MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 24463, Manners Street, Wellington • New Zealand
13th Floor, Mid City Tower • 139-143 Willis Street, Wellington
Telephone (04) 802 4830 • Fax (04) 802 4831
E-mail mpdt@mpdt.org.nz
Website www.mpdt.org.nz

PUBLICATION OF THE NAME OF THE DOCTOR OR THE COMPLAINANT IS PROHBITED	**DECISION NO:**	295/04/119C
	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 C medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Dr F E Bennett, Dr I D S Civil, Ms S Cole, Dr M Honeyman (Members)

Ms K L Davies (Hearing Officer)

Ms G J Fraser (Secretary)

Mrs H Hoffman and Ms P Dunn (Stenographers)

Hearing held at Wellington on Thursday 29 and Friday 30 July 2004

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

Mr M McClelland and Ms J Gibson for Dr C.

Introduction

1. Doctor C is a registered medical practitioner. At all relevant times Dr C held vocational (specialist) registration as a xx. He practiced as a xx in xx.

2. In March 2004 a CAC laid a disciplinary charge against Dr C. The particulars of the charge are set out in paragraph 7 of this decision. The essence of the charge is that Dr C did not provide the complainant with appropriate information when Dr C diagnosed the complainant's prostate cancer. In addition, the CAC alleges Dr C spoke to the complainant in a harsh and unprofessional manner.

   The charge alleges Dr C's conduct constituted professional misconduct[1] or in the alternative, conduct unbecoming a medical practitioner which reflects adversely on his fitness to practice medicine[2] (conduct unbecoming).

3. The Tribunal has unanimously determined that the second limb of the charge has been established and that, when viewed cumulatively, the particulars found in paragraphs 2.1 (a) (b) (c), 2.2 and 2.3 of the charge constitute conduct unbecoming.

4. Counsel for the CAC is invited to make any submissions she may wish in relation to penalty by Tuesday 31 August 2004. Counsel for Dr C should file and serve their submissions in relation to penalty and name suppression by Tuesday 14 September 2004. Counsel for the CAC may respond to submissions in relation to name suppression by Tuesday 21 September 2004.

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1 Section 109(1)(b) Medical Practitioners Act 1995.
2 Section 109(1)(c) Medical Practitioners Act 1995.

5. On 9 July 2004 the Tribunal granted the complainant permanent suppression of his name and prohibited publication of any details which could identify him. In addition the Tribunal now prohibits publication of the evidence found in paragraphs 28 and 31 of the complainant's brief of evidence as well as comments made by Dr C about a histology report dated 6 November 2000 (pages 45 and 47 of the agreed bundle of documents submitted to the Tribunal).

6. On 8 June 2004 the Tribunal granted Dr C interim suppression of his name pending determination of the charge by the Tribunal. That order will remain in force until the Tribunal has had an opportunity to consider whether or not Dr C should receive permanent suppression. The Tribunal's reasons for granting Dr C interim name suppression will be set out in its Decision in relation to permanent name suppression. In that Decision the Tribunal will also explain the reasons for granting the complainant name suppression.

The Charge

7. The notice of charge particularised the allegations against Dr C in the following way:

> *"1. The content of communication with [the complainant] about the treatment of his prostate disease was inadequate in the following respects:*
>
> *1.1 On the three occasions that [the complainant] saw Dr C pre-operatively (the radical prostatectomy having been performed by another surgeon on 1 November 2000) on 7 August 2000, 14 August 2000 and 21 August 2000 Dr C:*
>
> *(a) failed to adequately explain to [the complainant] that Dr C was 'staging' his disease or to explain what 'staging' was;*
>
> *(b) failed to provide [the complainant] with literature regarding his condition despite Dr C recording in his notes that he had done so;*
>
> *(c) failed to adequately discuss with [the complainant] other options available to treat prostate cancer;*

2. The manner of [Dr C's] communication with [the complainant] about the treatment of his prostate disease was inappropriate, and unprofessional and caused distress to [the complainant] in the following respects:

2.1 when [the complainant] first presented to Dr C on 7 August 2000:

(a) Doctor C carried out a trans-rectal ultra-sound scan of the prostate which [the complainant] found painful and Dr C commented to him to the effect 'What' s the matter with you? lots of people do this for fun'.

(b) [The complainant] asked Dr C about headaches he was experiencing and Dr C commented to him to the effect 'Of course you have got headaches because it (the cancer) is all through your head as well';

(c) Dr C commented to [the complainant] to the effect that the cancer was going' to kill' him;

2.2 when [the complainant] presented to Dr C for the results of his biopsy on 21 August 2000 in relation to some of the MRI scan results being negative Dr C made comments to the effect 'What's the matter, it (the cancer) is all through the rest of you anyway';

2.3 on the one occasion Dr C saw [the complainant] post operatively on 12 February 2001 when [the complainant] called upon Dr C at his rooms, in reply to a comment by [the complainant] that he had had a successful radical prostatectomy by another surgeon, Dr C commented to the effect 'so what' and 'don't worry it (the cancer) will get you'.

Summary of the CAC Case

8. The CAC's case was substantially based on the evidence of the complainant. He explained he is a xx near xx. At the time of the events of this case the complainant was xx years old.

9. In June 2000 the complainant was found to have a very high PSA (serum prostate- specific antigen). The PSA level was 70.2. An elevated PSA is frequently a warning of prostate cancer. The elevated PSA finding occurred after the complainant had experienced high blood

pressure and headaches during the preceding 8 months. The complainant's GP was a friend of the complainant. The GP drove out to the complainant's xx to advise him of the PSA result. The GP arranged for the complainant to be seen by Dr C who, in addition to being a xx had maintained a special interest in urology. Doctor C saw the complainant on three occasions in August 2000. The charge focuses on what was said by Dr C to the complainant during each of these consultations.

First Consultation: 7 August 2000

10. The complainant was accompanied by his wife to this consultation. During the consultation Dr C examined the complainant with an ultra-scan probe. Doctor C also did a physical examination of the complainant's external genitalia. He performed a rectal examination. These examinations were carried out in an examination room adjacent to Dr C's consulting rooms. The complainant's wife remained in the consulting room during the clinical examinations.

11. The complainant found the rectal ultrasound procedure very painful. He thought the ultrasound may not have been lubricated. The complainant winced in pain. His evidence was that when he winced Dr C said "What's wrong with you? Lots of people do this for fun".

12. After the examinations the complainant returned to the consulting room. When discussing his assessment of the patient's circumstances Dr C is said to have told the complainant and his wife that the complainant had prostate cancer and that it was going to kill him. When the complainant asked if he could have an operation Dr C is alleged to have said that an operation was not an option and repeated that the complainant's prostate cancer would kill him and that he simply had to accept his condition was incurable.

13. When the complainant asked Dr C about the headaches the complainant had suffered Dr C is alleged to have said "Of course you have got headaches because it is all through your head as well".

14. Doctor C prescribed Flutamide (prescribed for the palliative treatment of advanced prostate cancer) and arranged for the complainant to return the following week for a prostate biopsy.

The complainant was adamant Dr C did not provide him with any pamphlets or other handouts at this consultation.

Second consultation: 14 August 2000

15. The complainant went to the second consultation by himself. A prostate biopsy was done which involved 7 passes through the prostate, and 7 biopsy cores taken. The complainant told the Tribunal no pamphlets or handouts were given to him at this consultation.

Third consultation: 21 August 2000

16. This was the final consultation the complainant had with Dr C. The complainant's wife went to this consultation but remained in the waiting room while the complainant saw Dr C in his consulting room.

17. Prior to this consultation the complainant had an MRI. The results of the MRI were conveyed to the complainant by his GP prior to the consultation with Dr C on 21 August. The MRI revealed a partial aneurism at the neck of the basal artery but showed no sign of cancer.

18. At the consultation on 21 August Dr C advised five of the biopsy results were positive for cancer, but two, which Dr C had thought would be positive were in fact negative.

19. The complainant told the Tribunal that when he told Dr C about the encouraging MRI results Dr C said "What's it matter, its all through the rest of you anyway".

20. The complainant's evidence was that Dr C never explained about "staging" the disease, or the options for treatment. The complainant also said that no pamphlets or literature were given to him at the third consultation.

Following Events

21. Because of his dissatisfaction with the advice he received from Dr C, and the way Dr C had spoken to him, the complainant decided to travel to Auckland for a second opinion. There he made contact with Dr Robin Smart a senior and very experienced Urologist. Before seeing Dr Smart arrangements were made by another doctor and friend of the complainant for the

complainant to undergo a full body scan and a bone scan. Neither test revealed signs of cancer being spread through the complainant's body.

22. The complainant saw Dr Smart on 30 August who explained possible treatment options (radiotherapy/radical prostatectomy). The complainant also said Dr Smart gave him detailed pamphlets and brochures which explained the possible treatment options in more detail. Doctor Smart instructed the complainant to stop taking Flutamide because it could impact on the reliability of the bone scan. Arrangements were made for a further bone scan which was carried out on 21 September 2000. This scan was also reported as being negative.

23. Doctor Smart performed a radical prostatectomy on 1 November 2000. The complainant's lymph glands were examined under frozen section during the operation and did not reveal any cancer.

24. The complainant saw Dr Smart on a number of occasions following surgery. Doctor Smart advised the complainant he had made a good recovery. The complainant's PSA levels have been zero since surgery.

Meeting with Dr C on 12 February 2001

25. The complainant explained that on 12 February 2001 he happened to be walking past Dr C's rooms when he decided to visit Dr C. The complainant saw Dr C and explained Dr Smart had performed a radical prostatectomy and that the results were encouraging. The complainant said that after he had explained what happened Dr C said "So what", and that when the complainant was leaving Dr C's rooms Dr C said to the complainant "Don't worry, it will get you".

26. The complainant reflected on Dr C's comments and attitude. He telephoned xx Hospital and from there was put in touch with the Health and Disability Consumers Advocacy Service. Several drafts of a letter of complaint were prepared by an advocate before a formal letter of complaint was completed and forwarded to the Medical Council on 12 September 2001.

Summary of Dr C's Case

27. Doctor C explained he graduated MB Bs from xx in xx. He obtained **not for publication**. He left New Zealand in xx and has only recently returned to this country. He is currently working as a locum xx in xx. **not for publication**.

28. Doctor C's evidence was that he had no recollection of the complainant. The events in question took place four years ago and despite trying to do so, Dr C had no independent recollection of the events in question. Doctor C's evidence as to what occurred in this case was based upon notes he made on 7, 14 and 21 August 2000 as well as 12 February 2001. His evidence was also based on his usual method of managing persons in the complainant's position.

29. Doctor C told the Tribunal he dictated his notes immediately after the consultations in question. There was evidence from Dr C's former secretary which suggested he may have usually dictated his notes later on the day of the consultation. In any event, the Tribunal is satisfied Dr C dictated notes on 7, 14 and 21 August 2000 as well as 12 February 2001. Dr C forwarded the notes to his secretary to be typed. He then edited them and sent them in the form of a reporting letter to the patient's GP. Thus, in this case, the Tribunal had before it letters written by Dr C to the complainant's GP on 7, 14 and 21 August 2000 and 12 February 2001.

30. Doctor C's notes recorded the complainant's visit to his rooms on 7 August 2000 and that the complainant's symptoms and history were:

- A xx year old xx;
- Headaches for the preceding 9 months;
- PSA of 70;
- Marginally high serum calcium level;
- Controlled diabetic;
- A father who had died of prostate cancer aged 75.

Doctor C's notes also record that an MRI scan had been organised. Doctor C's reporting letter to the complainant's GP contains the following paragraph:

> *"I told Mr and Mrs [complainant] that this is Ca prostate probably fairly advanced until proven otherwise. He will need to have a biopsy and I have organised that. I have started him on some Flutamide one three times a day while we are waiting. He has an MRI which he should go through with. It might give us some insight as to what his skull looks like. Be that as it may he will still need an isotope bone scan which I will organise after the biopsy. I have not gone into therapy with him today as I think he had quite enough to absorb in one go. I have given him some literature to read. The next phase of the investigation will be the biopsy and then we will take it from there".*

31. Doctor C's notes of 7 August 2000 also record that his rectal examination of the complainant revealed a prostate weighing an estimated 30g. Doctor C assessed the prostate as being nodular and probably malignant on the left lateral lobe, especially near the lateral edge. Doctor C could not feel any infiltration of the nodes into the rectal wall, or the other side of the pelvis. The abdominal ultrasound carried out by Dr C showed no abnormality. The rectal ultrasound showed some abnormal images on the left lateral peripheral zone. There appeared to be little benign disease in this region.

32. Doctor C explained he never performed rectal ultrasounds without lubrication. He said it would be almost impossible to perform this type of examination without lubrication. Doctor C also said he never abuses his patients but that on occasions he would try to lighten the atmosphere by making casual comments. Doctor C thought if the complainant winced during the rectal ultrasound scan he might have said "Yes it is uncomfortable, but some people do this for fun". Doctor C told the Tribunal that he would never have said "What's the matter with you, some people do this for fun".

33. The Tribunal was told by Dr C that when he spoke with the complainant and his wife on 7 August 2000 he did not give them a diagnosis. He explained he would not have been able to assess the extent of the disease until after biopsies had been taken and staging performed. Doctor C said he advised the complainant of the need for a biopsy and staging.

34. Doctor C ardently denied telling the complainant that the cancer was all through the complainant's head. He acknowledged suggesting there may be secondaries but that this could not be confirmed until further investigations had been completed.

35. Doctor C told the Tribunal he gave the complainant standard pamphlets which explained prostate cancer and treatment options. The literature given to the complainant also included directions for fasting and use of laxative suppositories prior to biopsies being taken on 14 August.

36. Doctor C told the Tribunal that he did not tell the complainant that the cancer was going to kill him. He referred to his reporting letter to the complainant's GP and said that he told the complainant that the complainant had prostate cancer which was probably fairly advanced until proven otherwise.

37. Doctor C's notes record the complainant returned to Dr C's rooms on 14 August. On this occasion Dr C did 7 passes of the prostate and took 7 cores for analysis. In his reporting letter to the complainant's GP Dr C explained the abnormality in the prostate appeared to be on the left lateral lobe. Arrangements were made for the complainant to return to Dr C's rooms on 21 August.

38. When the complainant returned on 21 August 2000 Dr C had received and examined the biopsy results. Five of the 7 cores showed cancer. The complainant's condition was assessed as being moderately differentiated cancer. In his reporting letter to the complainant's GP Dr C noted that the area of the prostate which he thought was cancerous when he performed the ultrasound rectal examination in fact proved not to be cancerous (according to the biopsies).

39. Doctor C's reporting letter to the complainant's GP recorded that he did not have the MRI results at the time of the consultation on 21 August. In the same letter Dr C said that if the MRI did not show abnormalities it would be necessary for the complainant to undergo a bone scan before Dr C could stage the disease.

40. Doctor C could not remember what the complainant said about the MRI results. Doctor C said it would be customary for him to look at a written report from a radiologist rather than rely on what a patient thought the MRI results were. Doctor C was certain he would not have said to the complainant that even if the MRI results were negative it did not matter because the cancer was all through the complainant anyway.

41. Doctor C rejected the complainant's concern Dr C had not explained the process of staging the complainant's disease.

42. Doctor C explained that while he could not remember what was actually said about staging, he said he normally explained the staging process by using a rural analogy. Doctor C told the Tribunal:

> *"I usually used the analogy of finding facial eczema in one's paddock. One goes to the edge of the property and works backwards. If the end paddock also has facial eczema then the whole property would have been affected. In a rural environment like xx, everyone understands the analogy."*

43. After the complainant visited Dr C on 12 February 2001 Dr C wrote a brief letter to the complainant's GP. That letter contained the following:

> *"[The complainant] came in to tell me that I was so wrong about my prognosis about his Ca prostate. I looked back over the notes, I never said it was inoperable. What I said was that his high PSA made it unlikely that the disease is localised. Robin Smart has since operated on him and declared him cured. Surgery was in November, at the moment his PSA is about zero. I told [the complainant] that I am sorry I gave him the impression that he is not curable, that certainly wasn't what was recorded on the notes. I was in the process of staging him when he went to see Robin Smart. I wished him the very best of luck as a cure is concerned".*

44. Doctor C denied telling the complainant that his cancer would "get him" during the complainant's visit on 12 February 2001, or at any other time.

Legal Principles

Onus and Standard of Proof

45. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[3] where the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[4]

> *"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.*[5] *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".*

46. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[6] 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)*[7]:

> *"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".*

47. In *Cullen v The Medical Council of New Zealand*[8] Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

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3 (1984) 4 NZAR 369
4 (1967) 1 NSWLR 609
5 [1966] ALR 270
6 [1989] 1 NZLR 139 at 163
7 Unreported HC Wellington M 239/87 11 October 1990
8 Unreported HC Auckland 68/95, 20 March 1996

> *"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".*

48. Where the Tribunal has made a finding adverse to Dr C it has done so because the evidence satisfies the tests as to the onus and standard of proof set out in paragraphs 45 to 47 of this decision. The allegations against Dr C are at the lower end of the spectrum of charges heard by the Tribunal. Where the Tribunal has made a finding against Dr C it has done so because it is very satisfied that the CAC has discharged the onus placed upon it.

Professional Misconduct

49. Doctor C, was charged with professional misconduct, or, in the alternative, conduct unbecoming a medical practitioner.

50. It is not necessary to traverse in detail the development of the concept of professional misconduct in this country. Suffice to say there now appears to be complete acceptance of the way the Tribunal has described the test in its recent decisions as being a two stage evaluation.[9]

51. 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 act/or omissions under scrutiny would be reasonably regarded by the doctors colleagues and representatives of the community as constituting professional misconduct?"*

The second limb of the test requires an answer to the following question:

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[9] See for example, *McKenzie v MPDT*, unreported, HC Auckland, CIV2002-404-153-02, 12 June 2003, Venning J; *F v MPDT*, HC Auckland, AP 113/02, 20 November 2003, Frater J

> *"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" are additional to the test of professional misconduct articulated by Jefferies J in *Ongley v Medical Council of New Zealand.*[10] The words "representatives of the community" have been added by the Tribunal because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative, and a chairperson who must be a lawyer. The composition of the Tribunal has altered since Jefferies J delivered his seminal decision in *Ongley*. The new 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.[11]

53. The second limb of the test of professional misconduct recognises the observations in *Pillai v Messiter [No.2];*[12] *B v Medical Council;*[13] *Staite v Psychologists Board*[14] and *Tan v Accident Rehabilitation Insurance Commission*[15] that not all acts or omissions which constitute a failure to adhere to the standard expected of a doctor will in themselves constitute professional misconduct.

Conduct Unbecoming a Medical Practitioner

54. In recent decisions the Tribunal has concluded that under the Medical Practitioners Act 1995, conduct unbecoming a medical practitioner is a disciplinary offence which parallels professional misconduct. The Tribunal has consistently recognised that under the Medical Practitioners Act 1968, conduct unbecoming was a less serious form of professional misconduct. In recent decisions the Tribunal reasoned that the language employed by Parliament in the 1995 statute

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10 Supra

11 *B v MPDT*, unreported, HC Auckland, HC11/96, 8 July 1996, Elias J; *Lake v Medical Council of New Zealand*, unreported, HC Auckland, 123/96, 23 July 1998, Smellie J

12 (1989) 16 NSW LR197

13 Supra

14 (1998) 18 FRNZ 19

15 (1999) NZAR 369

suggests conduct unbecoming is not a lesser version of professional misconduct, but rather a parallel offence which focuses on conduct that falls outside the scope of a doctor's "professional" conduct. The Tribunal's reasoning was based on the following points:

- the description of conduct unbecoming found at s.109(1)(c) Medical Practitioners Act 1995 includes the requirement that the conduct in question must reflect adversely on the fitness of the practitioner to practise medicine. When viewed objectively, this conveys a considerable "sting", and may involve allegations of graver culpability than professional misconduct.

- the penalties for professional misconduct and conduct unbecoming found in s.110 Medical Practitioners Act 1995 are identical. This reinforced the Tribunal's belief that professional misconduct and conduct unbecoming were parallel offences and not hierarchical.

- the Tribunal reasoned that it is axiomatic there must be a distinction between professional misconduct and conduct unbecoming. If there were no legal distinction then s.109(1)(c) Medical Practitioners Act 1995 would be otiose. The Tribunal thought that the distinction between the two categories could be logically maintained by ensuring charges of conduct unbecoming focused on allegations which extended beyond a doctor's professional conduct.

55. The Tribunal's most recent explanation of its analysis of the distinction between professional misconduct and conduct unbecoming can be found in *M 287/04/118D* (8 June 2004). Two days after the Tribunal delivered its decision in that case the District Court delivered its judgment in *Perera v MPDT*[16]. In that judgment the learned District Court Judge referred to an early decision of the Tribunal in which the Tribunal had signalled its understanding of the distinction between professional misconduct and conduct unbecoming under the 1995 Act. The District Court Judge concluded that although the Tribunal's view may have had the merits of simplicity and clarity it did not appear to accord with a long established pattern of decisions, most of which were decided under the Medical Practitioners Act 1968.

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[16] DC Whangarei, MA 95/02, 10 June 2004, Hubble DCJ.

56. The Tribunal now unhesitatingly accepts the District Court has determined conduct unbecoming is capable of being viewed as a less serious form of professional misconduct. The Tribunal must now adhere to the directions of the District Court in *Perera* and when hearing a charge of professional misconduct, the Tribunal shall now consider the possibility the conduct in question amounts to conduct unbecoming.

57. In assessing whether or not established acts or omissions constitute conduct unbecoming the Tribunal bears in mind it must be satisfied the conduct reflects adversely on the doctor's fitness to practise medicine. In *CAC v Mantell*[17] the District Court said:

> *"The text of the rider in my view makes it clear that all the prosecution need to establish in a charge of conduct unbecoming is that the conduct reflects adversely on the practitioner's fitness to practise medicine. The focus of the inquiry 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".*

The rider in s.109(1)(c) Medical Practitioners Act 1995 is also discussed in *W v CAC*[18] where the Court said:

> *"It is also to be borne in mind that what the Tribunal is to assess is whether the circumstances of the offence 'reflect adversely' on fitness to practise. 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 practise 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."*

58. The suggestion in *W* that the phrase "reflects adversely" on the doctor's fitness to practise refers to a scale of seriousness which may include the view that the doctor should not practise at all has to be tempered by the observation that a doctor found guilty of conduct unbecoming cannot

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[17] DC Auckland, MP 4533/98, 7 May 1994

[18] DC Wellington, CMA 182/95, 5 May 1999

have their name removed from the Register of medical practitioners (s.110(2) Medical Practitioners Act 1995).

59. In assessing whether or not a doctor is guilty of conduct unbecoming the Tribunal has asked itself the following questions bearing in mind the guidance given by the District Court in *Perera*:

- When viewed objectively has the doctor behaved in a way 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 conduct unbecoming which reflects adversely on the doctor's fitness to practise medicine;

- 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?

Dr C's Professional Obligations

First Particular of the Charge

60. The first particular of the charge alleges Dr C failed to adequately inform the complainant about:

- the process of staging the complainant's disease;

- the complainant's condition;

- the options available to treat prostate cancer.

61. The Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996 ("the Code") greatly assists in determining Dr C's professional duties and obligations to the complainant in relation to the allegations contained in the first particular of the charge.

62. The Code sets out the duties of health professionals to inform patients and obtain consent to medical procedures. The provisions of the Code relevant to the case before the Tribunal are:

- 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."

- 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 …"

- 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".

- Right 6(3) which provides:

  "Every consumer has the right to honest and accurate answers to questions relating to services …"

- Right 7(1) which provides:

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

63. Medical Ethical codes provide helpful guidance in assessing Dr C's responsibilities in relation to the allegations set out in the first particular of the charge.

64. The 1994 New Zealand Medical Association Code of Ethics (in force in 2000), recognised:

> *" … the right of all patients to know … the available treatments together with their likely benefits and risks"*[19]

and the duty of doctors to:

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[19] Paragraph 7 1994 NZMA Code of Ethics

> *"Exchange such information with patients as is necessary for them to make informed choices where alternatives exist."*[20]

65. For completeness, the Tribunal notes that the current NZMA Code of Ethics (which came into force in 2002 and therefore cannot be relied upon in assessing Dr C's duties and responsibilities in this case) reads:

> *"Doctors should ensure that patients are involved within the limits of their capacities, and 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".*[21]

66. Statements issued by the Medical Council of New Zealand also assist in assessing Dr C's responsibilities to his patient in this case.

67. 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.

68. The first comprehensive statement for the New Zealand medical profession on information for patients and consent was issued in June 1990.[22] That statement was issued in response to the Cartwright Inquiry.[23] 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 this 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."*

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[20] Paragraph 11 1994 NZMA Code of Ethics

[21] Paragraph 10 2002 NZMA Code of Ethics

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

[23] The report of the Cervical Cancer Inquiry Into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and to Other Related Matters, 1988.

69. In 1995 the Medical Council published a pamphlet summarising its 1990 guidelines 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 67 of this decision.

70. The key elements in the Medial Council's 1990 and 1995 statements for the medical profession on information and consent can be summarised in the following way:

- Information must be conveyed to the patient in a way which enables the patient to make an informed decision.
- 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 options available.
- The assessment of whether or not a doctor has discharged their responsibilities to properly inform a patient is measured from the standpoint of the expectations of a reasonable patient, and not the viewpoint of a reasonable doctor.

71. In its 1990 and 1995 statements the Medical Council said:

> *"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 medical misconduct and could be the subject of disciplinary proceedings."*

72. 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 this decision, the 2002 Medical Council statement is similar to the Medical Council's 1990 and 1995 statements on "Information and Consent".

73. The common law also provides some guidance when assessing Dr C's duty to have informed the complainant about the possible treatment options available in this case. The promulgation of the Code as a Statutory Regulation in 1996 renders it unnecessary to trace the concept of "informed consent" in other jurisdictions. Suffice to say New Zealand has been substantially sheltered from the common law development of informed consent because of the passage of our accident compensation legislation which first came into force on 1 April 1974. That legislation effectively abolished common law claims for compensation for personal injury caused by negligence.

74. It is to be noted however that even prior to the passing of the Accident Compensation Act 1972 New Zealand Courts had made it clear that doctors had a duty to answer patients' questions honestly and accurately. This point is pertinent to particular 1.1(c) of the charge which is linked to the complainant's statement that at his first consultation with Dr C he:

> *"… asked Dr C whether [he] could have an operation to have the cancer removed, however Dr C would not entertain any suggestion that an operation could be possible and just repeated the assertion again that the cancer would kill [him]."*[24]

75. In *Smith v Auckland Hospital Board* [25] the Court of Appeal upheld a decision of the High Court in which it was said that the relationship between doctor and patient was sufficient to impose on the doctor a duty to use care in answering questions put to the doctor. The Court of Appeal emphasised that the doctor's duty existed in that particular case because the patient placed reliance upon answers given by doctors before the patient decided to consent to a femoral arteriogram. The Court of Appeal stressed that the case turned upon the fact that the doctor's inadequate answer was in response to a question which was specifically asked of him.

76. The common law has, at least since 1965, required doctors to answer patients' questions honestly and accurately. This obligation is now codified in Right 6(3) of the Code.

Second Particular of the Charge

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[24] Complainant's brief of evidence, paragraph 16

[25] [1965] NZLR 191

77. The second particular of the charge focuses on Dr C's alleged failure to communicate in a sensitive and respectful manner with the complainant.

78. The Code also provides clear assistance in determining Dr C's professional duties and obligations to the complainant when evaluating his culpability in relation to the second particular of the charge.

79. Right 1(1) of the Code provides:

> *"Every consumer has the right to be treated with respect."*

Closely related is Right 3 which provides:

> *"Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual." (*emphasis added)

80. A doctor's duty to treat patients with respect and dignity, now enshrined in Rights 1(1) and 3 of the Code mirror medical ethical obligations. For example, the International Code of Medical Ethics[26] stresses the duty of a doctor to practise:

> *"… with compassion and respect for human dignity."*

The same obligation could be found in paragraph 1 of the 1994 NZMA Code of Ethics.

81. In assessing Dr C's duties to communicate with the complainant in a compassionate and caring manner, assistance can be derived from Professor D. Cole's book "Medical Practice in New Zealand: a Guide to Doctors Entering Practice".[27] Professor Cole reminds New Zealand doctors that their patients:

> *" … have the right to be treated with kindness, care and dignity throughout the management of their ill health or other medical management period."*

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[26] 1949, 1968 and 1983

[27] Medical Council of New Zealand, 1995, page 10

Assessment of the Evidence

82. It was common ground that in discharging its tasks in this case the Tribunal had to assess the credibility of the two key witnesses, namely the complainant and Dr C.

83. The Tribunal carefully assessed both the complainant and Dr C when they gave evidence. The Tribunal had the benefit of assessing the demeanour of both witnesses, especially when responding to careful and thorough cross examination undertaken by two senior and very experienced counsel.

84. The Tribunal concluded the complainant was a very honest man who endeavoured to recall events which occurred almost four years ago as accurately as he could. The complainant is clearly a very industrious and intelligent man who was motivated solely by his desire to ensure Dr C remedied the manner he communicated with his patients. In many respects the complainant presented as a typical New Zealand xx – resourceful, honest and motivated by commendable goals.

85. Notwithstanding the Tribunal's belief the complainant was honest when giving his evidence, the Tribunal believes that the complainant's recollection of comments attributed to Dr C in August 2000 and February 2001 may not have been a verbatim re-statement of what was actually said. This should not be construed as a criticism of the complainant. The events in question occurred four years ago, and although most of the comments attributed to Dr C were recorded in a letter written in September 2001, it is notoriously difficult for anyone to recall with absolute precision the words used by doctors in consultations. Having made this observation, the Tribunal believes that the complainant accurately recalled the general tenor of the comments made by Dr C during the consultations in August 2000 and the meeting in February 2001.

86. The Tribunal believed Dr C was a very thorough clinician and that his clinical management of this patient appeared to have been beyond reproach. It quickly became apparent however that Dr C was in the habit of speaking in a very blunt and direct manner. Doctor C was aware that he had been criticised in the past about his style of communication and he thought he had mellowed over the years. It was clear to the Tribunal however that Dr C still speaks in a very blunt and direct manner and that he possibly does not appreciate how his directness can be

readily misunderstood.

87. The Tribunal is very confident that when the complainant was seen by Dr C on 7 August 2000 Dr C formed the view the complainant had advanced prostate cancer and that the patient's condition was probably incurable. There were sound clinical reasons for Dr C reaching this conclusion on 7 August. The Tribunal is also very satisfied Dr C proposed to stage the extent of the complainant's disease after undertaking appropriate tests (biopsies, bone scan and MRI) and that no final decision would have been made about treatment without staging having been completed. However the Tribunal also believes that at the consultation on 7 August Dr C bluntly told the complainant to expect the worst and that his style of communication was direct and easily construed as being unsympathetic. The Tribunal believes that Dr C's style of communication on 7 August continued on the other occasions he met with the complainant in August 2000 and February 2001.

88. The Tribunal has carefully studied Dr C's comprehensive reporting letters to the complainant's GP and have preferred the evidence recorded in Dr C's notes where they clearly contradict the complainant's recollections of events. As will become apparent, the Tribunal believes Dr C's notes only provide a clear contradiction to the complainant's recollection of events in relation to one element of the charge, namely the allegation Dr C failed to provide him with literature relating to his condition.

89. The Tribunal carefully listened to the evidence given by the complainant's wife. Her evidence primarily related to the consultation on 7 August 2000. Counsel for Dr C submitted that the complainant's wife did not corroborate the complainant's evidence as to what was allegedly said by Dr C during that consultation. The Tribunal's assessment is that whilst the complainant's wife could not recall precisely what words were said by Dr C she did not directly contradict what the complainant said about the consultation on 7 August, other than to suggest it was possible Dr C gave the complainant literature about his consultation (transcript p.97 l.14). In relation to the comments made by Dr C on 7 August the complainant's wife affirmed that the complainant asked Dr C if he could have an operation. The complainant's wife stated "*Dr C advised that an operation would not be possible and he repeated that the cancer would kill [the complainant] and that we should just accept that*".

When cross examined the complainant's wife did not retract this evidence. She did acknowledge however Dr C may have spoken words to the effect "*Its cancer of the prostate, probably fairly advanced until proven otherwise"* (transcript p.95 l.25) and that Dr C "*implied that the cancer would kill"* the complainant (transcript p.95 l.20, emphasis added).

Tribunal's Findings in Relation to Each Particular of the Charge

Particular 1.1(a) "[Dr C] failed to adequately explain to [the complainant] that Dr C was "staging" his disease or explain what "staging" was".

90. The Tribunal is very satisfied Dr C conveyed to the complainant's GP that Dr C was planning to stage the complainant's disease. However, the Tribunal is equally and unanimously satisfied Dr C did not explain "staging" or the staging process to the complainant. The Tribunal believes that if Dr C had explained the staging process to the complainant he would have readily understood what staging entailed and the reasons for undertaking that process. The Tribunal is very convinced if Dr C had used the "facial eczema" analogy to describe staging then the complainant would have readily recalled that explanation. The Tribunal believes Dr C did not explain the staging process to the complainant. The Tribunal has concluded Dr C believed the complainant was struggling to come to terms with the news he had prostate cancer. The Tribunal also believed Dr C thought it desirable to convey to the complainant in no uncertain terms that the complainant probably had incurable prostate cancer, and that the complainant should not be distracted with additional information at the time of the consultations on 7, 14 and 21 August 2000.

91. A majority of the Tribunal believes that Dr C's failure to explain "staging" constituted a failure to adhere to the standards expected of a xx in Dr C's position. The majority believe that Rights 5(2), 6(1) and 6(2) of the Code required Dr C to explain staging to the complainant for the following reasons:

- explaining staging to the complainant would have been entirely consistent with Dr C's duty to communicate "openly, honestly and effectively" with the complainant (Right 5(2) of the Code);

- explaining staging would have been consistent with providing information to the complainant that a reasonable consumer in the complainant's circumstances would expect to receive (Right 6(1) of the Code);

- explaining staging would have been consistent with Dr C's duty to ensure the complainant had information that a reasonable consumer in the complainant's circumstances needed before consenting to further medical procedures (Right 6(2) of the Code).

92. A minority of the Tribunal (Drs Bennett and Civil) accept Dr C had a duty to inform the complainant about staging, but believe Dr C did not breach his duty because in the normal course of events Dr C would have explained the staging process if there had been further consultations after 21 August 2000. The minority members of the Tribunal believe that Dr C should not be criticised for not explaining the staging process during the course of the three consultations which occurred in August 2000 because Dr C was managing the amount of information he was giving to his patient and that it was reasonable for Dr C not to have explained staging at what were early stages of the therapeutic relationship.

93. All members of the Tribunal believe Dr C's failure to explain staging does not justify a disciplinary finding in this case. Those members of the Tribunal who have concluded Dr C failed to discharge his professional responsibilities to the complainant by not explaining the staging process believe his omission does not justify a disciplinary finding because the complainant had just three intensive consultations with Dr C over a two week period and Dr C reasonably anticipated having many more consultations during which he would in all likelihood have explained the staging process.

Particular 1.1(b) "[Dr C] failed to provide [the complainant] with literature regarding his condition despite Dr C recording in his notes that he had done so".

94. The Tribunal is unanimously of the view Dr C probably did give the complainant literature about his condition at the consultation which occurred on 7 August 2000. There are two reasons for the Tribunal reaching this conclusion:

- Dr C's letter of 7 August 2000 to the complainant's GP categorically states Dr C did give literature to the complainant that day. The Tribunal believes that in all likelihood this contemporaneous record accurately reflects what occurred.

- The complainant had biopsies taken on 14 August. The complainant needed to fast and take laxative suppositories and antibiotics prior to that procedure being performed. The explanation as to how a patient prepares for a prostate biopsy is usually set out in written directions. The fact the biopsies were able to be performed on 14 August strongly supports the belief the complainant complied with directions which are usually given to patients in pamphlets about the process for preparing for a prostate biopsy.

Particular 1.1(c) "[Dr C] failed to adequately discuss with [the complainant] other options available to treat prostate cancer"

95. This allegation relates to the complainant asking Dr C on 7 August 2000 if he could have an operation to have the cancer removed. The complainant's evidence was that:

> *"…Dr C would not entertain any suggestion that an operation could be possible and just repeated the assertion again that the cancer would kill [him]".*

96. In his reporting letter to the complainant's GP of 7 August 2000 Dr C candidly acknowledged he did:

> *"… not [go] into therapy with [the complainant] as … he had quite enough to absorb in one go".*

97. There is no evidence to suggest Dr C explained the possibility of surgery with the complainant at any of the consultations in August 2000. This is consistent with the Tribunal's belief Dr C was confident the complainant probably had incurable cancer and that it was better for the complainant to face the realities of his having an incurable condition rather than raise hopes by talking about surgery prior to the disease being staged.

98. The Tribunal is unanimously of the view Dr C had a duty to explain the possibility of surgery to the complainant when asked about this possibility on 7 August 2000. Doctor C should have

answered the complainant's question in a way which was qualified by the need for the staging process to be completed before any final decisions could be made about treatment options.

99. The Tribunal believes Dr C's duty to discuss the possibility of surgery with the complainant is fully consistent with the following provisions of the Code:

- Right 5(2) – discussing the possibility of surgery would have been consistent with "open, honest and effective communication";
- Right 6(1) – discussing the possibility of surgery would have been consistent with providing information which a reasonable consumer, in the complainant's circumstances, would expect to receive;
- Right 6(2) – discussing the possibility of surgery would have been consistent with Dr C's duty to give the complainant information that a reasonable consumer, in the complainant's circumstances, needed before making a choice before undertaking further medical procedures;
- Right 6(3) – discussing the possibility of surgery would have been consistent with Dr C's duty to provide honest and accurate answers to questions relating to services.

100. The Tribunal has concluded, by a very fine margin that Dr C's breach of his duties to the complainant in relation to Particular 1.1(c) of the charge does not justify a disciplinary finding against him. The Tribunal has concluded Dr C could be excused for not discussing surgery as a treatment option until the results of the biopsies, bone scan and MRI were available. That said, the Tribunal believes it would have been entirely reasonable and proper for Dr C to explain to the complainant that treatment options (including surgery) would be discussed once the results of the clinical tests were known.

<u>Particular 2</u>

101. Although particular 2 contains five sub-particulars it is convenient to deal with particular 2 on a cumulative basis.

102. It is not possible for the Tribunal to make findings as to precisely what words were used by Dr

C on 7 and 21 August 2000 or 12 February 2001. The passage of time between the events in question and the complainant's letter of September 2001 is by itself sufficient to cause the Tribunal to be cautious about drawing conclusions as to exactly what words were said by Dr C to the complainant on the days in question.

103. Notwithstanding the Tribunal's inability to determine exactly what Dr C said to the complainant, the Tribunal is nevertheless satisfied Dr C did make a series of comments similar in effect to those alleged by the complainant. The Tribunal's reasons for reaching this conclusion are:

- the Tribunal was impressed by the complainant's honesty and believe that in most respects he was a reliable witness;
- the complainant had no motive to mis-represent what was said to him by Dr C;
- the comments made by Dr C clearly had a significant impact on the complainant and were comments which the complainant was unlikely to forget (although the complainant may not have been able to recall exactly what words were spoken by Dr C);
- Doctor C is a blunt communicator who was very likely to have spoken to the complainant in a brusque and direct manner;
- Doctor C acknowledged the likelihood of his making a comment on 7 August 2000 to lighten the situation, and that his attempts at humour could easily have been interpreted as being offensive in the circumstances.

104. The Tribunal is unanimously of the view that on 7 August 2000 Dr C made comments which, if not identical to those recalled by the complainant were similar in meaning to those recalled by the complainant. In particular the Tribunal believes that on 7 August Dr C:

- tried to make a joke about people engaging in anal penetration "for fun" when carrying out the trans-rectal ultrasound scan of the complainant;
- told the complainant that his headaches were in all likelihood due to secondaries in his skull;

- told the complainant that his condition was likely to be terminal and that his cancer would probably kill him.

105. The Tribunal also believes that on 21 August Dr C told the complainant that his cancer was likely to be through the rest of his body, and that on 12 February 2001 he conveyed to the complainant his belief that the complainant's long term prognosis was not good and that there was a likelihood of cancer recurring.

106. The Tribunal believes Dr C conveyed these messages in a blunt and direct manner and that his communications could readily be construed as unsympathetic and offensive in the circumstances.

107. The Tribunal believes that when viewed cumulatively, the matters complained of in Particular 2 of the Notice of Charge constitute a breach of Dr C's duty to treat the complainant with respect and dignity. Doctor C breached the obligation described by Professor Cole as one which requires doctors to treat their patients with "kindness, care and dignity".

108. The Tribunal is unanimously of the view that its cumulative findings in relation to Particular 2 of the charge pass the tests of conduct unbecoming a medical practitioner set out in paragraph 58 of this decision. The Tribunal finds Dr C's indiscretions constitute "conduct unbecoming" as that term has been described by the District Court in *Perera*. That is to say, the Tribunal has concluded Dr C's conduct does not meet the test of professional misconduct, but his conduct justifies a finding of conduct unbecoming a medical practitioner.

109. The Tribunal's reasons for reaching this conclusion are:

- Doctor C's comments to the complainant on 7, 21 August 2000 and 12 February 2001, fell well below the standard of behaviour reasonably expected of a xx in his circumstances when viewed from the dual standpoints of the reasonable expectations of the profession and community;

- Doctor C's conduct reflects adversely on his fitness to practise medicine in that his behaviour was inconsistent with the conduct expected of a xx in his circumstances and his behaviour justifies a disciplinary sanction, albeit at the lower end of the spectrum of penalties available to the Tribunal;

- A disciplinary finding is justified in this case in order to:
  - uphold professional standards; and
  - punish Dr C.

The Tribunal believes that it is essential doctors consistently communicate with their patients in a manner which is respectful and in a way which recognises and acknowledges the dignity of individual patients.

110. The Tribunal has considered whether its findings in relation to Particulars 1.1(a) and (c) when viewed cumulative in relation to its finding in relation to the particulars in Part 2 of the charge justify an additional disciplinary finding. Having concluded the CAC has not established the first particular of the charge constitutes either professional misconduct or conduct unbecoming, the Tribunal does not believe it appropriate to impose any cumulative finding in relation to the first particular of the charge.

Summary

111. Doctor C's conduct when speaking to the complainant on 7, 21 August 2000 and 12 February 2001, when viewed cumulatively amounts to conduct unbecoming a medical practitioner which reflects adversely on his fitness to practise medicine.

112. The Tribunal invites counsel to file submissions on penalty and name suppression in accordance with the timetable set out in paragraph 4 of this decision.

DATED at Wellington this 17th day of August 2004.

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal