MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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PUBLICATION OF THE NAME OF THE DOCTOR, WITNESSES AND COMPLAINANT AND ANY DETAILS WHICH MAY IDENTIFY THEM IS PROHIBITED	**DECISION NO:**	303/04/120C
	IN THE MATTER	of the Medical Practitioners Act 1995
		-AND-
	IN THE MATTER	of a charge laid by Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **R** medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Ms J Courtney, Dr R S J Gellatly, Dr U Manu, Dr J L Virtue (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Monday 27 September through to and including Thursday 30 September 2004

APPEARANCES: Mr M Heron for Complaints Assessment Committee ("the CAC")

Mr A H Waalkens QC and Ms C Garvey for Dr R.

Introduction

1. Doctor R is a general practitioner. He practises in xx. On 19 April 2004 a Complaints Assessment Committee ("CAC") laid a charge of disgraceful conduct against Dr R. The charge was laid pursuant to s.93(1)(d) of the Medical Practitioners Act 1995 ("the Act"). The charge was subsequently amended on two occasions prior to the hearing by the CAC. The details of the charge heard by the Tribunal are explained in paragraph 5 of this decision.

2. The Tribunal heard the charge over four days commencing 27 September 2004. On 30 September, after hearing the evidence and submissions from counsel the Tribunal retired to consider its decision. Later on 30 September the Tribunal advised that the evidence heard by the Tribunal did not meet the requisite standard to establish the charge. As the charge was not proven it was dismissed by the Tribunal.

3. In this decision the Tribunal explains its reasons for the decision it announced on 30 September.

4. Doctor R was granted interim name suppression in a decision delivered by the Tribunal on 16 September 2004. The Tribunal's interim decision will remain in force until the Tribunal has had an opportunity to consider any further submissions on whether or not the Tribunal's interim order should lapse or be made permanent. If Dr R wishes to apply for permanent name suppression his application and supporting evidence and submissions should be filed within 14 days of the date of this decision. The CAC will have 10 days to respond.

The Charge

5. The charge, as amended for the second time on 18 August 2004 alleged between 1985 and 2000 Dr R:

> *"…acted in a way that amounted to disgraceful conduct in a professional respect in that he behaved towards his patients in a manner that contravened the Medical Council's statement on sexual abuse in the doctor/patient relationship …"*

The charge was subdivided into three separate allegations, each of which was supported by specific particulars:

> *"1. He abused his position as a medical practitioner and took physical and emotional advantage of his patients by engaging in inappropriate sexual relationships with women patients in his care:*
>
> *<u>Particulars</u>*
>
> - *In 1997 Dr [R] advised Dr [C] that he had had sexual relations with unnamed patients;*
> - *In December 1999 and subsequently Dr [R] advised Dr [M] that he had sexual relations with two different patients namely Ms [S] and Ms [J].*
>
> *2. Doctor [R] failed to act appropriately when performing cervical smears and/or internal examinations on women patients by not wearing surgical gloves and/or conducting examinations without an appropriate chaperone:*
>
> *<u>Particulars</u>*
>
> - *In 1986 when employing Ms [HP] as a nurse he did not use a chaperone when seeing women patients.*
> - *Between 1987 and 2000 when employing Dr [M] and Dr [C] he did not use a chaperone when seeing women patients;*
> - *In 1999 in the course of discussion with Dr [M] Dr [R] said he never used gloves when conducting internal examinations.*
>
> *3. Doctor [R] made inappropriate remarks of a sexual nature, or asked inappropriate questions that were sexually orientated, or were sexually suggestive, when consulting patients.*

Particulars

- *When seeing Ms [JK] he asked her about details of her sex life when not related to the consultation;*
- *He asked Ms [JP] about her 'love life' when not related to the consultation;*
- *When treating Ms [HK] he asked her to disrobe when the door was open and to bend over so that he could examine her bottom".*

The notice of charge alleged that *"…collectively and/or individually these charges and particulars amount[ed] to disgraceful conduct in a professional respect".*

Further Amendments to the Charge

6. When Mr Heron opened the case for the CAC he sought leave to substitute the reference to internal examinations in the third particular of the second charge with a reference to "cervical smears". That application was not opposed and was accordingly granted by the Tribunal. When Mr Heron closed he sought leave to further amend the second charge by deleting the reference to "and/or internal examinations". That application was not opposed and was accordingly granted by the Tribunal.

7. Mr Heron also sought leave during his closing submissions to delete the reference to Ms [J] in the second particular of the first allegation of the charge. Mr Heron wanted the Tribunal to substitute the reference to Ms [J] with a reference to "other un-named patients". That application was vigorously opposed by Mr Waalkens. Mr Heron's application was based on the fact that no evidence about Ms [J] had been presented to the Tribunal. Mr Waalkens was very concerned that this element of the charge should be amended after the conclusion of the evidence because he had cross examined the witnesses on the basis that the charge alleged Dr R had sexual relations with, inter alia, Ms [J].

8. The Tribunal was uncertain as to whether or not Dr R would have been genuinely prejudiced by the amendment sought by Mr Heron. The Tribunal was concerned that the application to make a significant amendment was made after evidence had been heard. The Tribunal opted to take a cautious approach and declined to allow the first particular of the charge to be amended.

Suppression of Names and Identifying Details of Witnesses and Others Named During the Hearing

9. All witnesses of fact sought orders from the Tribunal under s.106(2)(d) of the Act suppressing publication of their names, or any matters that could identify them.

10. None of the applications relating to the witnesses was opposed. Similarly, both parties supported the proposition that persons named in the evidence as having had sexual relationships with Dr R should also have their names and identifying features suppressed from publication by the Tribunal.

