Natural Therapist and Iridologist, Mrs C

A Report by the

Deputy Health and Disability Commissioner

(Case 10HDC00970)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In February 2008, Mrs A consulted Iridologist and Natural Health Practitioner Mrs C about a lesion on her head.

2. Over the following 18 months Mrs C provided treatment, which included cleaning the lesion, discussion around oral remedies, and applying topical remedies. No other health practitioner saw the lesion during this time.

3. Over this period, the lesion grew and was frequently infected. By the time Mrs A sought hospital treatment, the lesion was 10 x 11cm and some underlying bones were damaged. Mrs A was diagnosed with cancer and underwent major surgery. Sadly, she died in 2010.

Decision summary

4. Mrs C did not inform Mrs A of her opinions about her condition, and misled Mrs A about her qualifications. Mrs C therefore breached Rights 6(1), 6(1)(a)[1] and 7(1)[2] of the Code.

5. Mrs C did not adequately communicate and document that Mrs A's situation was outside her expertise. She did not document her suggestion that Mrs A seek further advice. Mrs C acted unethically in failing to take appropriate steps when she had reached the limits of her expertise, and in forming an inappropriate relationship with Mrs A. Mrs C therefore breached Right 4(2)[3] of the Code.

6. Mrs C did not minimise the potential harm to Mrs A, and therefore breached Right 4(4) of the Code.

7. By discouraging Mrs A from obtaining further treatment Mrs C failed to ensure co-operation among providers to ensure quality and continuity of services, and so breached Right 4(5) of the Code.

8. Mrs C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

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[1] Right 6: Right to be Fully Informed
(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — (a) an explanation of his or her condition.

[2] Right 7: Right to Make an Informed Choice and Give Informed Consent
(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

[3] Right 4: Right to Services of an Appropriate Standard
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Complaint and investigation

9. On 16 August 2010, the Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs A, by Mrs C. This was supported by a letter written to HDC by Mrs A shortly before her death. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by Mrs C in 2008 and 2009.*
- *The adequacy of information provided to Mrs A by Mrs C in 2008 and 2009.*

10. An investigation was commenced on 19 January 2011. This report is the opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Mrs A	Consumer (deceased)
Ms B	Complainant
Mrs C	Provider/Natural Therapist and Iridologist

12. Information was reviewed from:

Mr A	Mrs A's husband
Ms D	Friend of Mrs A
Mrs E	Mrs A's hairdresser
Ms F	Mrs C's daughter
Ms G	Mrs C's daughter
Dr H	General practitioner

13. Independent expert advice was obtained from ethicist Professor Grant Gillett, and is attached as **Appendix A**.

Information gathered during investigation

Background

14. Mrs A first noticed a lump on her head in about 1970. She recalled that at the time, her general practitioner (GP) said it was a harmless sebaceous cyst. Twenty years later, it had grown to the size of a large pea, and Mrs A's recollection was that her GP at this point suggested it should be removed. Mrs A explained that her circumstances at the time made this difficult.

15. In 2001, Mrs A was experiencing sinus and middle ear problems. After consulting her GP, Dr H, and two ENT[4] specialists, her symptoms continued and she sought

[4] Ear, Nose and Throat.

alternative help. Mrs C was recommended to her by a family friend. Both Mrs A and her daughter, Ms B, consulted Mrs C, in her capacity as an iridologist. They travelled together to Mrs C's clinic in another town[5] approximately every three months for several years. At these sessions, Mrs A complained of middle ear problems and, later, vertigo. Mrs C provided advice and gave them charts relating to iridology to take home. Ms B recalled Mrs C being friendly and welcoming, and told HDC that the sessions were quite social occasions.

16. Initially Mrs A's husband, Mr A, did not attend the consultations as he remained at the family home, but later he would sometimes be at the house they rented in the town where Mrs C had her clinic (in order to reduce travel to treatments) when Mrs C visited to treat the lesion.

2007

17. During 2007, Mrs A experienced dizziness, with pain in her ears, maxilla[6] and forehead. When her GP, Dr H, offered her a sinus X-ray on 19 April 2007, she declined. Dr H commented that:

> "[Mrs A] was not a frequent [attendee] at my Surgery. Prior to developing her carcinoma of the scalp I had not seen her since the 19th of April 2007. At no stage did she present to me with any lesions on her scalp or skin issues.
>
> In general [Mrs A] was very cautious about traditional medical services and did tend to the alternative practices hence her reliance on advice from alternative practitioners."

Mrs C's training and practice

18. Mrs C told HDC that she moved to New Zealand when she was 20 years old. She said: "… I did my Iridology training through [an iridology training course] and seminars over several years 30 yrs ago …"

19. Mrs C stated that she has not attended any courses in the past 20 years, as most are run in a main centre, which is difficult for her to get to. She said she was unable to provide any certificates or proof of her qualifications because they were destroyed in a flood.

20. Mrs C advised that she is a natural therapist and iridologist, and that this generally involves looking into her patients' eyes and providing advice regarding the person's lifestyle or diet. Mrs C stated that her advice may include referrals to see a doctor, specialist or herbalist.

21. Mrs C does not belong to a professional body, but sought assistance in responding to HDC from an officer of a natural health practitioners society. Mrs C said she had trained in iridology and natural health with a natural health product company, but the manager of the company was unable to provide details of any training.

[5] Mrs C's clinic has two signs on the exterior, one reading "[Mrs C], Natural Health Consultant" and the other, "[Mrs C], Iridologist, Health Consultant".
[6] Major bone of the upper jaw.

22. Ms B advised HDC that Mrs C told her that she had trained as a nurse years ago and kept up to date by reading literature, such as medical journals. Mrs A stated: "[Mrs C] told us she was a trained nurse from [overseas] and that she had a qualification as an Iridologist and Natural Practitioner." Mrs A's friend, Ms D, said that once she and Mrs A went to visit Mrs C. During the visit, Mrs A referred to Mrs C, and said that "she is a medical nurse". Ms D said that Mrs C "was standing right there and didn't deny it".

23. In contrast, Mrs C advised HDC: "I have never been a trained nurse (nor claimed to be)." Mrs C stated that she could not recall ever meeting or seeing Ms D.

Initial consultation regarding lesion

24. Ms B said that, in February 2008, Mrs A showed her the lesion, which she had previously kept hidden under a hat. Ms B had not seen it for months, and noted that it had grown and was infected. Mrs A stated in her complaint that she thought the lesion was "just a cyst" based on what she had been previously advised by her GP.

25. Ms B said that she made an appointment for her mother to see Ms B's doctor because Mrs A was embarrassed to go to her own doctor as she had let the lesion get so infected. However, Mrs A decided to go to a pre-existing appointment with Mrs C before seeing the GP.

26. Mrs A said that she showed Mrs C the lesion on 12 February 2008, by which time it was eight to ten centimetres in diameter. Differing recollections of this consultation have been provided to this Office. Mrs C stated that Ms B was not present at the first consultation about the lesion. Mrs C told HDC:

> "At the first consultation I said [the lesion] was cancer. But then I didn't use the word cancer (even when [Mrs A] asked) because legally I'm not allowed to diagnose cancer. I said to [Mrs A] 'you told me it was a cyst … you told me the doctor told you it was a cyst, so that's what I'm treating it as …'. I didn't speak of cancer except at the very beginning."

27. In response to my provisional opinion, Mrs C said that Mrs A told her that her (Mrs A's) GP had said there was nothing further that could be done about the lesion.

28. Mrs C also told HDC that the first time she saw Mrs A's lesion, she was revolted by it, and told Mrs A it was cancerous, and that she could not believe anyone would leave it in that state. Mrs C described the lesion as "rotten and oozing pus … lots of cyst left growing" and it had "eaten half [her] head". Mrs C advised that she said: "We'll give it three months and if it's not improved, you have to promise me you'll go to the doctors and the hospital — and she agreed."

29. Mrs A reported that Mrs C said she could heal the lesion, and that she would need three months to do so. Mrs A said that Mrs C asked her not to go to her doctor during that time.

30. Ms B said she was present at the consultation on 12 February. She said that when her mother asked, "Is it cancer?" Mrs C said "absolutely not", and said, "It's what your doctor said ─ a cyst." In response to my provisional opinion, Mrs C denied that Ms B was present at this consultation.

31. Mrs A spoke of Mrs C as a "convincing lady", and Ms B believes she and her mother were brain-washed by Mrs C. Ms B said: "We trusted her implicitly as every piece of advice we had got previously had ended in a good result."

32. However, Mrs C stated that, despite telling Mrs A that she could not treat the lesion and that she did not want to treat it, Mrs A persisted, and Mrs C gave in. Mrs C maintained that Mrs A had assured her that she had sought conventional treatment, that the lesion had been cut out, although she told HDC this "seemed most implausible to [her]", and that it would heal itself. Mrs C described her treatment as a "stop-gap measure … until [Mrs A] went to the hospital or died". Mrs C recalled telling Mrs A that she could possibly grow some new skin around the edges, but would still require plastic surgery.

33. Mrs C told the media[7] that it was not until a year after the initial consultation that she found out the lesion was 20 years old, and realised then that it must be more than a cyst, at which point Mrs C was concerned that she might be blamed for the situation.

Treatment of lesion

34. Ms B said that Mrs C cleaned the lesion on 12 February 2008, and that Mrs A was screaming and "nearly passed out several times". Mrs C put kumarahou ointment[8] on the lesion.

35. For the first few weeks after the initial consultation, Mrs A was treated by Mrs C every second or third day. Ms B told HDC that her mother's lesion did significantly improve in those first few weeks — the infection reduced, and her mother's skin colour and general well-being improved. Accordingly, Ms B said that she and her mother were optimistic ("[Mrs C] convinced us both"). Mrs A was taking only paracetamol at that time.

36. As time passed, Mrs C's treatments became more frequent. By April 2008, Mrs A was seeing Mrs C every day. From 1 May 2008, Mrs A began renting a house in the town where Mrs C had her clinic as the travel from her home town had become difficult. From this point, Mrs C treated Mrs A at her rental home. Later, the treatments increased to twice a day. Mrs C visited Mrs A's house late at night (often until 2 or 3am), and returned at 6.15am. Mrs C stated that, by this point, she "was having less than 3 hours sleep a night".

37. Mrs C's treatment consisted of picking off dead skin and washing out the lesion with colloidal silver because it was oozing and weeping. This process took hours. Mrs A stated that "[e]ach day [Mrs C] came she pulled skin and stuff off my head which

[7] The media interviewed Mrs A and Mrs C.
[8] Kumarahou cream is believed to help ulcerated skin and other skin conditions (www.healthpost.co.nz).

made it bleed a lot but she assured me it was the only way to do it if I wanted it to be healed properly". Ms B told HDC that part of Mrs C's treatment was:

> "picking parts of cyst with tweezers, and if she got a lot out, it was a successful treatment. It bled and bled. They used so many tissues every day. Mum was pale — you could see the lack of blood."

38. Three months into the treatment, Ms B became concerned because she believed the lesion was growing, while Mrs C was saying it was getting smaller and better. Mrs A told the media that Mrs C "was telling me that it was infection, and if she could kill that infection then she could kill the cyst".

39. Mrs A's friend, Ms D, said that she kept in contact with Mrs A through phone calls and text messaging. Ms D recalled Mrs A telling her that Mrs C kept promising a cure and saying that she was winning.

40. Mrs A told the media that Mrs C would say to her, "You just have to have faith in me. If only you would think more positively." Mrs C told HDC that she would never ask anyone to "have faith in [her]".

Mrs A's fears

41. Ms B explained that her mother was concerned about the lesion because she was "petrified she might get cancer, petrified of the treatment, and of chemotherapy … it was her biggest fear". Ms B said that Mrs A had never had surgery, that there were allergies to some anaesthetics in the family, and that she had watched her mother die.

42. Mrs A's husband, Mr A, and Ms D also spoke of Mrs A's reluctance to go to the hospital. Ms B stated that her mother wanted to believe that this alternative treatment was going to cure her, because facing surgery and chemotherapy was too frightening. Ms B told the media that her mother "wanted to believe that she was going to be helped and cured by somebody who would come and visit her at home and use lots of lotions and potions".

43. Ms B said that she tried to intervene physically to get her mother to the doctors, but Mrs A ended up sitting on the floor, refusing to move. Mrs A stated that "[i]t got to the stage I was too frightened to go to the doctor". As she became sicker, family members and friends encouraged Mrs A to seek another practitioner's advice, but Ms B explained that her mother said she was "scared of telling [Mrs C] she had given up on her treatments". Ms D told HDC that Mrs A was frightened of Mrs C.

Conventional treatment

44. Mrs A said that Mrs C told her she would need three months to treat the lesion and "asked that [Mrs A] did not go to a conventional doctor during the three months until her creams and dressings had worked". Mrs A stated that she agreed because Mrs C said the lesion was a cyst, and this was the same advice Mrs A had previously been given by her GP.

45. Ms B recalled Mrs C asking Mrs A to "promise" she would not see her GP for three weeks, then, on the second or third visit, stating that she needed three months to fix the lesion. At this point, the lesion "had improved. The ointments did treat some of the infection … mum felt better than she had for a while."

46. Mrs A said that after the first three months, Mrs C told her that the lesion was improving, but she needed a further three months to treat it.

47. Ms B said that part-way through the first three months of treatment, Mrs C started saying the treatment needed to continue until August 2008, so Mrs C, Mrs A and Ms B "started talking about August being the month where [Mrs A's] head will be fixed or on the road to being fixed or [Mrs C] would decide to give up".

48. Mrs A said that after August 2008 "[Mrs C] said she still needed more time". Mrs A remained living there, and Mrs C visited her every day. Mrs A said that at that time the lesion was becoming more painful, and the chemist queried the amount of Nurofen she was taking and recommended that she see a doctor. When Mrs A told Mrs C about this advice, "her reply was very negative: i.e. it wasn't cancer and they probably wouldn't treat it now and [Mrs C] said I'd probably get a bug or swine flu if I went to hospital. After hearing this time and time again I was to [sic] frightened to go." Mrs A said that Mrs C kept saying she had new, pale coloured, skin growth and showed the skin to Mr A.

49. Mrs C told HDC that, although new skin did grow around the edge of the wound, the cyst continued to grow underneath. She said that Mrs A became upset when told this and asked why it kept growing. Mrs C said she responded, "That is what cysts do," and repeated that without treatment to kill the cyst it would continue to grow. Mrs C said she suggested using hydrogen peroxide to kill it, but Mrs A refused.

50. Mrs C said that Mrs A was always asking her what the lesion looked like, and she told Mrs A that "even if we could kill the cyst, [Mrs A] was going to need plastic surgery …" Mrs C said she told Mrs A, "It's not going to grow new skin or new bone. The most it can do is grow new skin around the edges and it's not going to do that as long as the cyst is there."

51. Mrs A said she asked 80 to 100 times whether a doctor could work beside Mrs C, but Mrs C's response was always negative.

52. Ms B recalled Mrs C saying that it was not cancer, but that it was Mrs A's choice whether to go to hospital. However, Ms B further recalled Mrs C warning them that the consequences of seeking hospital care were that Mrs A would require surgery and radiation treatment, and commenting that the radiation might not work.

53. In contrast, Mrs C denied asking Mrs A not to see a doctor. Mrs C claimed that when she first saw the lesion, she said that Mrs A should be in hospital. Mrs C recalled Mrs A asking her what the hospital would do, and replying that the hospital would cut the lesion away, provide radiation to kill it, and do a bone and skin graft.

54. Mrs C stated that she never actively discouraged Mrs A from seeking other treatment, but went along with what Mrs A wanted to do. Mrs C told HDC: "I am quite sure/adamant that on more than one occasion my advice to [Mrs A] was that she needed to seek the advice/ treatment of medical specialists …"

55. In her response to my provisional decision, Mrs C said she strongly encouraged Mrs A to seek medical assistance. She said that Mrs A wanted to avoid the distressing and unpleasant treatment that seeking conventional treatment would mean.

56. Mrs C described Mrs A weeping and begging her to clean the lesion, and telling her she would rather be dead than go back to the doctors. Mrs C stated that she agreed to "pick off the cyst" and clean it up for three months, and that Mrs A agreed to go to the hospital after this time.

57. Ms B recalled that Mrs C had in previous years recommended visits to the doctor (such as to get a blood test). However, Ms B believed Mrs C's perspective of the medical profession became more negative in 2008.

58. Mrs C spoke to HDC of her continued close relations with some clinicians in the health sector, but also of difficult encounters with some health professionals who "did not have time for" natural therapy.

Level of expertise

59. Mrs C said she told Mrs A she was not an expert in this area. Conversely, Mr A told HDC that Mrs C "never said it was beyond her". Mrs A said that when she was preparing to leave to go to the hospital, Mrs C said the lesion was not cancer.

60. Mrs C acknowledged to HDC that the treatment of Mrs A was "way out of [her] league" and said she told Mrs A this, but felt she had no option but to continue treatments as she was under great emotional pressure to continue helping. In response to my provisional opinion, Mrs C advised that Mrs A frequently threatened suicide when Mrs C suggested stopping the treatment.

61. Mrs C told HDC that she felt she was put in a difficult position, as Mrs A had asked her not to discuss her health or illness with Ms B. Mrs C said: "I continued to treat her even when I knew that ultimately she needed to be treated in a hospital environment." Mrs C admitted that she was practising out of her scope, and stated that "the mistake I made was not anything to do with skills or knowledge, it was caring too much".

62. When asked whether Mrs C went to anyone for professional support during her treatment of Mrs A, Mrs C replied, "No, where would I go? There aren't any natural therapists or iridologists in this area." Mrs C further stated that she did not have the time anyway.

Mrs C's philosophy

63. Mrs C acknowledged to HDC that Mrs A needed to see a doctor. However, Mrs C said that her philosophy is to "[work] with what the patient wants to do, often in spite of my personal views because the patient's wishes should always come first".

64. Mrs C also stated that "if you care about a person … then you try and do the best for them even though it may turn out to be the wrong thing." She believed it was up to Mrs A's family to convince her to go to the hospital.

65. Mrs C expressed her belief that natural therapy is about "encouraging people to take responsibility for their health and do something about it … not depending on me".

66. Mrs C stated in response to my provisional opinion: "I believe that I acted in a fair and reasonable manner, given the circumstances. I assisted [Mrs A] acting in good faith for her benefit."

Medication/remedies

67. Mrs C mostly recommended treatments and remedies, which Mrs A's family sourced from various health shops. Mrs C would occasionally buy Mrs A treatments that were more difficult to find.

68. Mrs C recommended various topical creams and lotions for cleaning the lesion, including kumarahou ointment, rose water and calendula.[9] Mrs C said she told Mrs A that Goldenseal[10] helped to kill tumours. When the topical remedies irritated Mrs A's skin, Mrs C tried something different.

69. Mrs C used colloidal silver on the lesion. She told Mrs A that colloidal silver is good for healing and would keep the lesion clean. Mrs C also stated that she "encouraged [Mrs A] to take some herbs for [her] nerves and a good multi-vitamin and mineral formula; most of which [she] never did".

70. Mrs C bought glyco-nutrients for Mrs A, which she said are a mixture of common herbs. Mrs C said: "I told [Mrs A] it was predominantly used for people with cancer, for killing growths." Mrs C also recommended peroxide as being the best way to kill the lesion. Ms B understood that some of the remedies were to ensure the rest of Mrs A's body was as healthy as possible, in order to have the best chance of healing her head.

71. Ms B recalled that from December 2008, Mrs C suggested the use of hydrogen peroxide (both topically and orally) — a treatment Mrs C gave to cancer patients. Mrs A refused to use it topically because it would sting. Mrs A was aware that Mrs C used this with cancer patients, and questioned Mrs C about this. Mrs A stated that Mrs C said it was a precautionary measure.

72. Ms B stated that her mother began taking Parafen for her pain, which Mrs A bought over the counter. Ms B said that, on Mrs C's recommendation, her mother was taking larger doses than recommended on the packet. Ms B said that Mrs C supplied her mother with codeine, which was prescribed for Mrs C or her daughter, and also supplied Mrs A with diclofenac and antibiotics prescribed for Mrs C or her family

[9] Calendula is used for wound healing (www.medicinenet.com) and for various other health issues.
[10] Goldenseal is advertised as a "traditional herb primarily used for supporting optimum health of the mucous membranes." (www.healthpost.co.nz).

members. Ms B acknowledges that she also gave her mother antibiotics that had been prescribed for herself.

73. Mrs C said that she did not supply Mrs A with diclofenac or codeine or any medications prescribed for her children or grandchildren. Mrs C also said that she had not consulted a general practitioner since 1978, and therefore could not have provided Mrs A with medications prescribed for herself.

74. On 29 October 2010, Ms B supplied HDC with medication she said Mrs C had given to her mother. This included a quantity of brownish-grey powder and a box of capsules labelled "Baike Wan". Mrs C said that although she recommended Baike Wan to clients, they bought it themselves.

Clinical records

75. Mrs C supplied no records of her treatment of Mrs A. Mrs C advised HDC that her standard practice is to keep a carbon copy of any advice she provides for clients on completing an iridology check-up. She would keep the copy for a year then shred it. However, Mrs C said that "[a]s for clinical notes on [Mrs A] there obviously were none, as it was nothing to do with iridology and I was round there every night and morning, just cleaning the head". However, in her response to the provisional opinion, Mrs C said: "The first consultation for her head would have been documented as when she arrived it was for a regularly scheduled appointment."

Professional boundaries

76. Mrs C acknowledged that she "form[ed] a closer relationship with [Mrs A] than perhaps, in hindsight was wise …" In 2008, a member of Mrs C's family won free flights for two passengers. On 26 December 2008, Mrs A and Mrs C used the free flights to travel together for a few days, and stayed with Mrs A's family. In Easter 2009, when Mrs C went to stay with her family, Mrs A stayed in a motel close to her so that Mrs C would be able to continue the treatment. Mrs C submitted that Mrs A having travelled there demonstrates that Mrs A was not controlled by Mrs C.

77. Mrs C said that Mr A would often come and get her from work. She said that her grandson, who was frequently in her care, slept at Mrs A's house at times. Mrs C's daughter, Ms F, stated that "as a family we felt mum had given up her own life in order to care for [Mrs A] and her family. Mum would go to [Mrs A's] straight after work and more often than not would be there until the early hours of the following morning." Mrs C's other daughter, Ms G, said that her mother "no longer assisted [Mrs A] as a client but as a friend".

78. Mrs C admitted that professional boundaries "had long gone, [the boundaries were not] there. It concerned me but I was caught — I would have had to have gone against what I had said and abandon her."

Payment

79. Mrs C said that she accepts payment from her clients in money or goods on a voluntary basis, and "does not expect money from cancer patients". Mrs C stated: "I

didn't charge [Mrs A]. Didn't charge her at all." Mrs C said: "I'm more interested in people's health than money."

80. Ms B said that Mrs C had an understanding with her clients that they would pay between $20 and $50 depending on the length of the appointment and the client's ability to pay. Mr A advised HDC that his wife did not pay Mrs C for treatment, but Mrs A paid in cash for the medications Mrs C supplied.

Progression of Mrs A's illness

81. Mrs A's hairdresser, Ms E, told HDC that she saw Mrs A's lesion prior to her moving to the town where Mrs C had her clinic, and described it as being about five centimeters in diameter, dry around the edges, and weeping from the middle.

82. Ms B said that over the time that Mrs C treated the lesion, it grew (almost doubling in size), and smelled bad. Ms B described the lesion at the time Mrs A went to hospital as "pulsating" and "you could see exposed brain". Ms B recalled her mother being in "terrific pain" and almost passing out during treatments. Mrs C acknowledged that the cyst continued to grow even though new skin grew around the edge of the wound. Ms B said that Mrs A was pale, weak, and getting infection after infection. Mrs A recalled Mrs C talking about new skin growth, and saying that the lesion was definitely healing.

83. Mrs C remembered there being new skin around one side, but said that there was new cyst growth in other places. She told HDC that Mrs A's health fluctuated, but said that "[t]here were times when [the lesion] didn't look too bad. It stayed the same, didn't get worse, didn't get better." Mrs C further said that in January 2009, when Ms B wanted to take her mother to hospital, "I said to [Ms B] that [her] mother's head is no different to what it has been the whole time … no better, no worse, can just keep doing what we're doing."

84. In 2009, Ms B became increasingly concerned about Mrs C's state of mind, given her lack of sleep, the medications she was on, and the pain she was experiencing due to her own injury. Ms B remembered being worried about the sense of desperation that she believed was evident from Mrs C, as "the lesion was growing quite alarmingly at that stage". Mrs C stated that "near the end I was shaking with tiredness".

Admission to hospital

85. Mrs A said that her daughter came to visit her in January 2009. When Ms B saw Mrs A's head, she went to Mrs C's office and left a note saying she was taking her mother to hospital. Mrs C arrived within five minutes while Mrs A was packing her bag. Mrs A said that Mrs C told them the lesion was a hole from where she had removed the cyst and was normal. Ms B disagreed and, following an argument with Mrs C, left. Mrs A decided not to go to the hospital at this time. Thereafter, Mrs C spent more time with Mrs A, treated the lesion twice a day, and increased the tablets and creams.

86. Mrs A stated that by Easter 2009 "I realised just how sick I was and I didn't no [sic] how to get out of [Mrs C's] control. I was scared to tell her this and I realised then just

how much she was manipulating and controlling me. It took me about another six weeks to get up the courage to ring [Ms B] and ask for help."

87. Mr A said that in May 2009 he and his wife made the decision that if the lesion did not get better they needed to go to the hospital. He said that when they mentioned doctors and hospitals to Mrs C she said "by all means do so" (go to the doctors or hospital), but then she gave examples of misdiagnoses and mistreatment at hospitals, whereas her treatment had been successful. When they asked for advice about which hospital to go to, "she wouldn't give us anything".

88. Ms B told HDC that her mother finally had the courage to go to the hospital in mid-June 2009, but needed a few days to think it through. On 22 June 2009, Mrs A and Ms B prepared to drive to hospital. Mrs A stated that Mrs C arrived at Mrs A's house and tried to talk them out of it, saying that they were wasting their time as the lesion was not cancer. She remembered Mrs C giving in to the plan to go to hospital, saying, "If you have to," but commenting that there was new skin. Conversely, Mrs C said she was pleased when she heard that Mrs A was going to hospital, saying, "Good that's where you should be."

89. In response to my provisional opinion, Mrs C submitted that the reason Mrs A went to hospital on 22 June 2009 was that Mrs C's daughter, Ms G, required Mrs C's assistance in transporting her children to school while she was ill,[11] and Mrs C therefore became unavailable to visit Mrs A each morning. Mrs C said that Mrs A was angry about Mrs C's decision.

90. At the hospital, Mrs A was formally diagnosed with cancer. Mrs A said that she was totally shocked when she was told it was definitely cancer. The DHB documentation details findings of an "ulcerated … squamous cell carcinoma",[12] measuring 10 x 11cm, with destruction of the underlying bones. A doctor told the media that "you can see the brain pulsating just underneath …"

Further comments

91. Mrs A told the media that she was angry with herself for not having acted earlier, and not listening to her family. Although Mrs A accepted partial responsibility, she believed she was misled by Mrs C.

[11] Mrs C provided Ms G's consultation note from 22 June 2009 showing that an off-work certificate was issued by Ms G's general practitioner.
[12] Cancer that begins in the tissue that forms the surface of the skin. www.medterms.com

92. Mrs C told the media: "I feel a sense of responsibility in the sense that I should have wiped my hands of it right at the beginning …" Mrs C told HDC that "[i]n retrospect there is no way I would go through that again. I was caught in a web. If I was a cold person I would have said no, it was killing me … If I came across a similar situation in the future I wouldn't do what I did [with Mrs A]. I would ask [such a client] to give me proof that they had been to the doctors/hospital."

Standards

93. The Health (Retention of Health Information) Regulations 1996 require every provider[13] to retain health information for "a period of 10 years beginning on the day after the date shown in the health information as the most recent date on which a provider provided services to that individual".[14]

Opinion: Breach — Mrs C

94. I consider Mrs C to be a health care provider under section 3(k) of the Health and Disability Commissioner Act 1994 (the Act). A "health care provider" includes "any … person who provides, or holds himself or herself out as providing, health services to the public or a section of the public, whether or not any charge is made for those services".

95. Mrs C held herself out to be a natural health practitioner and iridologist, with the skills to treat a wide range of health issues in the context of natural therapy. Therefore, I am satisfied that Mrs C provided "health services" in accordance with the definition in section 2 of the Act, and she is therefore obliged to comply with the Code.

96. I consider that the fundamental ethical principle of heath care — "primum non nocere" (first do no harm) is no less applicable to alternative practitioners than to medical practitioners. Even if a provider has a strong belief in the efficacy of alternative treatments, if the treatments prove unsuccessful, there must come a point at which a provider must "cry halt" or, at the very least, seek to involve other providers in the provision of care. In response to my provisional opinion, Mrs C said that she acted in good faith and for Mrs A's benefit. In this case I am concerned about the standard of the services Mrs C provided, Mrs C's failure to comply with ethical standards, and the information Mrs C provided to Mrs A.

[13] Regulation 4(k) defines "provider" as including: "any other person who provides, or holds himself or herself or itself out as providing, services to the public or to any section of the public, whether or not any charge is made for those services".
[14] Regulations 5 and 6.

Practising beyond expertise

97. Despite not being a member of a relevant association, Mrs C was nonetheless bound by the standards in the Code. Right 4(2) of the Code states that consumers have the right to services that comply with legal, professional, ethical, and other relevant standards.

98. Over a period of about 18 months, Mrs C regularly (and with increasing frequency) provided Mrs A with treatment, which involved cleaning her lesion, picking out dead skin and washing out the lesion with various remedies. Mrs C also suggested oral herbal remedies.

99. Mrs A and Ms B described the lesion growing, bleeding frequently, smelling unpleasant, and eroding Mrs A's skull. Mrs A became weak and was experiencing severe pain. She was suffering from ongoing infections.

100. My expert advisor, Professor Gillett, advised that any person purporting to be a health care practitioner ought to recognise the limits of his or her own expertise, and to recognise a case that is beyond his or her ability to treat according to the regimens of care falling within his or her own competence. He stated that any person whose patient outstrips the ability of a practitioner to provide adequate treatment should be encouraged to seek another opinion, or should be referred for such an opinion (depending on the standing of the practitioner concerned).

101. Mrs C recognised that she was operating outside her expertise — the treatment she undertook was, in her words, "way out of [her] league" — and that a doctor needed to provide treatment. However, Mrs C expressed her firm belief that a patient's wishes should be foremost, even in spite of Mrs C allegedly having differing views from Mrs A. Mrs C asserts that she felt she had no option but to continue the treatment.

102. I acknowledge that Mrs A was fearful of conventional treatment for a variety of reasons, and refused to go to a doctor or a hospital while Mrs C continued her treatment. I also accept that Mrs C could not force Mrs A to obtain medical advice. However, in light of Mrs C having recognised from the beginning that the lesion was "diseased" and "looked cancerous" and "needed plastic surgery", it was a case that was beyond her ability to treat. Certainly, after the first three months when the initial improvement was not sustained, it was time for Mrs C to "cry halt".

103. Professor Gillett advised that it is generally not acceptable for a practitioner to abandon a patient when the practitioner is the patient's main contact with any form of health care. In this case, Mrs A had a relationship with her GP, albeit she consulted him infrequently. She was also aware of the possibility of hospital treatment. Furthermore, Mrs C stated in response to my provisional opinion that when she told Mrs A she could not continue with the frequency of the treatments, Mrs A then sought medical assistance. I do not consider that Mrs A would have been left unsupported if Mrs C had decided not to continue with treatment when she realised she had exceeded her expertise.

104. It is striking that Mrs C stated in response to my provisional opinion that she refused to continue Mrs A's treatment because she wanted to be available to assist her daughter, not because she had recognised the limits of her expertise or because Mrs A required specialist treatment. However, by Mrs C's account, once Mrs C refused to continue, Mrs A immediately sought medical assistance. Sadly, this was too late.

105. Mrs C stated that Mrs A threatened to commit suicide if Mrs C did not continue the treatment. However, I note that Mrs C did not recommend that Mrs A seek mental health care in relation to those threats.

106. By not discontinuing her treatment of Mrs A, Mrs C did not comply with ethical standards and breached Right 4(2) of the Code.

Failure to minimise potential harm

107. Under Right 4(4) of the Code, Mrs A was entitled to have services provided in a manner that minimised the potential harm to her, and optimised the quality of her life.

108. Although in the initial stages of Mrs C's treatment, the lesion appeared to heal to some extent and Mrs A's general health improved, the lesion deteriorated over the 18 months of treatment. Mrs C's statements to HDC about the progression of Mrs A's illness are contradictory. She mentioned the growth of the lesion, but also said that it stayed the same.

109. Mrs C encouraged Mrs A's belief that the lesion was improving, despite knowing that it was continuing to grow. Mrs C said that new skin was growing around the edge of the wound. By her own account, Mrs C continued to suggest to Mrs A the possibility that she could "kill the cyst". Mrs C persevered with her treatment and did not communicate the severity of the situation to Mrs A. By failing to take appropriate steps to terminate the provider/consumer relationship as Mrs A's condition deteriorated, Mrs C exacerbated the harm to Mrs A, who was in severe pain and unwell.

110. Mrs C did not minimise the potential harm to Mrs A, and therefore breached Right 4(4) of the Code.

Inadequate co-operation

111. In February 2008, Mrs A went to one of her three-monthly sessions with Mrs C at her clinic and, for the first time, consulted Mrs C regarding the eight to ten centimetre wide lesion on her head.

112. I have been given conflicting accounts as to the information provided by Mrs C during her treatment of Mrs A's head. Mrs A believed the lesion was a benign cyst. She alleged that Mrs C affirmed that there was no cancer, said that she could heal it, and asked Mrs A not to see a doctor during the 18-month period. Ms B recalled her mother asking if the lesion was a cancer and that Mrs C said it was not.

113. Mrs C said that she never actively discouraged Mrs A from seeking other treatment, but rather followed Mrs A's desires. Mrs C told HDC that she believed the lesion was

cancerous from the first time she saw it, but understood that the lesion had previously been removed by a doctor. Mrs C recalled Mrs A begging her to continue treating the lesion. Mrs C retained no records of her discussions with Mrs A or her treatment. Because there is no documentation, Mrs C relied solely on her recall in describing the circumstances around her treatment of Mrs A.

114. It is through written notes that health providers are able to provide proof of a particular matter (in this case, that Mrs C advised Mrs A that the treatment she required was beyond her expertise and that she needed to seek another practitioner's assistance).

115. Baragwanath J pointed out in his decision in *Patient A v Nelson Marlborough District Health Board*[15] that it was desirable that the law should, in future, impose on doctors an obligation to establish and maintain a written and signed record. This Office has frequently emphasised the importance of record-keeping, which applies to all health care providers.[16] It is through the records that health care providers have the power to produce definitive proof of a particular matter. This Office has stated:[17]

> "Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted."

116. The information I have indicates that Mrs A was frightened about her condition and about the possible outcomes for her. In my view, the evidence suggests that although Mrs C did not prevent Mrs A from seeking other assistance, she persuaded her not to do so, and added to Mrs A's fear of what might happen to her if she did.

117. Mrs C asserted that she strongly encouraged Mrs A to seek medical assistance. However, the evidence from Mrs A, Ms B and Mr A is that Mrs C talked about misdiagnoses, mistreatments and conditions that might be contracted at hospitals. This had the effect of discouraging Mrs A from obtaining further treatment. In my view, Mrs C failed to ensure co-operation among providers to ensure quality and continuity of services, and so breached Right 4(5) of the Code.

Lack of records

118. As noted above, Mrs C did not keep any notes in relation to her treatment of Mrs A's head. She advised that her practice is to keep her notes for a year then shred them; however, she said she did not make notes in Mrs A's case because the lesion was nothing to do with iridology.

119. There were circumstances in this case that made it particularly important that Mrs C keep notes in regard to her treatment of Mrs A. For example, Mrs C was the only provider treating Mrs A for an extended period. In addition, Mrs C acknowledges that

[15] *Patient A v Nelson Marlborough District Health Board* (HC) BLE CIV–2003–406-14, 15 March 2001.
[16] Stent, R, "For the record". *New Zealand GP*, 12 December 1998.
[17] Opinion 08HDC10236, 28 November 2008, at page 11.

Mrs A's needs had outstripped Mrs C's ability to provide adequate treatment, and alleges that Mrs A disregarded her advice to seek treatment from a medical practitioner. At the very least, records of treatment provided, the progress of the lesion (such as measurements) and any advice that Mrs A should see another provider should have been kept. Not only do such records allow a provider to verify what occurred (as noted above) but, more importantly, they allow care to be provided in an appropriate fashion, given past treatment, particularly if a new provider becomes involved.

120. Mrs C did not adequately document her treatment of Mrs A. Mrs C therefore breached the standard requiring health care providers to maintain and retain adequate records, and so breached Right 4(2) of the Code.

Failure to provide adequate and/or accurate information

121. Both Mrs A and Ms B stated that the appointment on 12 February 2008 was the first at which the lesion was discussed, while Mrs C said that Ms B was not present at the first appointment. I accept Ms B's and Mrs A's statements that they travelled together to attend three-monthly appointments with Mrs C, and that Ms B was present at the appointment on 12 February.

122. When Mrs A first consulted Mrs C about the lesion, it measured between eight and ten centimetres in diameter. Mrs C agreed that the lesion was a cyst and treated it as such. Mrs A was reassured that the lesion was a cyst, as that was the same diagnosis as her GP had made.

123. Mrs C stated that she was not aware that the GP's diagnosis had been made years previously. However, Mrs C did not ask about the growth of the lesion, when Mrs A had last consulted a doctor about it, or any other clinical history.

124. Mrs C told HDC:

> "At the first consultation I said [the lesion] was cancer. But then I didn't use the word cancer (even when [Mrs A] asked) because legally I'm not allowed to diagnose cancer. I said to [Mrs A] 'you told me it was a cyst … you told me the doctor told you it was a cyst, so that's what I'm treating it as …'. I didn't speak of cancer except at the very beginning."

125. In contrast, Ms B said that when her mother asked, "Is it cancer?" Mrs C said "absolutely not", and said, "It's what your doctor said — a cyst." Mrs A was entitled to honest answers to her questions. If Mrs C was not qualified to diagnose Mrs A's condition, but thought the lesion was unlikely to be a cyst, she should have told Mrs A about both of these factors.

126. Mrs A accepted Mrs C's reassurances that the lesion was a cyst and not cancerous. Mrs C denies telling Mrs A that she had nursing training. However, Mrs A, Ms B and Ms D have all provided evidence to the contrary. Both Mrs A and Ms B stated that Mrs C had previously indicated to them that she had nursing training. On one such occasion, when Ms D was present, the subject of Mrs C's training was discussed by Mrs A and Ms B, and Mrs C did not say that she had no nursing training. Accurate

information about Mrs C's training and qualifications was essential in order for Mrs A to decide whether Mrs C's advice could be relied upon.

127. Consumers who seek alternative health care are entitled to be given information about their condition and the safety and effectiveness of the proposed therapy. This is information that a reasonable person in Mrs A's circumstances would expect to receive, in order to make an informed choice whether to undergo alternative therapy.

128. Mrs C acknowledges that, although she doubted the lesion was a cyst, she told Mrs A that she would treat it as a cyst, and provided the treatment she thought was appropriate to treat a cyst. Mrs A and Ms B both stated that Mrs C said she could heal the lesion. Ms D spoke of Mrs C promising a cure, and Mr A spoke of Mrs C saying she could "fix it".

129. The lesion worsened until it measured 10 x 11cm, with destruction of the underlying bones; however, Mrs C persisted with the treatment. Mrs A and Ms B claimed that Mrs C continued to say the lesion was not cancer, and advised Mrs A that the lesion was neither getting better nor worse, despite its worsening condition. Mrs A said that when she was preparing to leave for hospital, Mrs C told her she was wasting her time because the lesion was not cancer. In contrast, Mrs C said that she did not discuss the possibility of cancer with Mrs A after the initial appointment.

130. This Office has previously stated:[18]

> "Obtaining informed consent to treatment is not a one-off event. Mrs C had an ongoing obligation to provide Ms A with adequate information during the course of her treatment. In particular, a reasonable consumer, in Ms A's circumstances, would expect Mrs C to discuss her progress and keep her informed about the risks and benefits of continuing light therapy. A reasonable consumer in Ms A's circumstances would also expect to receive regular information about the other treatment options available. Ms A needed this information to enable her to make an informed choice about her treatment.
>
> I accept that Mrs C suggested that Ms A consult a doctor a few months into the light therapy treatment, and again in July 2006. However, in my view, Mrs C should have presented the option of conventional medical treatment more frequently during the course of the treatment, particularly when it became apparent that the breast tissue was not responding to light therapy. Furthermore, Mrs C should have had regular discussions with Ms A about the risks and benefits of continuing the treatment."

131. I accept that at the outset, Mrs A and Mrs C both believed that Mrs C's treatment would have a positive effect on Mrs A's lesion. However, an objective assessment of the information gathered shows that, as time went on, Mrs A's clinical condition deteriorated. In my view, Mrs C's failure to provide Mrs A with adequate information about the progression of her illness and her treatment options inappropriately raised

[18] 08HDC00218 (16 December 2008).

Mrs A's expectations and made her less likely to seek assistance from a medical practitioner.

132. Right 6(1) of the Code provides that every consumer has a right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. In my view, a reasonable consumer would expect accurate information about the provider's training, qualifications and experience. By misleading Mrs A as to her training, Mrs C breached Right 6(1) of the Code.

133. Right 6(1)(a) states that every consumer has the right to an explanation of his or her condition. By failing to inform Mrs A of her opinion that her condition was probably cancer, rather than a cyst, and that the lesion was worsening rather than improving, Mrs C breached Right 6(1)(a) of the Code. It follows that Mrs A was unable to make an informed choice whether to undergo the treatment recommended by Mrs C, and so Mrs C also breached Right 7(1) of the Code.

Professional boundaries

134. Over a period of years, Mrs A and Mrs C developed a close relationship. Initially, the consultations were social, and Ms B described Mrs C as friendly and welcoming.

135. While I acknowledge that Mrs C demonstrated concern and tried to help Mrs A, it is unwise for a provider to spend extended periods of time at a consumer's home and to go on holiday with the consumer while the consumer is under that provider's care, as the provider runs the risk of blurring professional boundaries. I consider that this relationship became one of dependency. The frequency of visits increased so much that, by mid-2009, Mrs C was spending several hours every morning and every night with Mrs A. Mrs C admits that she had lost all sense of professional boundaries in her care of Mrs A.

136. Professor Gillett provided a general guideline in these circumstances:

> "Where a practitioner and a patient are in a close relationship which is causing a distortion of normal patterns of care the practitioner ought, as far as possible, to involve a colleague with the expertise to offer independent and appropriate advice on the patient's problem.
>
> …
>
> In such a situation most practitioners should be aware of the professional risks of a relationship of the type that developed and apprise the patient of their own professional need to seek collegial guidance.
>
> …
>
> [A]t the point where s/he feels exposed to the risk of professional negligence or misconduct by a regimen of care on which a patient is insisting, the involvement of a colleague is his/her right regardless of the wishes of the patient."

137. This Office has previously stated:[19]

> "When ... [any provider] has a professional relationship with a client … he or she must take extreme care to establish and maintain the boundaries of that relationship. A breach of professional boundaries is a breach of trust and can result in physical and/or emotional harm to the client … If any doubt is raised about the appropriateness of the communication or relationship, guidance should be sought or the client referred to another provider.
>
> …
>
> The [provider] also failed to seek assistance once she realised she was 'out of her depth'. In short, her conduct was unprofessional and unethical, and amounted to a breach of the Code of Health and Disability Services Consumers' Rights".

138. I consider that the same standard applies to a provider such as Mrs C.

139. While I acknowledge that Mrs C was trying to help Mrs A, their relationship carried the risk of a significant power imbalance between the provider and consumer, and put Mrs A in a difficult position should she subsequently decide to cease treatment with Mrs C. In my view, Mrs C acted unethically by crossing professional boundaries in her close relationship with Mrs A, and so Mrs C failed to comply with ethical standards and breached Right 4(2) of the Code.

Summary

140. I have no doubt that Mrs C had good intentions, at least initially, in her treatment of Mrs A. Despite her intentions, Mrs C should have made a considered decision whether to commence treating Mrs A's head. Having decided to begin treatment, Mrs C had a responsibility to recognise when she should cease treating Mrs A. Providers should recognise the point at which the treatment needed exceeds their abilities and, at that stage, should advise the consumer of the alternatives available and, in circumstances such as these, refuse to provide further treatment.

141. Mrs C's failure to discuss the situation that had arisen made her susceptible to a loss of judgement with regard to the maintenance of professional boundaries. This case highlights the need for health providers to seek another provider's advice when faced with a situation that is beyond their expertise, and when the relationship between practitioner and consumer goes beyond a professional one. It also highlights the need for careful documentation of the history and the treatment, particularly if the consumer is alleged to have gone against a recommendation made by the provider.

142. I accept that Mrs A had the right to refuse to seek medical treatment. However, any such refusal should have been based on accurate information. As Mrs C did not appropriately disclose details of her qualifications, her perception of the lesion, and that the treatment was not improving the lesion, Mrs A was not in a position to make an informed choice about her treatment.

[19] 04HDC05983, 18 May 2005.

143. I consider that Mrs C's failures to provide accurate information, obtain informed consent, minimise harm to Mrs A, comply with relevant standards, and co-operate with other providers are serious breaches of the Code.

144. I consider that Mrs C breached Rights 4(2), 4(4), 4(5), 6(1), 6(1)(a) and 7(1) of the Code.

Recommendations

145. I recommend that Mrs C provide a written apology to Mrs A's family, to be forwarded to HDC by **18 July 2012**.

Follow-up actions

- Mrs C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of Mrs C's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings brought a claim before the Human Rights Review Tribunal. The Tribunal's decision making a declaration of breach of the Code of Health and Disability Services Consumers Rights but declining to award damages to the estate of the aggrieved person is available at:

http://www.nzlii.org/nz/cases/NZHRRT/2013/38.html

Appendix A — Independent advice to the Commissioner

The following expert advice was obtained from ethicist Professor Grant Gillett:

> "This report on the ethics of the conduct of [Mrs C] is made difficult by the fact that there [are] two widely divergent versions of the events and they have quite different ethical implications.
>
> **I will for the purposes of the opinion assume the following** (in part answer to the first point of your request).
>
> 1. That any person purporting to be a health care practitioner ought to recognise the limits of their own expertise and to recognise a case which is beyond his or her ability to treat according to the regimens of care falling within his or her own competence.
> 2. That any person whose patient outstrips the ability of a practitioner to provide adequate treatment within his or her own scope of practice should be encouraged to seek another opinion or should be referred for such an opinion (depending on the standing of the practitioner concerned).
> 3. That it is generally not acceptable for a practitioner to abandon a patient when s/he is the patient's main contact with any form of health care.
> 4. That a practitioner cannot compel a person to attend another practitioner and that attending a recommended provider or complying with a recommendation to seek further or alternative treatment is always a decision by the patient.
> 5. That the duty of care of any practitioner includes doing the best s/he can to facilitate appropriate care for the patient's condition.
>
> With these thoughts in mind we can approach the divergent views of what occurred in the current case, that of [Mrs A].
>
> It is agreed by all that [Mrs A] sought medical care for a lesion on her scalp some years before her contact with [Mrs C].
>
> It is also a matter of fact that [Mrs A] eventually died of an untreated cancer of the scalp.
>
> It is common to all accounts that [Mrs A] was seen by [Mrs C] for treatment to her scalp lesion from February 2008 until June 2009 during which time the lesion had clearly become untreatable by surgery or other oncological regimens. (It may have been untreatable from the first presentation in February 2008 but there is no means of knowing that.)
>
> It is alleged by [Mrs A's] daughter, [Ms B] and [Mrs A] herself that [Mrs C] systematically misdirected her by assuring her that the lesion was not a cancer and dissuading her from seeking conventional medical treatment.

It is contended by [Mrs C] that she attempted on many occasions to direct [Mrs A] to seek conventional medical treatment and to relinquish a burden of care that she found onerous and beyond her (self imposed and determined) scope of practice.

Evidence of [Mrs A].

- [Mrs A] claims in her hand written (printed) note (which I take to have been penned by herself) that the following events and actions marked her course of treatment.
- She had a small lesion on her scalp which she declined to have removed on at least two occasions by a doctor.
- She sought alternative help for sinus and middle ear infections which her doctor and two specialists allegedly said they could not do anything for.
- She went to [Mrs C] for iridology and naturopathy in February 2008 and was told that her problem could be treated in 3 months.
- That at this time she was asked not to go to a conventional doctor.
- She had treatment 7 days a week for 3 months and then told she would need another 3 months of treatment.
- [Mrs C] told her that her lesion was not cancer after a pharmacist had questioned her need for large amounts of pain relief.
- She was frightened to go to hospital and that was heightened by [Mrs C] telling her she might get a 'bug' or 'swine flu'.
- [Mrs C] accounted for changes in her lesion as signs that it was healing.
- She asked [Mrs C] about seeing a doctor 80–100 times.
- Her daughter, [Ms B] a science teacher disagreed with the diagnosis that this was a cyst and attempted to take [Mrs A] to hospital but [Mrs C] arrived and dissuaded her claiming that 'it was normal'.
- [Mrs C] continued to treat [Mrs A] and to reassure her that her 'cyst' was healing.
- Easter 2009 she again tried to 'get out of her [Mrs C's] control and decided to go to hospital'.
- [Mrs C] again arrived and tried to dissuade [Mrs A] from going and said [sic] 'your wasting your time as it is not cancer'.
- [Mrs A] went to hospital and was told it was cancer by [a doctor].

Evidence of [Mrs A's] daughter [Ms B].

- [Mrs A] was referred to [Mrs C] by a friend of the family in order to get treatment for minor health issues (sinus). She believed [Mrs C] and was prepared to go along with her because she did not believe medicine could explain everything and she found the advice given seemed to be common sense and to tally with advice that others might give.
- [Mrs A] hid her scalp lesion but on one occasion when [Ms B] was shown the lesion she, [Ms B], realised it had got much bigger and become infected.
- [Mrs A] was hesitant about seeing a doctor but [Ms B] convinced her to go [the time of this arrangement is not clear]. In the event [Mrs A] did not go to

the doctor because she had an appointment booked with [Mrs C] and 'It is impossible to change an appointment with [Mrs C]'.

- [Ms B] felt [Mrs A] was desperately wanting to believe [Mrs C] might be able to treat her lesion because she was scared of going to hospital and felt [Mrs C] offered an easier option. [It is alleged that [Mrs A] had received a prophecy that if she attended hospital before the age of 65 she would die (feedback to [HDC investigator] from [Mrs C]: point 7)]
- [Mrs A] was petrified that she might get cancer, petrified of the treatment and of chemotherapy. 'It was her biggest fear' (interview with [Ms B]).
- [Mrs A] had a number of fears of doctors and hospitals due to allergies in the family and the fact she had never had surgery.
- [Mrs C] reassured [Mrs A] that the lesion had improved and [Ms B] also had that impression and that her mother was better after treatment by [Mrs C].
- [Mrs A] did not totally blame [Mrs C] for the course of events but partly blamed her.
- [Mrs C] had in early 2008 recommended that [Mrs A] see doctor but had changed over the course of 2008.
- [Mrs C] secured medications for [Mrs A] from a number of sources in addition to her own treatment.
- On a number of occasions [Mrs A] resisted going to see a doctor when [Ms B] urged her to and on one occasion she sat on the floor and flatly refused to move.

Evidence of [Mrs C].

- [Mrs C] has made a number of ethically significant points on her evidence.
- She is clear that she has always represented herself as an iridologist and naturopath and not claimed any false qualifications or experience. [This point is supported by [the officer of the natural health practitioners society.]
- She originally saw [Mrs A] for problems in her sinuses or inner ear to do with vertigo.
- She was shown a large cyst like growth on [Mrs A's] head that she thought needed hospital treatment and she told [Mrs A] that the problem was 'way out of her league'.
- [Mrs A] refused to consult doctors about it and said she did not like them, that the doctors would cut it out, and that they had said there was nothing more they would do.
- [Ms B] was always supportive of her treatment of [Mrs A] and made efforts to make sure the relationship continued (including changes of residence).
- [Mrs A] developed a close, dependent, and highly emotional attachment to [Mrs C].
- [Mrs A] was sometimes 'very firm' in her own decisions about her treatment.
- [Mrs A] forbad [Mrs C] from discussing her case with [Ms B] or others.
- [Mrs C] works cooperatively with conventional medicine from whom she gets referrals and whom she encourages her other clients to see as and when they need to. She felt she could not abandon [Mrs A] despite her patient

making ill-advised choices and putting her in a very difficult and demanding situation.

You have asked me to give an ethical opinion on:
1. the general principles to be observed by those providing health care with particular reference to boundaries of practice and the recognition of the patient's best interests;
2. [Mrs C's] care of [Mrs A] given each version of the facts;
3. if there was a breach whether the breach was mild, moderate or severe.

1. General principle of health care.
I have above set out the following heads under which these could be summarised.

1. That any person purporting to be a health care practitioner ought to recognise the limits of their own expertise and to recognise a case which is beyond his or her ability to treat according to the regimens of care falling within his or her own competence.

2. That any person whose patient outstrips the ability of a practitioner to provide adequate treatment within his or her own scope of practice should be encouraged to seek another opinion or referred for such an opinion (depending on the standing of the practitioner).

3. That it is generally not acceptable for a practitioner to abandon a patient when s/he is the patient's main contact with the health care system.

4. That a practitioner cannot compel a person to attend another practitioner and that attending an alternative provider or complying with a recommendation to seek alternative treatment is always a decision by the patient.

5. That the duty of care of any practitioner includes doing the best s/he can to facilitate appropriate care for the patient's condition but that a patient of sound mind remains the arbiter of what health care choices s/he will make and what constitute his or her best interests even where that seems to run counter to what a competent practitioner would advise.

To these I would add one further general guideline in view of the facts of the case.

6. Where a practitioner and a patient are in a close relationship which is causing a distortion of normal patterns of care the practitioner ought, as far as possible, to involve a colleague with the expertise to offer independent and appropriate advice on the patient's problem.

Opinion if the facts are as claimed by [Mrs A] and [Ms B], her daughter).
[Mrs A] and [Ms B] in various ways and at various points in their evidence claim that [Mrs C] impeded them in accessing conventional medical care for

what eventually was diagnosed as a cancer of the scalp that had eroded away the skull. They claim that [Mrs C] treated this as if it were a cyst susceptible to naturopathic treatment and dissuaded them from seeking other help.

[Mrs A] does not, in her evidence, express any fear or reluctance to access medical help or further opinions on her lesion and speaks as if [Mrs C] made it psychologically difficult for her to do so.

[Ms B] is somewhat less clear and seems to indicate that her mother [Mrs A] may have had considerable misgivings over accessing conventional medical care until she was forced by the progression of her condition to accede to the urging of her daughter to do so. She confirms that her mother was petrified of cancer and all that the diagnosis implied.

She speaks of [Mrs C] convincing her mother that the lesion was getting better but does not conclusively corroborate the claim that [Mrs C] impeded [Mrs A's] obtaining alternative advice. [Ms B's] evidence suggests that [Mrs C] was supportive of [Mrs A's] reluctance to seek conventional medical advice.

There are a number of points at which [Ms B's] story is not directly supportive of [Mrs A's] version of events and does not refute the allegations of [Mrs C] about evidence of dependency and an asymmetrical and inappropriate maintenance of an increasingly difficult relationship.

If, however, it is true that [Mrs C] did not at any stage recommend that [Mrs A] see a conventional practitioner and obtain more appropriate treatment for what proved to be an invasive cancer of the head, she violated the first principle above and failed to recognise the limitations of her own practice. She would thereby, through inaction and possibly ignorance, put her patient in the way of harm.

If, further, she did not facilitate or cooperate with an expressed wish of the patient to seek an alternative opinion she is in violation of the second principle above and has, in the event, violated the ethical duty to do her best to keep her patient from harm.

There is no allegation that [Mrs C] abandoned her patient.

If [Mrs C] misled [Mrs A] as to the nature of her condition and led her to believe that it was other than it, in fact, was, then, even if [Mrs C] herself could not be expected to make a diagnosis that fell outside her own area of expertise she would have compounded her failure under her first duty by providing misleading advice that is likely to have resulted in delay of treatment and harm to her patient and this behaviour constitutes not only deceit in regard of her own expertise but also causally harmful deceit in the context of the patient's condition.

[Mrs C] had no duty (nor capacity) to compel or otherwise force her patient to seek alternative care even if she deemed it more appropriate and thought it an advised course of action. A patient of sound mind (whatever their fears and motives) is entitled to make his or her own health care choices once appraised, to the best of his/her caregiver's ability, of the nature of the condition being treated.

[Mrs C] may have had a duty to try and mitigate any unprofessional dependence that [Mrs A] was developing on her although a practitioner's ability to do so is seriously limited when the possibility that one could actually or be considered to have abandoned the patient is a factor in clinical decision-making. It is plausible that [Mrs C] did not want to abandon [Mrs A] rather than being motivated by fear of disclosure of a disastrous regimen of care (as is alleged).

Opinion if the facts are as claimed by [Mrs C].
If, as claimed by [Mrs C], she repeatedly attempted to direct [Mrs A] to alternative and more conventional care for what she recognised to be a serious condition outside her scope of practice, one can only sympathize with her unenviable position.

[Mrs C] seems, by her evidence, to have on several occasions wanted [Mrs A] to seek alternative advice for a serious lesion which she found appalling and daunting but alleges that she was stymied in attempting to do so by her patient's refusal to allow her to share information with others including her family or to seek other treatment.

[Mrs C] alleges that she was aware of [Mrs A's] pathological aversion to the conventional medical system and her irrational fears and anxieties about what might happen to her.

[Mrs C] also gives some evidence that she was aware of an unhealthy and to some extent unprofessional relationship that, perhaps driven by [Mrs A] had been allowed to develop existed between them fuelled by [Mrs A's] irrational attitudes towards her own health and to the possibility of serious illness.

It is easy to be wise in retrospect but in such a situation most practitioners should be aware of the professional risks of a relationship of the type that developed and apprise the patient of their own professional need to seek collegial guidance. They should communicate that to the patient as part of a 'contract' (or agreed partnership) of care. Such an arrangement may have averted the terrible depths to which this situation eventually descended and the acrimony that has resulted.

However, if the facts are as outlined by [Mrs C] then she had very few choices and [Mrs A] ultimately prevailed in her wish to delay seeing conventional doctors, with the possibility of being submitted to surgery or other invasive procedures, for as long as possible. That option carried a terrible cost for all

involved and steps to ensure that such a course of events could not easily happen again would be worthwhile for the sake of future New Zealand Health care arrangements in a context of increasing use of alternative and complementary therapies.

It seems to me that relationships of the kind [Mrs C] alleges that she has with other health care professionals should be fostered and a firm line should be taken by any health care professional that, at the point where s/he feels exposed to the risk of professional negligence or misconduct by a regimen of care on which a patient is insisting, the involvement of a colleague is his/her right regardless of the wishes of the patient.

If the events are as [Mrs C] claims then she does not appear to have violated any ethical standards except, perhaps, to have been too accommodating to a patient's wishes in a highly unusual situation.

Remarks in amplification of ethical opinions.
I offer these remarks not on the basis of my expertise in ethics but as a clinical provider with considerable experience in dealing with patients who have distressing and serious clinical conditions requiring surgery to the head and/or the brain. These remarks are therefore to be regarded as informal observations only and not within my scope of agreed and acknowledged expertise.

Patients such as [Mrs A] are not common but, if I have formed a correct opinion on the basis of the evidence given to me, they pose particular problems for health care practitioners. [Mrs A] seems to me to have been an anxious and dependent person prone to minimising or denying her health care problems out of an almost morbid fear of what they may portend. She seems to have been overly willing to accept reassurance even in the face of seemingly compelling evidence that it was misplaced. She seems to be the kind of person who draws others into close and emotionally demanding relationships and then to place great dependence on those others to the point where they come to realise that they have taken on a burden that is not lightly to be set aside and will prove very costly. Unfortunately committed and well-meaning practitioners are most often those who are badly affected by such relationships and the experiences that result, particularly when they do not exert the kind of hard-headed attention to evidence that for many is a *sine qua non* of professional life. I have some sympathy for the plight of [Mrs C] if events are as she portrays them but it is not my position to form an opinion on the facts of the case."