ORDER PROHIBITING PUBLICATION OF NAMES, ADDRESSES OR IDENTIFYING PARTICULARS OF APPELLANT AND COMPLAINANT

IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

CIV-2009-404-000951

IN THE MATTER OF	of an appeal pursuant to Section 106(2)(a) of the Health Practitioners Competence Assurance Act 2003
BETWEEN	DR G Appellant
AND	DIRECTOR OF PROCEEDINGS Respondent

Hearing: 16 September 2009

Appearances: A H Waalkens QC and A L Credin for the Appellant
G C Hollister-Jones and A Mills for the Respondent

Judgment: 13 October 2009
(Recalled, and Re-issued on 12 November 2009)

JUDGMENT OF DUFFY J

This judgment was delivered by Justice Duffy
on 13 October 2009 at 12.00 pm, pursuant to
r 11.5 of the High Court Rules

Registrar/Deputy Registrar
Date:

Counsel: A H Waalkens QC P O Box 106215 Auckland 1143 for the Appellant

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[1] This is an interim judgment on an appeal against decisions of the Health Practitioners Disciplinary Tribunal finding that the Director of Proceedings has established a charge of professional misconduct against the appellant medical practitioner, Dr G; and imposing penalties for that offence. The professional misconduct was found to have arisen from Dr G engaging in a sexual relationship with one of his female patients, Ms N, who also worked as a health assistant at Dr G's medical practice.

[2] A majority of the Tribunal found that Dr G had engaged in a sexual relationship with Ms N, in circumstances where the sexual relationship developed in part through the doctor/patient relationship and at a time when the doctor/patient relationship subsisted. This was seen to meet the threshold of professional misconduct that warranted a disciplinary sanction. The minority disagreed with this view and found instead that the sexual relationship resulted from the working relationship Dr G and Ms N enjoyed through them both working at the same medical practice. The minority considered that this was a case where an employer had engaged in a sexual relationship with his employee, and then unwisely given medical treatment to that employee.

[3] The penalties imposed on Dr G were:

a) An 18 month suspension from medical practice;

b) The imposition of conditions on practice which required Dr G to undertake the Medical Council's sexual misconduct assessment, to undertake such treatments and conditions as the Medical Council may impose as a result of the assessment; following the suspension period, Dr G was to comply with such conditions as the Medical Council may impose upon him as a result of the sexual misconduct assessment, and Dr G was to meet the costs of the assessments and conditions of 18 months;

c) Dr G was ordered to pay $13,300 costs and disbursements to the Tribunal, and $20,000 costs and disbursements to the Director of Proceedings; and

d) The Tribunal refused to order the non-publication of Dr G's name.

[4] The penalty appeal was originally against the 18 month suspension, the requirement to undergo a sexual misconduct assessment, and the refusal to order non-publication of Dr G's name. During the course of the appeal, it became clear that a sexual misconduct assessment could be ordered before the Tribunal imposed a penalty. My concern was that Dr G has received serious and severe penalties in circumstances where the Tribunal had little evidence on the proclivity of Dr G to engage in prohibited sexual relationships. I suggested to the parties that I might be better informed about factors relevant to penalty if Dr G were to undergo a sexual misconduct assessment before the appeal was completely heard and determined. This approach required the consent of Dr G, as his appeal included a challenge to the Tribunal's order that he undergo a sexual misconduct assessment. His consent was forthcoming. He has agreed to the appeal being adjourned for the purpose of enabling him voluntarily to undergo a sexual misconduct assessment. The Director of Proceedings did not oppose the appeal being adjourned, but sought an interim determination on the issue of whether the Tribunal was correct in finding that there was professional misconduct which warranted a disciplinary sanction. Dr G does not oppose the delivery of an interim judgment on this issue.

Appellate jurisdiction

[5] The right of appeal being exercised in this case is found in s 106(2) of the Health Practitioners Competence Assurance Act 2003. Section 109 provides that the appeal is by way of rehearing. The Supreme Court in *Austin, Nichols & Co Inc v Stichting Lodestar* [2008] 2 NZLR 141 has reiterated the importance of appellants' rights of appeal being properly respected by the appellate court. The judgment stipulates at [5] that when dealing with general rights of appeal, the appellate court has "the responsibility of arriving at its own assessment of the merits of the case". At [16] there is the firm reminder that:

> Those exercising general rights of appeal are entitled to judgment in accordance with the opinion of the appellate court, even where that opinion is an assessment of fact and degree and entails a value judgment.

[6] *Austin Nichols* makes it clear that in respect of general rights of appeal, there is no legal principle that requires deference to be given to the decision-maker at first instance. If the appellate court reaches a different view on the merits and is, therefore, of the opinion the decision under appeal is wrong, the appellate court must act on its own view. At [19], *Austin Nichols* leaves no room for doubt that "wrong" means no more than the appellate court taking a different view on the merits:

> If the appellate court's opinion is different from the conclusion of the tribunal appealed from, then the decision under appeal is wrong in the only sense that matters, even if it was a conclusion on which minds might reasonably differ.

[7] Since *Austin Nichols*, this Court has recognised that previous authorities on appeals from health practitioner tribunals should now be seen in the light of the *Austin Nichols* decision: see *Dr E v Director of Proceedings* (2008) 18 PRNZ 1003 at [22]. There has, however, been a divergence of view on whether *Austin Nichols* is applicable to all aspects of an appellate decision under s 109, or whether in one respect an appellate court should approach the matter as if it were dealing with an appeal from the exercise of a discretion. In *Dr E*, Ronald Young J decided that a decision on whether or not wrongful conduct (in terms of the Act's criteria) justified a finding of professional misconduct was "an exercise of discretion entrusted to the Tribunal" and, therefore, subject to the principles of *May v May* (1982) 1 NZFLR 165 (CA). This view of the decision on what might constitute professional misconduct would confine the appellate court's ability to substitute its view for that of the Tribunal. In *Harman v Director of Proceedings* HC AK CIV 2007-404-3732 12 March 2009, Wild J rejected the view that the Tribunal was exercising a discretion when it came to determining if what had occurred amounted to professional misconduct. At [48] Wild J said:

> The issue for the appellate Court will be: was the Tribunal's finding(s) of professional misconduct wrong?

[8] The view expressed in *Dr E* is inconsistent with *Austin Nichols*, whereas that expressed in *Harman* is in accord with *Austin Nichols*. A decision on whether or not

wrongful conduct, which constitutes negligence, malpractice or bringing discredit on the profession concerned, justifies a finding of professional misconduct requires an assessment of fact and degree, and entails a value judgment. This is the very exercise which was recognised in *Austin Nichols* as requiring an appellate court to form its own judgment. An appellate court may choose to defer to the view of the Tribunal value, but this should only occur when the appellate court considers the Tribunal's decision to be right.

[9] This is not to say that the traditional reluctance of appellate courts to interfere with findings on credibility no longer applies. The statement in *Austin Nichols* at [17] that "there was no basis for caution in differing from the assessment of the tribunal appealed from", since there was "no question of credibility", suggests that a different approach would have been taken had the appeal in *Austin Nichols* involved credibility findings. There is no reason to think that the traditional approach of appellate courts when dealing with credibility findings has been affected by *Austin Nichols*.

[10] In the present appeal, the parties were agreed that the appeal should be approached in accordance with the principles expressed in *Austin Nichols* and in *Harman*. Furthermore, the issues raised in the appeal are unconnected to the Tribunal's findings on credibility and, therefore, the extent to which this Court on appeal might reconsider credibility findings is not in issue.

The Tribunal's decision

[11] Dr G is a registered medical practitioner, whose conduct is subject to the Health Practitioners Competence Assurance Act 2003, as well as the generally accepted ethical requirements of the medical profession. The Medical Council has for many years followed a policy of what it describes as a zero tolerance for medical practitioners engaging in sexual relationships with their patients. The charge laid against Dr G is that he:

> Being a registered medical practitioner, acted in such a way that amounted to professional misconduct.

> In particular: between 22 December 2006 and 26 June 2007 ... had a sexual relationship with your patient Ms N.
>
> The conduct alleged amounts to professional misconduct.

[12] The Tribunal found that Dr G had engaged in a sexual relationship with Ms N from 22 December 2006 to at least 29 May 2007. Dr G does not challenge this finding. The Tribunal also found that Dr G had engaged in this sexual relationship at a time when Ms N was his patient. This finding of the Tribunal is challenged.

[13] Ms N first saw Dr G as a patient in 2004 when she went to him for an immigration health check. She became the health assistant at his medical practice on 3 October 2006. Their sexual relationship commenced on 22 December 2006 when the first act of sexual intercourse occurred. The Tribunal found that Ms N did not consult Dr G again as a patient until April 2007. By then, she had been his employee since 3 October 2006, and their sexual relationship had been active since 22 December 2006.

[14] The Tribunal found that in April 2007, Dr G provided Ms N with the following medical services:

a) On 18 April 2007, following a consultation over vaginal itch, Dr G ordered a mid-stream urine test; he signed the laboratory test form, and later, on 3 May 2007, he reviewed the test results, which were returned as normal;

b) On 8 May 2007, he administered a contraceptive injection (depo provera), which was not recorded in Ms N's clinical notes, and told Ms N that the injection would enlarge her thighs, which he would prefer; and

c) On 9 May 2007, he took a cervical smear test, which he reviewed as normal on 12 May 2007 and recorded this in Ms N's clinical notes.

Throughout 2004 to June 2007, Ms N was recorded on the "books" of Dr G's practice, but not as a capitated patient.

[15] On the strength of the above facts and findings, the majority concluded that there was a continuous doctor/patient relationship from September 2004 until 27 June 2007, when the relationship in all respects broke down.

[16] The reasons the majority gave for finding there was an ongoing doctor/patient relationship from September 2004 to June 2007 were:

a) From the time of the 2004 consultation, Ms N regarded Dr G as her doctor.

b) In May 2005, Ms N took her relative, who was visiting from overseas, and in need of a doctor, to Dr G, on the basis he was Ms N's doctor.

c) In 2007, during their employment relationship, Dr G provided medical services to Ms N at her request. This meant he "affirmed that she was his patient".

d) Once their sexual relationship had commenced, Dr G did not refer Ms N elsewhere.

e) Towards the end of September 2006, Dr G told someone from the Primary Health Care Organisation that one of his patients was going to be his health assistant.

f) The employment relationship of Ms N and Dr G did not end the doctor/patient relationship but, instead, was co-terminus with it.

g) Dr G had conceded that Ms N was a patient, but not a regular patient.

h) The fact that capitation was not claimed for Ms N did not affect her status as a patient of Dr G.

[17] The majority's conclusion that the doctor/patient relationship between Dr G and Ms N lasted from September 2004 to June 2007 meant that their sexual relationship fell squarely within this timeframe and could be seen to have arisen

from the doctor/patient relationship. Consequently, the majority had no difficulty in concluding that Dr G had commenced a sexual relationship with someone who was his current patient. The majority then went on to conclude that this conduct amounted to both misconduct and to the bringing of discredit to the medical profession. The conduct was also found to cross the threshold for attracting disciplinary action.

[18] The minority took a different view of the length of the doctor/patient relationship. The minority found that at the time the sexual relationship began, the doctor/patient relationship of 2004 was over. The sexual relationship was considered to have arisen not from the earlier doctor/patient relationship but from the more recent employment relationship. Dr G was seen as having unwisely provided medical services in 2007 to someone who by then was the doctor's employee and lover.

What did occur between Dr G and Ms N?

[19] The first step in assessing if there has been professional misconduct is to determine if the Tribunal was correct when it found that the sexual relationship arose from a current relationship of doctor and patient. This finding is a touchstone of the majority's decision.

[20] Determining if a current doctor/patient relationship exists requires a case specific analysis. This will include an evidentiary enquiry into the existence, nature and duration of such a relationship: see *Z v The Director of Proceedings* HC WN CIV-2007-485-2631 3 October 2008, Dobson J. At [37] Dobson J recognised the relevance of the Tribunal members' technical expertise, as well as their educated common sense to answering this question. At [38] the Judge concluded that the Tribunal would be entitled to apply its own reasonable and objective standards and criteria to reach a determination:

> The Tribunal would be entitled to apply its own reasonable, objective standards as to the extent of professional contact required between any patient and a doctor before an ongoing patient/general practitioner relationship is deemed to exist. Practitioner members of the Tribunal would

> be entitled to apply their own objectively measurable criteria to that enquiry …

[21] In Dr G's case, the majority has not identified in their decision the standards and criteria they applied to reach the conclusion that the doctor/patient relationship was ongoing from 2004. They refer to the facts they relied upon to reach their conclusion, but what it is about those facts that caused them to reach the conclusion they did is unsaid.

[22] The majority took account of Ms N's evidence that she regarded Dr G as her doctor from 2004 onwards, as well as the fact that in 2005, she brought her relative to him to receive medical services, because she saw him as her doctor. But they did not assess the reasonableness of Ms N's view. Whilst a patient's subjective view of who is her current doctor will be relevant, I consider that an objective analysis of the reasonableness of this view is required before it can be relied upon by the Tribunal. If a patient has seen the same doctor more than half a dozen times over the same number of years, the frequency of the contact may be obvious enough to indicate an ongoing relationship to most persons. But it will be a matter of degree as to whether or not infrequent contact can still indicate an ongoing relationship, as opposed to a relationship that ends and then starts anew when further contact occurs. The duration of doctor/patient relationships is usually indeterminate. The medical profession must have some indicia by which doctors determine when a patient has ceased to be a current patient. In a case like this one where there was only one medical visit in 2004 and then a gap until 2007, the basis for accepting Ms N's view that Dr G was her current doctor from 2004 onwards needed to be further specified.

[23] The majority took account of Dr G's concession that Ms N was a patient but not a regular patient, as well as his statement to the employee of the Primary Health Care Organisation that he was going to employ one of his patients as his health assistant. Once again, the majority do not say why this evidence influenced their decision. Naturally, the doctor's understanding of the currency of the doctor/patient relationship is relevant. But just as with the patient's subjective view, before any effective reliance can be placed on the doctor's view, the Tribunal needs to assess and evaluate how this view fits with the facts. It is not enough for the Tribunal to simply take the doctor's view and apply it as part of its decision-making.

[24] When Dr G's statements on the currency of the doctor/patient relationship are assessed, they show themselves to be less helpful than the majority seemed to think. The concession Dr G made that Ms N was his patient drew a distinction between a patient and a regular patient. He did not consider Ms N to be a regular patient. No one explored with Dr G what he actually meant when he described Ms N as not a "regular patient". The description could be applied to someone whose visits are so infrequent that he or she could also be described as a former patient who on each visit renews the doctor/patient relationship, only for it to lapse again until the next renewal.

[25] Much the same can be said of Dr G's statement to the employee of the Primary Health Care Organisation that he was employing a patient as his health assistant. A comment made in this context, when the precise description of the relationship's currency is not in issue, is of little assistance. It could be seen as an admission that Dr G was to employ someone who undoubtedly was a current patient as his health assistant. But, equally, the statement could simply be a loose and imprecise description of the status of the relationship with Ms N. At the time the statement was made, the currency of the doctor/patient relationship with Ms N was not in issue. There was no need for Dr G to be exact in the way in which he described the relationship. Adjectival qualifications like irregular, current or former, which may have thrown more light on the status of the relationship, were unnecessary in the context of the discussion with the Primary Health Care Organisation's employee. Consequently, the statement made in this context has little relevance.

[26] For this Court to reach a conclusion on whether the majority was right to take account of what Ms N and Dr G said about the nature and duration of their doctor/patient relationship, something more was required than what the majority has specified in its decision.

[27] The majority found that because Dr G had provided medical services to Ms N at her request in 2007 during their employment relationship, this meant that he had "affirmed that she was his patient". No reason is given for this conclusion. Why should the provision of medical services some three years after no more than an

immigration health check constitute an affirmation of an ongoing doctor/patient relationship from the time of the health check? Whatever standards and criteria caused the majority to reach this conclusion, they are unspecified in the decision.

[28] On the face of it, another equally probable and plausible view of what has taken place is that a one-off medical service was provided in September 2004; then a second discrete set of medical services were provided in April and May 2007.

[29] The finding that the provision of medical services in April 2007 "affirmed" that Ms N was Dr G's patient does not speak for itself. Something more is required to explain what is meant by "affirmed" in this context and why this "affirming" could have the effect of reviving a defunct relationship to the point where it could then be viewed as having never ended.

[30] The majority found that the employment relationship of Ms N and Dr G did not end the doctor/patient relationship, but that the two relationships ran parallel with each other. No reasons are given for this finding. I consider the finding does not speak for itself and reasons for it should have been provided. Moreover, the finding presupposes that the doctor/patient relationship was ongoing from 2004 until 2007, at which time it was overlain with the employment relationship. This does not help to explain why the doctor/patient relationship could be seen to be ongoing from 2004.

[31] The majority's finding that once the sexual relationship had commenced, Dr G did not refer Ms N elsewhere has no relevance to a decision on the currency of the doctor/patient relationship. Whilst Dr G's failure to refer Ms N to another doctor once their sexual relationship had commenced would be a relevant factor in determining whether or not any professional misconduct he was found to have committed should attract a disciplinary sanction, I have difficulty seeing how the finding can assist in determining whether or not the doctor/patient relationship was ongoing from 2004.

[32] The majority's finding that the fact that capitation was not claimed for Ms N did not affect her status as a patient of Dr G seems to me to be a neutral factor which

supports neither one view nor the other of the currency of their doctor/patient relationship.

[33] The circumstances of this case do not obviously fit with an ongoing patient/doctor relationship. First, until 2007, Dr G provided no medical services to Ms N after the immigration health check in 2004. The purpose of an immigration health check is to inform the Immigration Service of a potential immigrant's health. At the time such a check is carried out, the immigration status of the person being checked is unresolved; the person may or may not be able to remain in the country. The provision of this type of medical service does not of itself indicate the commencement of the usual doctor/patient relationship.

[34] Secondly, interposed between the medical service in 2004 and the medical services in 2007 was a medical service from a separate medical practitioner. In mid 2006, Ms N attended another doctor's practice, in Papatoetoe, for the purpose of obtaining blood tests, as part of her application for a health assistant's position with the Auckland District Health Board. The Board has a policy of requiring prospective nursing employees to be tested for HIV, Hepatitis B and other illnesses. Ms N said that her partner had arranged for her to see a doctor close to their address. The fact that it was only to have blood tests taken, rather than a full consultation for a particular malady, is not of itself indicative of the nature of this doctor/patient relationship. As at 2006, the only service Dr G had provided was the immigration health check. Although this might have been more extensive than a request for blood tests, the services both Dr G and the doctor at the other practice provided were of a similar type. In both cases, Ms N sought the services because other persons had required her to do so, and the services were sought in circumstances where she did not perceive of herself as being ill and requiring medical treatment. I consider that the consultation with another doctor in 2006 could be sufficient to sever the doctor/patient relationship that arose from the 2004 health check. The majority, however, did not refer to this consultation in their decision, and so nothing was said about its impact, if any, on their analysis of the ongoing nature of the doctor/patient relationship.

[35] The doctor/patient relationship here is quite different from those cases where there have been frequent consultations over the years that were uninterrupted by visits to other medical practices. Here, the doctor/patient relationship was infrequent and interrupted by the use of another doctor's services. Because the currency of the relationship is not obvious, I consider that once it was contested, any decision on the relationship's currency demanded expression of the criteria being applied and the rationale for relying on the evidence that forms part of the majority's decision. As it stands, the majority's decision falls short of Dobson J's test in *Z*, and the views I have reached on what was required.

[36] The importance of reasons to support findings made in judicial decisions is dealt with in *Lewis v Wilson & Horton* [2000] 3 NZLR 546. At [79] the Court of Appeal said that, "without reasons, it may not be possible to understand why judicial authority has been used in a particular way". Much the same has happened here. In this case, the majority has identified the evidence it relied on to find the doctor/patient relationship was ongoing from 2004, but the rationale for that reliance is not given, nor is it apparent. When conclusionary statements are self-evident, no more is required. But when they are not, their rationale must be expressed. This is the only way in which their reasonableness can be objectively measured. This is more so when the circumstances of the case do not obviously fit with the view that has been reached.

[37] Moreover, in this case, the insufficiency of the majority's decision on the currency of the doctor/patient relationship is emphasised by the minority decision, which illustrates that there is another way of looking at the relationship's currency.

[38] The minority concluded that there was insufficient evidence of continuity in a doctor/patient relationship. The immigration medical check in September 2004 was seen by the minority as limited to obtaining information for the Immigration Service, with no obligation on Dr G to provide treatment. Ms N taking her relative to see Dr G in May 2005 was seen simply as a step of taking a family member to a doctor, who Ms N happened to know, with this event being put no higher than that. This meant that, in the minority's view, since the sexual relationship developed two years after the first provision of medical service, with no medical treatment given in the

meantime, the sexual relationship commenced at a time when there was no doctor/patient relationship.

[39] Like the majority, the minority did not express the standards and objectives he applied to arrive at his view. This makes it hard to assess the minority's view. However, the presence of both the majority and the minority view confirms that there is more than one way of viewing the currency of the doctor/patient relationship in this case.

[40] The majority's failure to express a proper basis for its finding on the duration of the doctor/patient relationship is an error that makes their decision on this issue unreliable and wrong. Moreover, because this decision was the touchstone for them going on to find that Dr G was guilty of professional misconduct, their decision on that issue is similarly affected. It then becomes necessary to see if there is any evidence that would support the majority's decision.

[41] In this case, the Director of Proceedings produced no evidence of the standards and criteria generally accepted in the medical profession for determining when there is a current doctor/patient relationship. Here, there has been the provision of a discrete medical service in September 2004 in the form of the immigration health check; and then the provision of a separate group of medical services between April 2007 and May 2007. Absent objective criteria indicating that such circumstances can amount to an ongoing doctor/patient relationship, I consider it equally, if not more, probable that the break in time between the first medical service and the second group of medical services is sufficient to preclude there being an ongoing doctor/patient relationship from September 2004 until May 2007.

[42] Apart from the contested evidence on which the Tribunal reached a view, in order to make its findings, it heard other contested evidence from Ms N and Dr G respectively, which it left undetermined. I do not propose to make any use of this other evidence when forming my view on what has occurred. I consider that an appellate court is less well placed to form a view on such evidence than is the Tribunal, which had the benefit of seeing and hearing the delivery of this evidence.

[43] The burden of proof in proceedings before the Tribunal is the civil standard of balance of probabilities. Since I consider it equally, if not more, probable that the doctor/patient relationship was not ongoing from 2004, it follows that the Director of Proceedings cannot establish that there has been an ongoing doctor/patient relationship from 2004.

[44] The view I have taken of the duration of the doctor/patient relationship impacts on the majority's finding of professional misconduct. It means that Dr G cannot be seen as having engaged in a sexual relationship with someone who was a current patient. He must instead be seen as a doctor who has engaged in a sexual relationship with a former patient and who, during the course of the sexual relationship, has begun providing new medical services to Ms N, who was then his lover. It is then a question of whether this conduct amounts to professional misconduct in terms of the charge laid against him.

[45] The charge covers the period between 22 December 2006 and 26 June 2007. Since the last sexual contact was on 29 May 2007, and the first medical service was provided in April 2007, it is clear that during April and May 2007, Dr G was both in a sexual relationship and a doctor/patient relationship with Ms N. As the charge is framed, it is not dependent on the doctor/patient relationship preceding the sexual relationship. The charge does not allege that Dr G commenced a sexual relationship with someone who was already his patient. It is enough on the language of the charge if the two relationships were occurring at the same time, which for the limited period of time I have identified they were. To that extent, Dr G's conduct comes within the particulars described in the charge.

[46] Does it amount to professional misconduct to provide medical services to someone with whom you have already commenced a sexual relationship? The majority considered that once the sexual relationship began, Dr G should have referred Ms N elsewhere, although this was said in the context of their view of the facts. Certainly a referral to another doctor would have been a wise course of action. The question is whether it amounts to professional misconduct not to do so.

[47] In the course of the hearing, counsel for Dr G was critical of the prosecution not producing evidence from a medical ethicist or some similarly qualified expert on appropriate professional conduct. Apart from the guidelines from the Medical Council on doctors not entering into sexual relationships with their patients, there was no evidence before the Tribunal. This was unfortunate. It means that there is little to use as a measure against Dr G's conduct.

[48] The Tribunal is a specialist body and includes medical practitioners. Members of the Tribunal with specialist knowledge are entitled to apply their skill and specialist knowledge to the cases before them. But this should not occur during the decision-making process behind closed doors in circumstances where the defendant professional has no idea of the standards and criteria against which his or her conduct is being measured. In order for a defendant professional to have a fair opportunity to answer adverse views of his or her conduct, the ethical yardstick against which the conduct is being measured needs to be known.

[49] The relevant Medical Council guideline concentrates on sexual relationships arising from the doctor/patient relationship. The guideline makes it clear that there is zero tolerance for a sexual relationship arising from an existing doctor/patient relationship. This is not so when the sexual relationship arises from a former doctor/patient relationship, though in that regard, the guideline is clear to point out the difficulties in such relationships. It states because each doctor/patient relationship is individual and because everyone reacts differently to circumstances, it is difficult to have clear rules on when it is or is not acceptable for a doctor to have a relationship with a former patient. It is noted that a former patient can be harmed by having a relationship with his or her doctor. But whether or not this is so is linked to the intensity of the doctor/patient relationship. Here the length of the professional relationship, frequency of conduct, and type of care provided are all relevant. The guideline notes that where a former doctor/patient relationship was "very minor or temporary", a total ban on any subsequent relationship is unfair and unrealistic. An example given is where a doctor treats a minor condition, such as a sprained ankle, in a one-off situation. Where a sexual relationship between a former doctor and patient is seen as never acceptable is where the doctor/patient relationship involved psychotherapy, or long-term counselling, or emotional support; the patient has had or

has a condition or impairment likely to confuse his or her judgment or thinking about what he or she may want to do; the patient has been sexually abused in the past; or the doctor/patient relationship has ended for the sole purpose of initiating a sexual relationship.

[50] The guideline's policy of zero tolerance for sexual relationships with persons who are already patients is no more than a general principle, every case must be judged on its facts: see *Director of Proceedings v Medical Practitioners Disciplinary Tribunal & Wiles* [2003] NZAR 250. At [50] Ellen France J said:

> There can be no principle that every case of a sexual relationship between a doctor and patient must result in a disciplinary finding, each case must be judged on its facts.

[51] Also relevant in this respect is the comment by Oppal J in *Patterson v College of Physicians & Surgeons of BC* [1988] 5 WWR 398 at 401, cited by Ellen France J in *Wiles* at [50]:

> Sexual relations between a doctor and a patient will not in all circumstances constitute infamous conduct. Rather the surrounding circumstances must be examined.

[52] Dr G engaged in a sexual relationship with a former patient. The original medical service is analogous with the treatment of a minor condition referred to in the guidelines. When the circumstances thus far are considered against the guidelines from the Medical Council, I can see nothing to suggest that it was improper for Dr G, in terms of the guidelines, to commence a sexual relationship with Ms N in December 2006. The problem lies with the subsequent provision of medical services to Ms N in April 2007 and May 2007 when she was also his lover.

[53] There was no evidence before the Tribunal, and therefore before this Court, of the circumstances in which it is considered appropriate or inappropriate for a medical practitioner to provide medical services to someone who already was his lover, particularly when that person has been a former patient. The only available guidance is from what can be gleaned from the Medical Council guidelines relating to doctors entering into sexual relationships with patients.

[54] The first step is to identify the nature of the medical services provided. The Tribunal found that Dr G had ordered a mid-stream urine test in April 2007, and reviewed the results of that test in May 2007; administered a contraceptive injection in May 2007, and later, in May 2007, he took a cervical smear test and then reviewed the results of that test. Before considering the appropriateness of him providing those services, it is necessary to look further at one of them.

[55] Counsel for the Director at the appeal hearing accepted that to allege Dr G had injected Ms N with a contraceptive for the purpose of contraception, and to enhance the size of her thighs in his eyes, was a serious allegation that had not been put to Dr G in cross-examination. Certainly, Dr G would have been aware of Ms N's evidence and, in his own evidence in chief, he had denied giving the injection. But an allegation of this nature should have been specifically put to the doctor. This was especially so, given that there was no record in Ms N's medical notes of her having received the injection. Nor was there any other extrinsic evidence to prove the injection had been given. There was nothing more than oral contested evidence from Ms N and from Dr G to prove this event had occurred.

[56] Before the Tribunal, the Director submitted that it was open to the Tribunal to find that the contraceptive injection had been given, based on a general view that Ms N was a more credible witness than Dr G. However, during the appeal hearing when counsel for the Director was asked how such a serious allegation could be sustained without being the subject of direct cross-examination, the concession was very properly and responsibly made that in such circumstances, the allegation could not be sustained. In this regard, counsel for the Director properly discharged the ethical obligations required by his own profession. The importance of cross-examination and the consequences of failing to do so is spelled out in Glissan's *Cross-examination Practice and Procedure* at 95, citing Lord Halsbury's speech in *Brown v Dunne* (1893) 6 r.67:

> The principle is simple. It is elementary and standard practice to put to each opposing witness so much of one's own case (or defence) as concerns that witness, so as to give him fair warning and an opportunity of explaining the contradiction and defending his own character. It is both unfair and improper to let a witness' evidence go unchallenged in cross-examination and later argue that he should not be believed. The rule finds its clearest exposition in *Browne v Dunne* (1893) 6 r 67 in the speech of Lord Halsbury.

[57] Before the Tribunal, Dr G's denial of administering the contraceptive injection went unchallenged. Counsel for the Director accepts it should have been challenged, since it was the Director's case that the denial should be disbelieved. In such circumstances, I consider it would be both unfair and improper to take the evidence on the administration of the contraceptive injection into account as one of the medical services the doctor provided to Ms N.

[58] This leaves only the medical services of ordering of and reviewing of the mid-stream urine test, and the taking of and then reviewing of the cervical smear test. There was a reference in the evidence to Dr G writing a medical certificate for Ms N, but since the Tribunal has not listed that as one of the services it found Dr G to have provided, I do not propose to consider that any further.

Has professional misconduct occurred?

[59] The Medical Council's guidelines make it clear that when a doctor commences a sexual relationship with a former patient, she or he should be referred to another doctor. Implicit in that guideline is the indication that between the lovers, there should be no resumption of the doctor/patient relationship. But I have nothing to inform me of the appropriateness of a doctor treating his wife, de facto partner or girlfriend. Particularly, if the treatment involved is the ordering or taking of routine tests that are read and diagnosed by another practitioner at a diagnostic laboratory. At some point the circumstances of a former patient who is in a sexual relationship with a doctor may cross over into the category of a wife, de facto partner or girlfriend who during the course of the relationship is treated by the doctor.

[60] I have not found the Medical Council's guidelines on sexual relationships with former patients helpful in determining the outcome of this case. Those guidelines seem to me to be more relevant to circumstances where the former doctor/patient relationship has been stronger and more closely connected in time with the commencement of a sexual relationship than is the case here. For example, in *Wiles*, the first act of sexual intercourse was found to have occurred within one to three months of the ending of the doctor/patient relationship, which had been of long duration.

[61] In this case, the original doctor/patient relationship is remote from the commencement of the sexual relationship. The medical services that were provided after the sexual relationship had commenced were minor and not of a type where there would be any patient dependency on the doctor, with the consequential patient vulnerability that can entail. The mid-stream urine tests and cervical smear tests, which Dr G carried out, are standard routine medical tests. Their results would have been diagnosed at the laboratory to which they were sent for reading. The intervention of a third party to carry out the diagnosis meant there was no risk of the doctor losing his objectivity owing to the sexual relationship with Ms N. Nor do I consider the cervical smear test to be invasive in the way the Director suggested. Ms N is a health assistant and someone who at the time of the test being taken had been in a consensual sexually intimate relationship with Dr G for some three months. It is difficult to see how someone in those circumstances could reasonably find the steps the doctor would need to take to obtain a cervical smear invasive.

[62] In many ways, the medical services Dr G provided could be seen as analogous to a doctor providing such services to his wife, de facto partner or girlfriend. There is no evidence to inform me on whether it is unacceptable for a doctor to take standard routine tests such as a cervical smear test or a mid-stream urine test from his wife, his de facto partner or his girlfriend. Furthermore, should the conduct be looked at differently simply because the doctor is married and having an extra-marital relationship with his employee? Community standards and what might bring a profession into disrespect are different today from 50 years ago. Whatever personal views might be held about the appropriateness of Dr G's conduct, whether it could amount to professional misconduct inviting disciplinary action, requires objective proof of standards of conduct for members of the medical profession as a measure against which to view his conduct.

[63] The difficulty with the case is that the view I have formed of the facts differs from that of the Tribunal. There is no evidence that would inform a Court on the acceptability or otherwise of a doctor providing the type of services to his lover that Dr G provided. No publications setting out the general standards of conduct the Medical Council expects of doctors, in terms of providing services to family members or persons intimately associated with a doctor, were drawn to my attention.

[64] Given the way in which the Director presented his case to the Tribunal, it is understandable that there is a gap in the evidence. However, if the parties have an opportunity to address the Court further, the Court can be referred to publications without the need for them to be proved. The Court can also, after hearing from the parties, refer the case back to the Tribunal for reconsideration, if this appears to be necessary.

[65] At the end of the hearing, I had indicated to the parties that an interim decision on the proof of the charge would be delivered. As it has turned out, I have found that the facts do not support the factual conclusions the majority has reached. Dr G has established ground 2.1(d) of the amended notice of appeal: that is, that the majority was wrong in finding that the sexual relationship arose out of a doctor/patient relationship. As matters stand, there remains a live issue as to whether or not the conduct, which I have found attributable to Dr G (being the conduct between April-May 2007), is sufficient to meet the threshold for upholding the disciplinary charge: that is, ground 2.1(f) of the amended notice of appeal. I have found (at [43]-[44]) that Dr G's conduct technically falls within the scope of the charge, because for a period of time he provided medical services to someone with whom he was also in a sexual relationship. This finding makes it necessary to consider whether or not the conduct, as I have found it to be, constitutes professional misconduct that attracts a disciplinary sanction.

[66] I propose to provide the parties with an opportunity to file further submissions. The submissions should deal with whether or not Dr G's conduct as I have found it to be constitutes professional misconduct under s 100. The submissions should also cover whether the Court should determine the matter or refer it back to the Tribunal for reconsideration.

[67] As regards the penalty the tribunal imposed, because I have found the factual basis for its reasoning to be wrong, even if, for different reasons, the charge is found to be proven, the penalty will need to be considered afresh. The parties should also address this matter.

[68] Dr G is to file and serve submissions within 21 days of the delivery of this judgment, or such further time as the Court directs, should he be unable to provide submissions within that timeframe. The Director is to file and serve submissions within 21 days of the receipt of Dr G's submissions. Dr G has 10 days, following receipt of the Director's submissions, to file and serve any submissions in reply. Leave is reserved to both parties to seek further time, should there be any difficulty in meeting the Court's timetable directions.

Duffy J