11. The Tribunal acceded to these requests. The Tribunal's reasons for suppressing the names and identifying features of all witnesses of fact, and others identified in the evidence can be succinctly stated:

    11.1 It was appropriate to suppress the names and identifying features of those who work or worked with Dr R. Allowing publication of the names of those who work or formerly worked with Dr R would effectively negate the Tribunal's earlier order granting Dr R interim name suppression because it would have been very easy to identify Dr R if the names of those he worked with were able to be published.

    11.2 It was appropriate to suppress publication of the names of those who Dr R had sexual relationships with, and those who he allegedly had sexual relationships with because there was no over-riding public interest in allowing publication of the names of these women in circumstances which would probably cause them considerable embarrassment.

    11.3 Five witnesses, Drs M and C, Ms JK, Ms P and Ms HK were complainants. All gave evidence of either a sexual, intimate or distressing nature. These witnesses were entitled to the specific protections for complaints set out in s.107 of the Act. Section 106(2) requires the Tribunal to have regard to a complainant's privacy which is described in s.106(2) as being "without limitation". When s.106(2) is considered in conjunction with the special protections afforded to complainants by s.107, it is apparent that, in the absence of compelling public interest considerations,

the Tribunal would normally consider it desirable to grant complainants name suppression under s.106(2)(d) of the Act.

Legal Principles

Burden and Standard of Proof

12. The allegations levelled against Dr R are very serious. Because the charges are very serious the onus on the CAC requires a high standard of proof.

13. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[1] where the High Court adopted the following passage from *Re Evatt: ex parte New South Wales Bar Association*[2]*:*

> *"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*[3]*. 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."*

14. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[4] where it was explained the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand*[5]:

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

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1 (1984) 4 NZAR 369
2 (1967) 1 NSWLR 609
3 [1966] ALR 270
4 [1989] 1 NZLR 139 at 163
5 Unreported HC Wellington M238/87, 11 October 1990

15. In *Cullen v The Medical Council of New Zealand*[6] Blanchard J adopted the directions given by the legal assessor to the Medical Practitioners Disciplinary Committee on the standard of proof required in medical disciplinary fora:

> *"The MPDC's legal assessor, Mr Gendall, correctly described it in the directions which he gave the committee:*
>
> > *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious 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 or not, you have got to be sure in your own minds, satisfied that the evidence establishes the facts."*

16. The standard of proof is crucial in this case. Because the allegations are very serious the CAC is obliged to satisfy the Tribunal to a high standard that the allegations are correct. The CAC is not obliged to prove the allegations "beyond reasonable doubt" but must nevertheless surpass a high threshold when alleging a doctor is guilty of disgraceful conduct.

17. In his closing submissions Mr Heron properly conceded that the allegations in the second and third elements of the charge do not amount to disgraceful conduct, but that the Tribunal should find a lesser charge[7] made out against Dr R in relation to these matters.

18. The standard of proof carried by the CAC is less onerous in relation to allegations of professional misconduct and conduct unbecoming a medical practitioner. Nevertheless, as will be seen later in this decision, the Tribunal believes the allegations in the second and third elements of the charge have not been established on the balance of probabilities.

Disgraceful Conduct in a Professional Respect

19. A charge of "disgraceful conduct in a professional respect" is reserved for the most serious instances of professional disciplinary offending. Doctors found guilty of disgraceful conduct in a professional respect are at risk of having their name removed from the register of

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6 Unreported HC Auckland 68/95, 20 March 1996

7 Professional misconduct or conduct unbecoming, refer s.109(1)(b) and (c) of the Act

medical practitioners. In *Duncan v Medical Practitioners Disciplinary Committee*[8] the Court of Appeal said:

> *"A charge of disgraceful conduct in a professional respect has been described by the Privy Council as alleging conduct deserving of the most serious reprobation."*[9]

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

20. If the CAC had proved the first element of the charge to the requisite standard the Tribunal would have had no hesitation in finding Dr R guilty of disgraceful conduct. A doctor who engages in "inappropriate sexual relationships with women patients" will almost invariably be found guilty of disgraceful conduct.

Lesser Charges

21. It is not necessary for the Tribunal to restate the legal tests of professional misconduct and conduct unbecoming a medical practitioner because, as will be seen later in this decision, the CAC was unable to establish to the requisite standard a factual basis for the Tribunal to find Dr R guilty of lesser offences.

Summary of the CAC Case

22. It is convenient to summarise the CAC's case by referring to the three allegations and sets of particulars set out in the notice of charge.

First Allegation

23. There was no dispute about the background events leading to the matters before the Tribunal. It was agreed:

23.1 Doctor R commenced full time general medical practice in 1983;

23.2 In February 1987 Dr C joined Dr R's practice;

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8 [1986] 1 NZLR 513

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

23.3 In 1995 Dr R and his wife separated for the first time;

23.4 In 1997 had a relationship with Ms [M], a sister of a patient of Dr C, and subsequently also a patient of Dr C;

23.5 During 1998 Dr R had a relationship with an employee of the practice (Ms F);

23.6 In late 1998 Dr R reconciled with his wife and rented a property to his patient Ms S;

23.7 In May 1999 Dr C decided to leave the practice;

23.8 In September 1999 Dr M commenced work as a locum with a view to becoming a permanent doctor at Dr R's practice;

23.9 In late 1999 early 2000 Dr M and Dr R had a relationship. That relationship ended in February 2000;

23.10 In May 2000 Dr M left the practice.

23.11 In June 2000 Dr B joined Dr R's practice.

24. The contentious evidence adduced by the CAC in relation to the first allegation was:

24.1 The evidence of Dr C in which she said that in 1997 Dr R told her that "*… he had had affairs with patients … and … that he had been very careful as to whom he had picked, that they had a lot more to lose than he did.*"

24.2 The evidence of Dr M who said that in December 1999 Dr R told her that he was having an relationship with his patient Ms S and that he had had a relationship with another patient, and that he made similar comments to Dr M in February 2000.

<u>Second Allegation</u>

25. The CAC's case in relation to the second allegation was based on the following evidence:

25.1 Ms HP, a nurse employed by Dr R during 1985 and 1986 told the Tribunal that Dr R did not use a chaperone when seeing women patients.

25.2 Doctor M's testimony that Dr R *"… never used a chaperone when seeing women patients (unless they asked for one)"*.

25.3 Ms JK's testimony that Dr R never *"offered [her] a chaperone or asked [her] if [she] wanted one …"*.

25.4 Doctor M told the Tribunal that in late 1999 Dr R told her that he *"… never [wore] gloves when doing smears"*.

Third Allegation

26. The CAC's case in relation to the third allegation was based upon the following evidence:

26.1 Ms JK told the Tribunal that when she consulted Dr R about routine medical matters he asked her details of her sex life which were not relevant to the consultation.

26.2 The testimony of Ms JP who told the Tribunal that Dr R asked her questions about her *"love life"* in circumstances that were not relevant to the consultation.

26.3 Ms HK who told the Tribunal that when she consulted Dr R about a boil on her bottom he told her to remove her trousers and bend over when the door to the consulting room was open and in circumstances that HK believed enabled her to be seen by persons in the waiting room.

Summary of the Case for Dr R

First Allegation

27. Doctor R acknowledged having had extra marital affairs and sexual relationships with, inter alia, Ms F, when she was employed at the practice. Doctor R also told the Tribunal that he and Dr M had a sexual relationship although it is apparent from the testimony of both Dr M and Dr R that their relationship did not develop into one that involved sexual intercourse.

28. Doctor R strongly denied having had sexual relationships with patients, or that he told Dr C and Dr M that he had engaged in sexual relationships with his patients. In particular:

28.1 Doctor R said that Dr C was mistaken when she told the Tribunal that in 1997 Dr R had told her he had had affairs with patients, and that he had been careful who he picked and that they had more to lose then he did.

28.2 Doctor R said that Dr M was not telling the truth when she told the Tribunal that Dr R had, on two occasions told her that Dr R had had sexual relationships with Ms S and another patient. Doctor R submitted that Dr M was a "woman scorned" and that her distress over the break-up of her relationship with Dr R motivated her complaint.

Second Allegation

29. Doctor R acknowledged that it was not his practise to use chaperones. He explained that when patients who knew him well consulted him he did not believe it was necessary to use a chaperone, and that his practise was consistent with those of his colleagues in general practice.

30. In 1993 the Medical Council of New Zealand issued a statement for doctors in relation to chaperones. An examination of that statement shows doctors should inform patients that they may have a chaperone in circumstances where the patient is to have an internal or intimate examination. The Medical Council statement does not go so far as to state that a doctor must have a chaperone present when conducting internal or intimate examinations on patients.

31. Part of Dr R's defence in relation to the second allegation is that there was insufficient evidence before the Tribunal to establish to the requisite standard that he did not offer patients a chaperone when conducting internal or intimate examinations, and that accordingly it was not proven that he had breached the terms of the Medical Council's 1993 statement.

32. Doctor R acknowledged that prior to 2000 he did not routinely use gloves when taking cervical smears. He was adamant however that he always used gloves when performing internal examinations. Doctor R told the Tribunal:

32.1 Taking a cervical smear does not involve the doctors hands touching a patient's genitalia or internal anatomy;

32.2 Since the complaint was lodged in 2000 he has made it his practise to use gloves when taking cervical smears as well as when conducting internal examinations.

Third Allegation

33. Doctor R explained that if he did ask patients about their sex life his questions were entirely appropriate in the context of the consultation. In particular:

33.1 Doctor R told the Tribunal he followed the "whole person care" philosophy of general practice, and that as part of this style of practice it was, on occasions, appropriate to make inquiries about a patient's sex life in order to gain an understanding of the patient's overall state of health.

33.2 Doctor R said any questions he asked patients about their sex life were not "sexually orientated" or "sexually suggestive".

33.3 Doctor R informed the Tribunal that HK was confused about the consultation in relation to the boil on her bottom. He relied on a diagram of the layout of the surgery which showed that it was physically impossible for persons in the waiting room to see into the room in which HK was examined. In any event, Dr R relied on the fact that the examination did not involve Dr R making inappropriate remarks of a sexual nature, nor did it involve him asking questions that were sexually orientated or sexually suggestive as alleged in the third set of particulars of the charge.

Evaluation of the Evidence

34. The Tribunal's task in this case involved a careful evaluation of the evidence presented by witnesses who testified about their recollection of events said to have occurred up to 18 years ago (in the case of Ms HP) and nine years ago (in relation to the evidence given by JK and HK).

35. It is notoriously difficult for witnesses to accurately recall events that occurred many years previously. With the passage of time witnesses' memories fade. Some witnesses convince

themselves that events occurred which may not have happened in the way they now recall. That is understandable in light of the passage of time.[10]

36. The difficulties of recalling evidence were graphically illustrated in this case by JK, an undoubtedly very honest and sincere witness who nevertheless made significant errors when trying to recall the years and sequence of events that were the foundation of her concerns about Dr R.

37. The key witnesses in relation to the first allegation in the charge were Dr M, Dr C and Dr R. Doctor R challenged Dr M's credibility. He suggested the Tribunal should not rely on her testimony because she was:

37.1 Inherently unreliable; and

37.2 Motivated by having been "scorned" by Dr R.

Doctor R also challenged the reliability of Dr C's evidence, and suggested the Tribunal should not accept her testimony relating to Dr R's alleged confessions to her because it was inconceivable she would not have responded to those allegations until three and a half years later. Doctor R also submitted that Dr C's evidence was tainted by discussions Dr C had with Dr M.

38. The evidence of Drs M and C is analysed in more depth in paragraphs 42 to 61 of this decision. Suffice to say at this juncture:

38.1 Whilst there were aspects of the testimony of both Drs M and C which were properly challenged by Dr R, the Tribunal believes both Dr M and Dr C were honest and generally reliable witnesses.

38.2 The Tribunal was satisfied that Dr R probably did tell both Dr C and Dr M that he had had affairs with patients. However, as has already been emphasised, the Tribunal's task in relation to the first allegation of the charge involves the Tribunal needing to be satisfied of the truth of the allegations on more than a simple balance of probabilities basis.

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[10] *Herron v McGregor* (1986) 6 NSWLR 246

39. The CAC called Dr Deborah Antcliffe as an expert witness. She was the only witness who did not seek name suppression from the Tribunal. Doctor Antcliffe is a consultant psychiatrist. She is currently:

39.1 An adviser to the Health and Disability Commissioner;

39.2 The Director of Area Mental Health Services for the Auckland District Health Board;

39.3 Clinical Director for the Buchanan Rehabilitation Centre; and

39.4 Clinical Director of Auckland District Health Board Community Mental Health Services.

In 2002 Dr Antcliffe was a member of the Royal Australia and New Zealand College of Psychiatrists Advisory Committee for the "Boundary Transgressions Project".

40. Doctor Antcliffe provided the Tribunal with a very useful analysis of the research on doctors who engage in sexual relationships with their patients. Doctor Antcliffe advised the Tribunal that research has established there are three reasons why sexual relationships between doctors and patients are unethical and harmful:

40.1 The doctor who engages in sexual relations with a patient commits a fundamental breach of trust. A doctor is required to have their patient's best interests uppermost in their mind. Doctors must put aside their own needs or desires when meeting their patient's needs. It is this fundamental obligation which underscores the patient's right to trust their doctor with intimate physical and psychological contact and information. The doctor has acquired power through expert knowledge, skill and status (both professional and social) which the patient is relying upon. This differential places the patient in a vulnerable position. The patient can only retain power and dignity in the relationship through the doctor adhering to professional boundaries. If the doctor breaches the boundaries there is an immediate exploitation of the patient. The patient is never able to fully consent to any activity that falls outside of professional boundaries because they are in a dependent position, and must trust the doctor to behave professionally.

40.2 It is impossible for the doctor to retain objectivity and professional judgment if they are engaged in an intimate relationship with their patient. This can lead to seriously deficient treatment.

40.3 A sexual relationship is more likely to occur with patients who are already vulnerable through having experienced previous sexual abuse and/or depression and/or loneliness. It is the doctor's responsibility to be aware of these vulnerabilities and manage, not exacerbate their patient's condition. Research has shown there is always a risk of significant transference when a patient becomes the subject of a sexual relationship with their doctor. Transference in this context means the displacement of feelings and emotions from prior relationships into the current relationship. The phenomenon of transference means a sexual relationship between doctor and patient often has much greater significance to the patient than to the doctor and when it ends the damage to the patient may be quite severe, as the underlying psychological problems have not been addressed.

41. Mr Waalkens questioned Dr Antcliffe's reliability as an expert because her opinions were based upon the evidence of CAC witnesses, and did not take account of the evidence of Dr R and his witnesses. Whilst it is always desirable for experts to have access to all relevant evidence when offering their opinions, Dr Antcliffe did qualify her evidence by emphasising that it was for the Tribunal to reach conclusions on crucial factual issues. The Tribunal found Dr Antcliffe's analysis of the research relating to boundary violations by medical practitioners particularly helpful. Her evidence in relation to these matters was unaffected by her not having had access to Dr R's evidence, or the evidence of his witnesses. Doctor Antcliffe's evidence assisted the Tribunal in appreciating the underlying philosophy and rationale of the Medical Council's statement on sexual abuse in the doctor/patient relationship first promulgated in June 1994.

Dr M

42. Doctor M was a key witness for the CAC. She explained that she graduated MB ChB in 1994. In September 1999 she commenced working as a "locum with a view" for Dr R. This meant that after a 6 month trial she would have the option of buying into the practice. Doctor M was employed to replace Dr C who had left the practice in May 1999.

43. Doctor M explained that approximately 2 weeks after she started working in Dr R's practice she went into the staff tearoom and saw Dr R sitting with Ms S. She said "*They were sitting knees entwined together, facing each other and holding hands.*"

44. Doctor M told the Tribunal that soon after she started working in Dr R's practice he began touching her *"in a nice way"*, and that he complimented her by saying she was attractive. Doctor M said *"the compliments became increasingly effusive as time went on"*.

45. In her evidence Dr M said that about 2½ to 3 months after she had been in the practice Dr R developed *"a close relationship"* with her. Doctor M said this was much more than a collegial relationship. She said Dr R told her *"… he was having terrible marital problems, that he had moved back with his wife earlier in the year and that it had been a disaster"*. Doctor M said Dr R was constantly telling her about how bad his marriage was and that he would *"pour his troubles out"* to her. She said she *"felt very sorry for him"*.

46. In late November/early December 1999 Dr M said Dr R told her *"… he didn't know what he was going to do to stop falling in love with [her]"*. Doctor M said that she was flattered by Dr R's attentions, that he started to phone her at home in the evenings.

47. Doctor M told the Tribunal that just before Christmas 1999 Dr R told her he was having a relationship with Ms S, the patient she had seen him with in the staff tearoom.

48. Doctor M explained that her relationship with Dr R continued to develop over Christmas, but it never evolved into sexual intercourse. They went out together on two occasions. Doctor M said Dr R telephoned her on a frequent basis when he was away on his holidays during the Christmas and New Year period. At that stage Dr R was still living with his wife and family.

49. Doctor M understood Dr R left his wife in February 2000, and that he moved into a house he owned. Doctor M acknowledged that she believed at that time her relationship with Dr R would develop. However, it soon became apparent to Dr M that Dr R did not want to be in a relationship with her and that Dr R began *"withdrawing"* from her and became *"aggressive and rude"* towards her. Doctor M said that Dr R repeated his earlier comments that he had had a relationship with Ms S and that she [Ms S] wanted to resume

their relationship. Doctor M also said Dr R told her that he never wore gloves when taking cervical smears.

50. Doctor M told the Tribunal Dr R made remarks to her about an Indian patient whom he wanted to have sex with. Doctor M was concerned that Dr R had mowed this patient's lawns and that he was attempting to engineer meetings with her. Doctor M said she became so concerned about Dr R's attentions to this patient that she confronted the patient and Dr R in a café. Doctor M acknowledged she was by this time very agitated and distressed. She apologised to the patient the following day for her behaviour. At this time Dr M also spoke to Dr R's wife about Dr M's concerns that Dr R was entering relationships with patients.

51. The morning after Dr M spoke to Dr R's wife Dr R remonstrated with Dr M. The professional relationship between Dr M and Dr R quickly deteriorated. Doctor M left the practice on 6 May 2000 in what were clearly turbulent circumstances. Doctor M left the practice without warning, leaving patients waiting to be seen in the waiting room. Doctor M was subsequently advised by a senior doctor about her responsibilities to report her concerns to the Medical Council. The Tribunal does not know exactly when Dr M's complaint was lodged with the Medical Council but understands it was a matter of months after she left Dr R's practice.

52. When Dr M was cross examined it became apparent that some of her evidence was not accurate. It is sufficient to note the following concerns about Dr M's evidence:

52.1 Doctor M told the Tribunal Dr R telephoned her almost every night for long periods (20 to 30 minutes) during the Christmas/New Year period 1999/2000. When Dr R's telephone records were produced it became apparent that Dr R had telephoned Dr M on a number of occasions, but that most calls were for less than a minute and that the longest call was 14 minutes 11 seconds on 22 January 2000;

52.2 Doctor M said that she did not appreciate the home telephone calls, however, when Dr R returned to work in January 2000, Dr M gave him an endearing "*welcome back*" card (Exhibit 5);

52.3 Doctor M said that a receptionist Ms R, told Dr M that Dr R should marry her and that Mrs R was very encouraging of the relationship between Dr M and Dr R. When Mrs R gave her evidence she firmly refuted Dr M's evidence on this topic.

52.4 Doctor M told the Tribunal that in 2000 she contacted Dr B, another woman doctor who joined Dr R's practice soon after Dr M left the practice. Dr M said she contacted Dr B at about the time Dr B started working at Dr R's practice to warn her about Dr R's relationships with patients. When Dr B gave her evidence to the Tribunal she firmly denied having ever spoken to Dr M and that Dr M was totally wrong when she claimed she had warned Dr B about Dr R.

53. Notwithstanding its concerns about aspects of Dr M's evidence, the Tribunal believes that Dr R probably did tell Dr M that he was having, or had had sexual relationships with patients, including Ms S. As has already been noted, this finding is not sufficient to satisfy the high onus on the CAC to prove Dr R in fact had a sexual relationship with one or more of his patients.

Dr C

54. Doctor C explained she graduated MB ChB in 1981. She obtained a Diploma in Obstetrics in 1983 and has been a Fellow of the Royal New Zealand College of General Practitioners since 1999.

55. Doctor C joined Dr R's practice in 1987. She remained in his practice until August 1999.

56. Doctor C told the Tribunal she first became concerned about Dr R in 1995 when Dr R and his wife first separated. She believed he was depressed and unhappy at the time.

57. In her evidence Dr C said that in 1997 (she thought it likely to be May 1997) Dr R was very unhappy. She tried to console him. Doctor C said that during the course of their conversation Dr R confessed to having had affairs with patients. Doctor C told the Tribunal that she was "*… horrified, shocked and amazed*" and said to Dr R "*you are mad you will get caught*" to which Dr R is alleged to have said that he had been very careful as to whom he had picked, that they had a lot more to lose than he did.

58. Doctor C said that she believed Dr R was not going to repeat his offending and she therefore decided to remain in the practice. However in May 1999 differences developed between Dr C and Dr R about the business structure of the practice. Doctor C decided to leave.

59. Doctor C explained that on 20 May 2000 Dr M telephoned her and explained what had happened to her when working for Dr R. Doctor C agreed to help Dr M make a complaint but felt her evidence should support Dr M's rather than *"lead the charge"*. Doctor C apparently made a detailed statement to the Medical Council in late 2000. A copy of that statement was not made available to the Tribunal.

60. Doctor C was cross examined extensively. The Tribunal had the following concerns about Dr C's evidence:

60.1 Doctor C did not take any steps to inform the Medical Council about Dr R's confession until she was spoken to by Dr M. It would appear Dr C's statement to the Medical Council was made approximately 3½ years after Dr R told her that he had affairs with patients. The Tribunal appreciates Dr C was probably in a dilemma about how to respond to what Dr R had told her in May 1997. Nevertheless, the Tribunal was concerned Dr C did not convey her concerns to the Medical Council for almost 3 ½ years.

60.2 Doctor C said that she also spoke to Dr B and warned her about Dr R having sexual relationships with patients. Doctor B firmly denied this and said Dr C told her that she left Dr R's practice because of a disagreement over the business structure of the practice.

61. It was not suggested Dr C was a "scorned woman". Nevertheless, counsel for Dr R suggested Dr C's evidence was *"wholly unreliable"*. The Tribunal disagrees with this assertion. Although the Tribunal has concerns about aspects of Dr C's evidence, it believes she was probably correct when she told the Tribunal that Dr R confessed to her that he had had affairs with patients. Doctor C described this confession as being *"indelibly burnt into her brain*" and that the confession was something she had had to live with. The Tribunal agrees that a doctor is unlikely to be mistaken or confused about such a startling revelation from a colleague.

Ms HP

62. Ms HP's evidence related to the second allegation in the charge. She told the Tribunal that she was employed by Dr R's practice nurse in 1985 and 1986. Ms HP said in her evidence that Dr R never used a chaperone when he was taking cervical smears or performing internal examinations.

Ms JK

63. Ms JK's evidence related to the third allegation in the charge. The Tribunal has already commented that it found Ms JK to be an honest person, however her evidence, on crucial matters was mistaken. Ms JK appreciated that she had crucial dates and times confused and apologised to the Tribunal for the errors in her evidence.

64. Ms JK explained that she thought the matters she was concerned about occurred in about 1998 or 1999. She said that in 1999 Dr R started asking her questions about her sex life when she consulted Dr R about matters that had nothing to do with sex. Ms JK found these questions embarrassing. Eventually, when questioning and comments of a sexual nature had gone on for about 18 months Ms JK said she challenged Dr R. She said Dr R then became embarrassed and did not make further comments to her. Ms JK said this occurred at about the time her daughter HK had to see Dr R about a boil on her bottom. Ms JK said that Dr R's behaviour when examining her daughter had such a marked impression on her that she did not go back to see Dr R again.

65. When Ms JK was cross examined it became apparent Dr R examined Ms JK's daughter in relation to the boil during the course of 1995. It also became apparent Ms JK consulted Dr R on three occasions in 1998. Thus the evidence clearly established that Ms JK was very confused about when she last consulted Dr R and was plainly wrong when she believed she had stopped seeing him about the time he examined her daughter. Ms JK was advised to concede in cross examination that this aspect of her evidence didn't "stack up".

66. Ms JK also suggested that Dr R had conducted internal examinations without wearing gloves, and without offering her a chaperone. Unfortunately Ms JK was not able to provide guidance on when this occurred. Furthermore, under cross examination it became apparent that the reference to a "internal examination" was in fact a reference to a speculum

examination when Dr R may have taken a swab to test for thrush. The medical records suggested Ms JK had had a hysterectomy long before she saw Dr R and in cross examination she said she could not *"really recall"* if she had had an internal examination with Dr R since she had had her hysterectomy.

Ms HK

67. Ms HK is the daughter of Ms JK. Ms HK's evidence related to the third allegation in the charge. Ms HK said that when she was about 15 or 16 years of age she went to Dr R because of a boil on her bottom. She said Dr R told her to remove her trousers and bend over. This consultation happened in Dr R's consulting room. Ms HK said she recalled the door *"was slightly ajar into the waiting room and that [she] felt that [she] was visible from the waiting room"*.

68. A diagram depicting the physical layout of Dr R's surgery at this time was made available to the Tribunal. It is apparent that Ms HK's recollections of the layout of the surgery were erroneous. It is also very clear that it would have been impossible for anyone in the waiting room to see into the room where Ms HK was being examined. Also of concern is the fact that despite her evidence that she was very perturbed by Dr R's behaviour when examining her, Ms HK appears to have returned to see Dr R on another occasion.

Ms JP

69. Ms JP's evidence related to the third allegation in the charge. She explained she became a patient of Dr R in 1985 and continued to see him until about 2000. During this time however she saw Dr C for gynaecological matters. Ms JP said that when she saw Dr R he asked her about *"her love life"*.

70. When cross examined Ms JP acknowledged she may have misunderstood Dr R. She said that she *"…didn't feel it totally out of line but [that she] felt uncomfortable"*. She acknowledged that when Dr R did perform internal examinations nothing inappropriate occurred.

Dr R

71. Doctor R graduated (**not for publication**).

72. Doctor R explained to the Tribunal that he is a practitioner who focuses on the "wellness" of a patient, rather than merely responding to the particular "sickness" the patient may present with. By this Dr R said that during consultations he pays attention to other signs or cues that the patient may have concerns which the patient may not have necessarily raised. In this regard Dr R explained that on occasions he raises with patients questions and concerns about what might otherwise be occurring in the patient's life. These questions and concerns may include matters of a sensitive nature – such as relationship problems and stresses. Doctor R supported this approach by referring the Tribunal to two text books:

    72.1 "Clinical Method a General Practice Approach" – Dr R C Fraser; and

    72.2 "You and Your Doctor, A New Zealand Guide to Better Health" – Professor R Richards.

73. Doctor R strongly denied telling Dr M and Dr C that he had sexual relationships with patients.

74. Doctor R described Dr M as being a *"complex person"*. He said that after a period of time Dr M became difficult to work with. He acknowledged that he and Dr M developed emotional feelings towards each other and, that a sexual relationship evolved although sexual intercourse never occurred. Doctor R said in February 2000 *"he called off the non professional relationship with [Dr M]"*. He said it was then the problems with Dr M started to develop.

75. Doctor R said Dr M was not telling the truth when she claimed Dr R had told her he was having a sexual relationship with Ms S and another patient. Doctor R said Dr M *"was making this up"*. Doctor R said Dr M became *"irrational"* when she approached the Indian patient whom Dr M thought Dr R was trying to start a relationship with. Doctor R said that when he challenged Dr M about her behaviour towards the Indian lady Dr M acknowledged that their professional relationship would have to end. Doctor R said Dr M *"was completely out of control"* and that he *"was disturbed at her behaviour"*.

76. Doctor R described how Dr M left the practice at very short notice and that Dr R's wife (also a medical practitioner) helped him run the practice until Dr B started working at the practice.

77. Doctor R acknowledged that he used not to routinely wear gloves when conducting cervical smear examinations, and that over the years he had not routinely used chaperones. Doctor R stressed that he had never been instructed or read that chaperones are mandatory, or that a doctor should wear gloves when taking cervical smears. Doctor R said that his practises at the time in relation to the issue of chaperones and gloves when taking cervical smears were entirely consistent with what he believed other practitioners did.

78. Doctor R said that Dr M was *"a person scorned"* and that her complaint and evidence were *"malicious"*.

79. Doctor R rejected Dr C's allegations that he had told her he had had affairs with patients. He did suggest that he may have told her that he had had extra marital affairs, but he said these had never involved patients.

80. Doctor R expressed surprise and concern Dr C never raised with him her concerns about him allegedly having affairs with patients. Doctor R said that the first he heard of Dr C having her concerns was after Dr M raised her complaint.

81. Doctor R said he was at a loss to understand the circumstances in which Ms JK said he asked her questions about her sex life. He was adamant he would not have embarked on such a discussion without any cue or indication that it was appropriate to raise the topic.

82. Similarly, Dr R said that if he asked Ms JP about her *"love life"* then it would have occurred in a proper context and *" from a cue of some kind"*.

83. Doctor R said that Ms JP never complained to him about any of the matters set out in her evidence. He rejected her concerns.

84. Doctor R told the Tribunal that Ms HK may have misunderstood his manner and/or comments when examining her and that he never had any sinister or improper motives when she consulted him.

85. The Tribunal carefully examined Dr R's demeanour and his responses to very careful cross examination. Doctor R's recollection of events was not always consistent. The following examples illustrate some of the concerns which the Tribunal had about Dr R's evidence:

85.1 Doctor R was adamant that he never told Dr M that he had never had sex with an Indian woman. He also said that he never made a statement like that to anyone else. It emerged however Dr R had made a statement to a Dr Moir that he had never had sex with an Indian woman.

85.2 Doctor R acknowledged telling Dr C that he had told a patient who was having trouble conceiving that he *"could get her pregnant"*. Doctor R said he was concerned his words could be misinterpreted. Doctor R also acknowledged that a general practitioner could never give an assurance to a woman having difficulty conceiving that the general practitioner could get their patient pregnant. The Tribunal thought Dr R's explanation that he had simply expressed himself in an unfortunate manner was an implausible explanation and that in all likelihood he had made an inappropriate remark to the woman in question.

86. After assessing Dr R's credibility and the credibility of Dr M and Dr C the Tribunal concluded Dr R probably did tell Dr M and Dr C that he had had sexual relationships with patients.

87. The Tribunal drew a number of conclusions that were favourable to Dr R. The Tribunal concluded:

87.1 Doctor R did not examine Ms HK or speak to her in a sexually suggestive manner;

87.2 Doctor R did not examine Ms HK in a room which anyone else could see into;

87.3 If Dr R did ask Ms JK and/or Ms JP about their sex lives he probably did so in the context of making inquiries about their total wellbeing and that he was not being sexually suggestive or otherwise sexually motivated when dealing with these patients.

87.4 Doctor R used gloves when conducting internal examinations. He did not do so when taking cervical smears, but his practise in that regard was consistent with that of other general practitioners at the time.

Ms HR

88. Ms HR is a receptionist who has worked for Dr R for the past 10 years.

89. Ms HR told the Tribunal about Dr M's *"infatuation"* with Dr R. She said Dr M would ring her late at night and speak to her for very long periods of time about Dr R. Ms HR denied telling Dr M that she thought Dr R should marry Dr M.

90. Ms HR also explained that it was not uncommon for patients to use the tearoom in the practice. She recalled Ms S bringing muffins to the practice and using the tearoom. The tearoom was apparently regularly used by a number of people. Whilst the Tribunal accepts Dr M saw Dr R in the tearoom with Ms S, it is left in some doubt about the extent of their physical closeness when they were in the tearoom together.

91. Ms HR told the Tribunal that she has never been aware of Dr R having a sexual or other inappropriate relationship with a patient. She said that although she and Dr R talk about all manner of topics he had never told her that he had had a sexual relationship with a patient. Ms HR said she was fully aware of the relationship between Dr R and Ms F when the latter worked at the practice. Ms HR described that relationship as being open and obvious.

Dr B

92. Doctor B explained she joined Dr R's practice in June 2000, a matter of weeks after Dr M had left. Prior to joining the practice, Dr B said Dr R told her about Dr M's allegations, and suggested she make contact with Dr C.

93. Doctor B told the Tribunal she telephoned Dr C. Doctor B said that Dr C told her about a minor incident between Dr C and Dr R but that nothing was said which suggested Dr R had had affairs with patients, or had made a confession of this nature to Dr C.

94. Doctor B was adamant that she never spoke to Dr M and that Dr M was totally wrong when she said in her evidence that Dr M had raised concerns about Dr R with Dr B.

95. Doctor B explained that she worked in many practices, predominantly with male doctors, over the years and that she could not recall any doctors routinely having chaperones present when examining patients. She also said that there was nothing wrong with a doctor taking

cervical smears without wearing gloves because a doctor's hands would not physically touch a patient's genitalia or internal anatomy when taking a cervical smear.

96. The Tribunal was concerned that Dr B:

96.1 Is a professional colleague and business partner of Dr R; and

96.2 Is a patient of Dr R (although not in the habit of consulting with Dr R)

96.3 Is practising medicine subject to Dr R's oversight in accordance with s.20 of the Act.

The Tribunal believed that Dr B's multiple levels of relationship with Dr R created an environment for potential conflicts of interest. Notwithstanding its concerns about the potential for Dr B's lacking objectivity when testifying on behalf of Dr R, the Tribunal believed Dr B was generally a reliable and credible witness.

Conclusions In Relation to the Particular Allegations in the Charge

First Allegation — *"[Dr R] abused his position as a medical practitioner and took physical and emotional advantage of his patients by engaging in inappropriate sexual relationships with women patients in his care."*

97. As has already been emphasised:

97.1 The Tribunal is satisfied Dr R probably did tell both Dr M and Dr C that he had had sexual relationships with patients.

97.2 Before the Tribunal could find Dr R guilty of disgraceful conduct in relation to the first allegation in the charge the evidence would need to satisfy the Tribunal of the truth of the allegations on more than the basis of a simple balance of probabilities.

98. The CAC did not charge Dr R with disgraceful conduct because he boasted about having had sexual relationships with patients. He was charged with disgraceful conduct because he abused his position as a medical practitioner by engaging in sexual relationships with patients. This allegation requires the CAC to prove to a high standard that Dr R did in fact have

sexual relationships with his patients. It was not sufficient for the CAC to simply prove that Dr R probably told Drs M and C about his activities with patients.

99. The evidence of Drs M and C was not corroborated by any person who might have been able to give direct evidence about Dr R's alleged sexual relationships with his patients. In particular, no patient or former patient gave evidence that he had had sexual relationships with them. The Tribunal does not know why the patients who Dr R allegedly had sexual relationships with were not called as witnesses. It would be wrong for the Tribunal to speculate about this lacuna in the evidence, and the Tribunal has not tried to ascertain why additional evidence was not called. Suffice to say, the evidence which was presented and accepted by the Tribunal did not establish to the requisite standard that Dr R had in fact engaged in sexual relationships with one or more of his patients.

Second Allegation — *"[Dr R] failed to act appropriately when performing cervical smears on women patients by not wearing surgical gloves and/or conducting examinations without an appropriate chaperone."*

100. In his closing submissions Mr Heron properly acknowledged that the CAC had some difficulties in proving the second allegation in the charge. The reasons for that can be stated briefly:

100.1 The professional obligations placed on Dr R by the Medical Council's statement on the use of chaperones (1993) does not a say a doctor must use a chaperone. The obligation upon doctors is to offer chaperones when conducting internal/intimate examinations.

100.2 The only evidence which suggested Dr R might not have offered a chaperone in appropriate circumstances came from Ms JK who, under cross examination, conceded that she could not *"really recall"* if she had in fact had an internal examination with Dr R since she had had her hysterectomy long before she became a patient of Dr R. The Tribunal was not satisfied this evidence was sufficient to prove Dr R did not offer the use of a chaperone when required by the Medical Council's directions.

100.3 The Tribunal accepts that prior to 2000 Dr R did not use gloves when conducting cervical smears. The evidence of Dr B and Dr R satisfied the Tribunal that whilst it is desirable for a doctor to use gloves when taking cervical smears, it is not a disciplinary offence to have failed to have worn gloves at the time in question. To avoid doubt, the Tribunal states that a doctor performing an internal or intimate examination must always wear gloves.

Third Allegation — *"[Dr R] made inappropriate remarks of a sexual nature, or asked inappropriate questions that were sexually orientated, or were sexually suggestive when consulting with patients."*

101. Mr Heron also properly acknowledged that the evidence of Ms HK did not support the third allegation in the charge. Whilst Dr R may have been insensitive to Ms HK's circumstances when examining a boil on her bottom, he clearly did not ask her to undress and bend over in circumstances where she could possibly be seen by persons in the waiting room. Furthermore, Dr R's comments were not of a *"sexual nature"* *"sexually orientated"* or *"sexually suggestive"*. Dr R's comments that she should remove her trousers and bend over whilst undoubtedly insensitive in the circumstances could not be construed as being *"sexual"*.

102. The Tribunal has already explained its concerns about the reliability of Ms JK's evidence. Even though the Tribunal was certain this witness was very honest, there were significant doubts cast about the accuracy of her memory. It is entirely possible Dr R asked Ms JK about details of her sex life as part of his *"whole of patient"* approach to the practise of medicine and that there was nothing sinister in his questions.

103. Similarly, Ms JP stated that whilst she had concerns about some comments and questions Dr R directed to her during consultations, she also acknowledged that she may have mis-interpreted the questions and comments that caused her concern.

104. In the final analysis, the Tribunal was left with sufficient doubt about the evidence in relation to the third allegation in the charge that it concluded the CAC had not established, even on the balance of probabilities, the facts necessary to prove that allegation.

Summary

105. The charge against Dr R must be dismissed. The CAC has not presented sufficient evidence to the Tribunal to prove the charge laid against Dr R to the requisite standard.

Recommendation

106. The Tribunal has no power to make orders against a doctor when disciplinary charges are dismissed. It will be apparent however the Tribunal has significant concerns about Dr R's ability to maintain appropriate boundaries. The Tribunal strongly urges that he always use a chaperone when carrying out any internal or intimate examinations of female patients.

DATED at Wellington this 15th day of October 2004

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal