theatre prior to Dr M's arrival that which effectively denied Dr M the opportunity to have a discussion with the patient on the ward.

83.4. The unawareness of Dr M that the patient received midazolam and in Dr M's practice premeds were uncommon (and she was informed about those cases where premeds were given).

83.5. Flaws in the handover process that resulted in some theatre staff not being aware that premeds had been given.

83.6. The failure by Dr Gray and other staff in theatre who knew that the patient received a premed to draw to Dr M's attention the fact that the patient had been administered midazolam.

83.7. The genuine desire of Dr M to do what she believed was the patients' strong wish.

84. The majority of the Tribunal believes a disciplinary finding is justified in order to maintain professional standards. The majority of the Tribunal believes that when viewed from the standpoint of a reasonable patient, it was not appropriate for Dr M to endeavour to obtain her patient's informed consent to a significant surgical procedure in the circumstances of this case. In particular, even though Dr M was unaware midazolam had been administered to her patient, she had every opportunity to inquire both of her patient and the anaesthetist to determine if her patient had received midazolam. Midazolam is a common pre-

medication. There was evidence before the Tribunal that by some assessments half of the patients undergoing significant surgery receive pre-medication. In any event, in the view of the majority of the Tribunal, Dr M's errors were compounded to an unacceptable level when she endeavoured to obtain her patient's informed consent to a significant surgical operation in the corridor of the theatre suite. The majority of the Tribunal agree with Dr Hutton's concern that endeavouring to obtain informed consent in those circumstances is totally inappropriate.

85. As foreshadowed earlier in this decision, the chairperson, Dr Laney and Dr McKenzie believe the appropriate finding is one of professional misconduct. They do not believe a finding of professional misconduct is more significant than a finding of "conduct unbecoming". Furthermore, they regard Dr M's conduct as being at the lower end of the spectrum of cases which constitute professional misconduct. Mr Searancke believes the appropriate finding is conduct unbecoming which reflects adversely on Dr M's fitness to practise.

Tribunal's Finding in Relation to the Second Particular of the Charge

86. The Tribunal is unanimous in its finding in relation to the second particular of the charge.

87. All members of the Tribunal are satisfied Dr M failed to adequately advise Dr Gray and other members of the theatre staff of her intention to perform an abdominoplasty on Mrs Morrison.

88. Doctor M told the Tribunal she announced her intentions to the theatre team in the theatre, before Mrs Morrison was anaesthetised. Other persons present have different recollections of how they learnt about the abdominoplasty. Assuming Dr M's recollection is correct, it is not appropriate for a surgeon to simply announce that a significant and time consuming surgical procedure will be performed when:

88.1 The surgery has already been delayed by at least an hour because of the unavailability of the surgeon.

88.2 The proposed surgery will double the time of the operation.

88.3 Theatre staff have commitments and obligations to other patients awaiting surgery.

89. It would have been very easy and appropriate for Dr M to have asked the theatre staff if there were any concerns or difficulties about performing an abdominoplasty on Mrs Morrison on the morning of 18 December. Had that question been asked it is likely issues about informed consent would have arisen. Unfortunately, Dr M did not take the responsible lead she should have taken when communicating with the theatre team on the morning of 18 December 2000.

90. Whilst the Tribunal is satisfied the Director of Proceedings has established in relation to the second particular of the charge Dr M failed to adhere to the standards expected of a xx in New Zealand, the Tribunal is also unanimously of the view that the shortcomings established do not justify a disciplinary finding against Dr M. The Tribunal believes Dr M has learnt a valuable lesson and that there is no need to impose a disciplinary finding against Dr M in relation to the second particular of the charge for the purpose of protecting the public, and/or maintaining professional standards and/or punishing Dr M.

Cumulative Charge

91. The Tribunal is unanimously of the view that the cumulative effect of its findings in relation to the first and second particulars of the charge do not justify any cumulative disciplinary finding against Dr M.

Conclusion

92. The Tribunal finds Dr M guilty of professional misconduct in relation to the first particular of the charge namely, in relation to her failure to obtain Mrs Morrison's informed consent to the undertaking of an abdominoplasty on Mrs Morrison on 18 December 2000.

93. The Tribunal will deliver its decision on penalty and name suppression after receiving and considering submissions on these topics in accordance with the timetable set out in paragraph 3 of this decision.

DATED at Wellington this 8th day of June 2004

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal