Professional discipline supports pro-therapeutic cultures

In this article Director of Health and Disability Proceedings, Aaron Martin, reviews recent disciplinary decisions and suggests professional discipline supports pro-therapeutic cultures.

Cancellation of a doctor's registration is a sanction of last resort. The High Court has made this principle clear over the years, and it is reflected in decisions of the Health Practitioners Disciplinary Tribunal. Twelve different doctors have had their registration cancelled since 2004 when the current disciplinary legislation came into force. In half of those cases, the professional misconduct in question has been of a sexual nature.

One doctor had his registration cancelled in 2013, and another has been struck off this year.[1] Failure to observe appropriate sexual boundaries was the issue in both of those cases. While there can hardly be said to be an epidemic of this behaviour, these are serious cases, and even one a year is one too many. Looking at it another way, were it not for the two sexual boundaries cases, there would not have been a doctor whose registration the Tribunal has found it necessary to cancel in over three years.

New Zealand is not alone in this. International literature indicates that in both Australia and New Zealand a doctor is 22 times more likely to be suspended or struck off if found to have had a sexual relationship with a patient than for any other type of misconduct[2].

Vulnerability, power, and trust

In November 2013 the Tribunal cancelled the registration of a psychiatrist charged with entering into a sexual relationship with a vulnerable patient, continuing that relationship after the clinical relationship had ended, and interfering with legal process by attempting improperly to influence and procure the withdrawal of HDC complaints. Abuse of power, patient vulnerability, and betrayal of the trust placed in the medical practitioner by the public and by the profession itself is often part of the narrative in cases like this. These themes provide the rationale for the strict prohibition on sexual contact in the doctor-patient relationship. The relevant obligations on doctors are often summarised by reference to the Medical Council's 'zero tolerance' policy on sexual relationships with patients: *Sexual Boundaries in the Doctor-Patient Relationship, guidelines for doctors* (MCNZ, October 2009) at 2.

In last year's case, the psychiatrist's patient had longstanding anxiety and depression, for which she had a significant past history of treatment, including counselling and medication. Key developmental themes related to her insecure attachment to both her mother and father and her involvement in trying to help her parents' dysfunctional relationship. Her fear of separation and abandonment were also suggested as contributing to her difficulties in relationships, as were her attraction to unavailable men, her sensitivity to rejection, and her problems with intimacy.

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[1] The practitioner has appealed the outcome in that case, not discussed here.

[2] Elkin, Katie et al, 'Removal of Doctors from Practice for Professional Misconduct in Australia and New Zealand' (2012) 10(1136) *BMJ Quality & Safety*

The psychiatrist actively took advantage of his patient's vulnerability and dependence on him, abusing his position of trust and power to begin a sexual relationship with her. (The Tribunal's decision is available at www.hpdt.org.nz/Default.aspx?tabid=379)

'Culture' matters

The Health and Disability Commissioner has been active in a sector-wide conversation about the importance of culture in a consumer-centred system. The 'way we do things around here' matters - whether it be in a hospital setting, rest home care, or a GP practice. Just as this is true of organisational cultures, it is also true of the culture of the profession overall. Culture is an important factor influencing the care patients experience.

When the Commissioner refers a doctor to the Director of Proceedings and a disciplinary charge is laid, three of the five people who sit on the Tribunal panel to hear the charge are themselves doctors. In this way hearings are a peer process. While sexual boundaries cases may not call on clinical expertise and experience to the same extent as a negligence case might, the presence of doctors on the panel does send a strong message to all practitioners about what is, and what is not, acceptable behaviour. An additional level of 'peer' process is provided by the guidance of expert witnesses - the doctor or doctors with standing in the profession who assist the Tribunal identify and apply relevant standards. Again, this ensures that in this country there is a 'peer to peer' dimension to disciplinary findings.

There are of course cases where disciplinary sanctions falling short of cancellation are imposed for less serious professional misconduct. Some of those cases also involve sexual boundaries in the doctor/patient relationship. Penalties imposed can include suspension from practice for a period of up to three years, a fine, or conditions on practise, for example requiring a chaperone, supervision, or training in ethics.

A case decided in October last year provides an example of a different kind of breach of appropriate sexual boundaries, and was a situation where the Tribunal decided that an 18 month suspension from practice as well as conditions on return to practice was the appropriate disciplinary response. That case concerned an inappropriate examination and the retrospective alteration of clinical notes by a general practitioner. The patient presented at an after hours clinic complaining of burning during urination and generalised aching all over her body. She had a history of urinary tract infections. The doctor requested that she lay down on the examination table. He did not offer her a chaperone, ask further questions, or explain the examination he was about to perform. During the examination the doctor asked the patient to remove her pants and underwear, pressed and massaged her legs and around her groin area, and touched her clitoris. He then asked her to remove her upper clothing. The patient was not offered privacy to undress or a sheet or blanket with which to cover herself.

The Tribunal found the examination was wholly unjustified in a young woman who presented with the symptoms that this patient is described as having given. (The Tribunal's decision is available at http://www.hpdt.org.nz/Default.aspx?Tabid=384)

It is often said in organisational contexts that managers get the behaviour they tolerate. No doubt this is also true of other cohesive cultures such as professions. Just as the Health and

Disability Commissioner encourages individual practitioners to speak up on the ward or in theatre when they see something going wrong, so too does the Disciplinary Tribunal voice the collective concerns of all doctors when it imposes sanctions for sexual misconduct.

Were it not for the robust disciplinary response taken by the profession when serious cases like these come to light, misconduct by a very small number of practitioners could potentially impact adversely on the confidence consumers have in profession as a whole.

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