# Psychiatrist, Dr C

## A Report by the

## Health and Disability Commissioner

## (Case 10HDC01018)

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## Executive summary

1. Ms A, aged 24, had a history of mental illness, which included a fear of separation, difficulty connecting with people her own age, and discomfort with intimate relationships.

2. Psychiatrist Dr C first saw Ms A on 18 April 2008 for an initial assessment. Dr C saw Ms A on four further occasions with her counsellor or case manager. The fifth appointment was on 13 June 2008, when Dr C saw Ms A alone.

3. On 15 June 2008, Ms A visited Dr C at his apartment. She had dinner with him, had sexual relations and stayed the night. Thereafter, Dr C and Ms A had an ongoing sexual relationship. Ms A travelled overseas with Dr C and stayed with him for periods of time. Dr C did not seek peer support as the personal relationship developed.

4. The therapeutic relationship ended on 18 August 2008. Dr C discharged Ms A by way of a telephone conversation and told her that she could call him if she had side-effects from her medication after discharge.

5. The sexual relationship continued until mid-February 2009. After the relationship ended, Dr C paid Ms A approximately $42,200.

6. Dr C induced Ms A to deny to HDC that an inappropriate relationship had existed and to provide inaccurate information to HDC.

*Decision*

7. By engaging in a sexual relationship with Ms A, Dr C sexually exploited her and breached professional and ethical standards. Accordingly, Dr C breached Rights 2[1] and 4(2)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

8. Dr C did not provide services to Ms A with reasonable care and skill. He formed an inappropriate relationship with her during the therapeutic relationship, discharged her by way of a telephone conversation, and told her that she could call him if she had side effects from her medication after discharge. These actions were inconsistent with Ms A's need for roles and relationships to be clearly defined. Accordingly, Dr C breached Right 4(1)[3] of the Code.

9. Dr C's attempts to induce Ms A to provide false information to HDC were a breach of legal and professional standards and, accordingly, a breach of Right 4(2) of the Code.

[1] Right 2 provides: "Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation."
[2] Right 4(2) provides: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[3] Right 4(1) provides: "Every consumer has the right to have services provided with reasonable care and skill."



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10. Dr C failed to provide services in a manner that minimised the potential harm to Ms A by failing to seek peer advice following the consultation with Ms A on 13 June 2008. Accordingly, Dr C breached Right 4(4)[4] of the Code.

11. Dr C was 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.

## Complaint and investigation

12. On 28 July 2010, the Commissioner received a complaint from Ms A about the services provided to her by psychiatrist Dr C. The following issue was identified for investigation:

    *Whether psychiatrist Dr C acted in accordance with professional and ethical standards from April 2008 to May 2009, during which period it is alleged that Dr C had an inappropriate relationship with Ms A.*

13. An investigation was commenced on 28 September 2010.

14. Information was received from the following parties, who were directly involved in the investigation:

| | |
|---|---|
| Ms A | Consumer/complainant |
| Dr C | Psychiatrist/provider |

15. Information was also reviewed from:

| | |
|---|---|
| Mr B | Consumer's father |
| Mrs B | Consumer's mother |
| Mrs C | Provider's wife |
| A district health board | Provider |
| New Zealand Customs Service | |
| An airline | |

Also mentioned in this report:

| | |
|---|---|
| Dr D | Ms A's doctor |
| Dr E | Psychologist |
| Dr F | Physician |

[4] Right 4(4) provides: "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."



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16. Independent expert advice was obtained from psychiatrist Dr Murray Patton, and is included as **Appendix A**.

## Information gathered during investigation

*Dr C's response to complaint*

17. On 29 October 2010, Dr C provided his response to Ms A's complaint and also answered questions put to him by HDC. In his response, Dr C stated that he had not breached ethical boundaries while he was caring for Ms A. His statement did not specifically deny that a sexual relationship had existed after the therapeutic relationship had ended. On 26 January 2011, Dr C was provided with a summary of Ms A's interview with HDC. In February 2011, Dr C refused to be interviewed.

18. On 16 May 2011, Dr C refused to respond to further questions from HDC. His lawyer stated: "Although he denies the allegations made by [Ms A] that there has been an inappropriate sexual relationship between him and [Ms A], he accepts that it is inevitable that [HDC's] investigation will conclude that there has, in [HDC's] opinion, been a breach of the Patients' Code of Rights."

19. Where Dr C has responded to allegations these have been included in the report. Where no response is included, Dr C has not commented on the statement or assertion.

*Background*

20. Ms A had a history of mental illness, including a fear of separation, difficulty connecting with people her own age, and discomfort with intimate relationships.

21. In June 2004, Ms A, then aged 20 years, was referred to a Community Mental Health Service (CMHS) by her doctor, where she was reviewed by a psychiatric registrar and then referred to a psychologist. Ms A had five sessions with the psychologist from October to December 2004, but did not attend her last session. Attempts at contacting Ms A were unsuccessful and her file was closed.

22. Ms A subsequently received private counselling but did not have contact with the CMHS again until December 2007, when she was referred back to the service. Ms A was assessed by the CMHS, and the plan was to continue with GP management and private counselling.

23. On 15 April 2008, Ms A's counsellor wrote to the CMHS advising that the counsellor was happy to continue working with Ms A, but noted that the counselling was costly and, if Ms A was under the CMHS, she could access a greater variety of services at no cost.



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*Consultations with Dr C*

24. Ms A was accepted by the CMHS and her care was assigned to Dr C, a locum psychiatrist employed by the CMHS. Dr C first saw Ms A on 18 April 2008 for an initial assessment.

25. Ms A said that her counsellor was also present at this consultation, which was very brief because Dr C had to leave. Dr C asked Ms A to prepare a timeline of her life. There are no notes from this assessment other than Ms A's timeline.

26. On 23 April 2008, Ms A saw Dr C again. Ms A advised HDC that her case manager was also present at this consultation, and they went through the timeline and briefly discussed her issues.

27. On 23 April 2008, Dr C wrote to Ms A's doctor, Dr D, summarising the consultation. Dr C noted in his letter that he went through Ms A's documented life history with her "to clarify certain points".

28. Dr C stated in the letter that he had asked Ms A to continue seeing him at weekly intervals until she was at a point where she could be referred to a psychologist for her ongoing care.

29. Ms A next saw Dr C on 2 May 2008. Dr C reported to Dr D that the focus of the consultation was "to get a sense of what [Ms A] had understood about our previous discussion". Dr C advised Dr D about the matters discussed during the consultation.

30. Ms A's next consultation with Dr C was on 9 May 2008. Ms A advised HDC that her case manager was not present, and she and Dr C discussed "more personal stuff".

31. Ms A recalls that, at that consultation, Dr C said that she was "very attractive".

32. Dr C reported to Dr D on 9 May following a further consultation with Ms A and described the progress that had been made during the consultation. Dr C advised that he intended to see Ms A once more in a week's time, following which he intended to refer her to a psychologist.

33. Dr C saw Ms A alone again on 13 June 2008. In his reporting letter to Dr D, Dr C advised that Ms A was tolerating her medication well, and while she continued to have some problems, she was feeling better overall. He suggested she start taking [a certain medication] at night to help her with her sleep. He stated: "I will see [Ms A] again in approximately 5 weeks time following my return from leave."

34. Dr C referred Ms A to a psychologist at the CMHS, Dr E, for psychotherapy. Ms A had her initial consultation with Dr E on 24 June 2008. In a letter to Dr C dated 1 August 2008, Dr E confirmed the psychological difficulties noted by Dr C and advised his initial treatment plan of seven cognitive psychotherapy sessions.

35. Ms A advised HDC that the session with Dr C on 13 June was similar to the previous one. She recalls Dr C commenting that they had "such limited time" in the session to



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discuss her issues. She said that "he wanted to know if I would like to come around to his flat and have some time to just ask any questions I wanted to". Ms A advised HDC that Dr C told her that his wife was living in a different town (Town 1). Ms A said that he gave her his cell phone number and suggested that she come to see him on Sunday 15 June.

36. Ms A said that she found Dr C to be "a very charismatic kind of caring man" and that she was "very in awe" of him, and thought he could help her get through her issues.

37. Ms A said that she tried to call Dr C several times on Saturday 14 June and Sunday 15 June but could not reach him.

38. Dr C said that his wife lived in Town 1, and he spent a few nights a week at his apartment in Town 2 and the rest in Town 1. He said that his wife also regularly stayed in Town 2.

39. Dr C's wife, Mrs C, advised HDC that in June 2008 she regularly visited Dr C at Town 2 during the week, and they both spent most weekends at their home in Town 1.

*Events of 15 June*

40. Ms A visited her parents at their home on 15 June. Ms A's father, Mr B, said that Ms A told them that Dr C had been very helpful to her and had even given her his cell phone number so she could contact him after hours. Mr B said that she told them she had been invited to Dr C's apartment that evening for a meal.

41. Mr B recalls that Ms A left their house between 5pm and 6pm, and he and his wife were "extremely unhappy" as they did not think that their daughter fully understood the inappropriateness of socialising with her physician. Mr B recalls that they made this "quite clear" to their daughter, but she replied that it was just a friendship. Ms A said that her parents told her not to go.

42. Mr B noted the events in his diary, a copy of which he provided to HDC. The entry on 15 June 2008 reads:

> "[Ms A] visited this afternoon. Having tea at her psychiatrist's place this evening. We told her this is unsafe for her! I am very concerned!!!"

43. Ms A recalls that she arrived at the apartment on 15 June at approximately 6pm and spoke to the receptionist, saying she wished to see Dr C. The receptionist directed her to Dr C's apartment on the third floor.

44. Ms A said that she told Dr C that she was parked in a limited parking zone, so he went downstairs with her and showed her where the guest parking was. He then took her back to his apartment, cooked them a meal, and they talked.

45. Ms A said that Dr C asked her what she wanted to get out of this time with him. She replied that she "just really liked him" and did not really know where it was going. Ms A said that part way through the meal, Dr C "got up and came around and he gave me



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a kiss". She recalled that she thanked him for the kiss, and noted it was her first kiss from a man.

46. Ms A said that Dr C told her that she was beautiful, then he initiated sexual intercourse and she stayed the night. Ms A stated that this was the first time she had had sexual intercourse, and that she made Dr C aware of that.

47. Mr B advised HDC that at approximately 10.30pm that evening he called his daughter's flat. Her flatmate answered and said that Ms A was not home. He left a message on his daughter's cell phone asking her to ring her parents.

48. Ms A said that on the morning of 16 June she and Dr C did not discuss the sex from the previous night, but Dr C arranged for her to return to the apartment the following evening. She said that he gave her his correct cell phone number, as one digit had been wrong, and kissed her on the cheek when she left.

49. Ms A's mother, Mrs B, said that she received a call from her daughter at approximately 6.30–7am on 16 June. Ms A told her that she had had dinner at Dr C's apartment and then gone home to her flat. However, when Ms A said that she could not hear her mother very well and "would need to get out of the elevator first", Mrs B asked her daughter if she was still at the apartment, and Ms A responded that she was not, that she was at her friend's place and would call her later. Ms A said she "kind of lied" to her mother, because she thought her mother would be angry and ring the police if she told her the truth.

50. Ms A said that, after leaving Dr C's apartment, she went to a female friend's house and told her what she had done, then went to a chemist to get the morning after pill and went to work.

51. Mrs B said that her daughter visited her and her husband later that day. Mrs B talked to her daughter about "some inconsistencies in her statements about last night", and that following "some debate", Ms A admitted that she had spent the night at Dr C's apartment and sexual relations had taken place.

52. Dr C denies that he offered Ms A support outside normal hours, invited her to his apartment, or gave her his telephone number or address. He said that during the consultation on 13 June, Ms A asked him if she could contact him if she needed further advice about her treatment, and he advised her that this was not possible as he had discharged her, but agreed that she could call him if she had side-effects from her medication.

53. Dr C said that Ms A "pitched up" at his apartment unannounced on Sunday 15 June 2008 after asking to be let in by security. Dr C said that Ms A told him she was interested in attending his presentation at the public hospital, and asked if he would drive her there as she lived in the vicinity. Dr C advised HDC that he agreed to drive Ms A to the presentation, but told her that it was "inappropriate" for her to be visiting him at his flat.



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54. Dr C asserted that Ms A responded that she was no longer his patient and "simply wanted to talk about nursing in psychiatry and what it entailed". He also said that, during this conversation, they discussed how she had no one to talk to. Dr C asserted that Ms A then thanked him for listening and left.

55. Dr C said that he asked Ms A how she knew where he lived, and she told him that she had asked someone at the hospital. Dr C did not respond to HDC's questions about whether he took any steps with regard to someone at the hospital having allegedly given his home address to a patient. As stated, Dr C has denied any inappropriate or intimate relationship with Ms A.

*Monday 16 June 2008*

56. Ms A said that Dr C invited her back to his apartment the following night and they had dinner together and talked about their family situations.

57. Ms A advised HDC that she again stayed the night, but they did not have sexual intercourse.

58. Dr C advised HDC that Ms A visited him "on a few occasions thereafter on her own volition" and he saw "no intention on her part other than seeking someone to talk to".

*Tuesday 17 June 2008*

59. On 17 June 2008, Ms A consulted a doctor at a medical centre. The notes from this consultation read:

> "Just became sexually active, asking re [contraceptive] pill …"

*Thursday 19 June 2008*

60. Ms A advised HDC that Dr C went to Town 1 on 18 June, but she stayed at his apartment with him on 19 June and they had sexual intercourse.

*The Hospital*

61. On Wednesday 25 June 2008, Dr C drove Ms A to the hospital, where he was giving a presentation.

62. Dr C advised HDC that Ms A had overheard a telephone call about the scheduled presentation during the consultation on 13 June, and indicated to him that she was thinking about studying nursing and would like to hear his talk, so he told her that she would be welcome to attend.

63. Ms A said that Dr C asked her to go with him and she accepted. She recalls that he advised her to say that she was a second year medical student if anyone asked. She said that after the presentation, she had lunch with Dr C and his colleagues, where he introduced her as a medical student.

64. Dr C accepts that he drove Ms A to the hospital to see his presentation, but claims that Ms A asked him to refer to her as a "nursing student" at the presentation, and denies



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that he suggested this. Dr C recalls that during the journey to the hospital, Ms A enquired about his family in casual conversation.

65. Ms A said that after the trip she was in frequent contact with Dr C by way of text messages and telephone calls, which were initiated by him because he wanted to see her. During this period, they frequently had sexual intercourse.

*Trip overseas*

66. On 2 July 2008, Dr C travelled overseas for one month with his wife. Ms A said that Dr C tried to telephone her from the airport before departing, but she missed the call. She said that he sent her a letter and a card, and that they were in constant text contact.[5] The nature of the texts was to inquire how she was.

67. Ms A said that Dr C gave her a bracelet, two necklaces, sweets, lingerie, and a watch when he returned.[6]

*Contact on return*

68. Ms A advised HDC that after Dr C returned, she continued visiting him at his apartment on the evenings he was in Town 2. She said that they would be together from approximately 6pm until 7.30am and there would be sexual intercourse, hugging, kissing and intimacy. Ms A said that Dr C would also see her at the hospital before her appointments with her psychologist. She said he would sometimes call her into his office before she saw her psychologist, to chat and see if she was "OK", and sometimes he would kiss and cuddle her. Ms A said that Dr C would give her notes. Ms A has given two of the notes to HDC. The notes are of a personal nature and refer to sexual relations.

69. The notes are handwritten. HDC requested that Dr C provide a sample of his handwriting. The sample he provided consists of 19 words. HDC obtained a report from the New Zealand Police document examination section, comparing the sample with the handwriting on the notes and an envelope addressed to Ms A. The conclusion was that there are indications that the notes and envelope were written by the same person who wrote the handwriting samples provided by Dr C.

70. Ms A said that she usually stayed at Dr C's apartment on Monday, Tuesday and Thursday nights. Dr C usually stayed in Town 1 on Wednesday nights and at the weekend. However, she said that he sometimes returned to Town 2 on Sunday night.

71. Ms A said that when she stayed at Dr C's apartment he sometimes dropped her at work and picked her up at the end of the day.

[5] Ms A advised HDC that she did not keep the letter, card, or any of the text messages he sent her.
[6] Ms A has kept the necklace and bracelet and showed these to HDC.



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*Discharge from care*

72. On 18 August 2008, Dr C wrote to Dr D, advising that he had spoken with Ms A by telephone and she had advised him that her medication had been helpful and she had not suffered any side-effects. Dr C also noted that Ms A "[was] currently working with Dr E and [an occupational therapist] in regard to Cognitive Behaviour therapy". Dr C stated that it "seem[ed] appropriate" at that point for him to transfer Ms A's medical care to Dr D, and recommended that Ms A continue taking her medication indefinitely.

*GP consultation*

73. On 18 August, Ms A consulted Dr D in relation to a recurrent urinary tract infection. The notes from this consultation state that Ms A had had "trouble with recurrent urinary tract [infection] since started new relationship, comes and goes … never had a problem prior to becoming sexually active now".

*Trip overseas*

74. Dr C's contract at the DHB was due to end on 31 October 2008. Dr C successfully applied for a position overseas.

75. Ms A said that Dr C told her that he needed to go there "to have some documents signed" and suggested that she accompany him.

76. On 26 September 2008, Dr C and Ms A flew overseas. The airline has confirmed that Ms A sat next to Dr C on the flight. Ms A said that they stayed at a hotel and shared a bedroom. Ms A advised HDC that she paid for her own flights, but Dr C paid for their accommodation.

77. Ms A said that after Dr C signed the required documents, they had dinner at a restaurant. The next day he bought her a "nice dress/top" to wear out to dinner that evening. She recalls that he took her to a "really nice restaurant by the waterfront", they went for a walk by the harbour and then returned to the hotel. Ms A said that they then had sexual intercourse.

78. Ms A said that Dr C had earlier suggested that she recommence studying nursing,[7] and suggested that she study in the area where his new job was. She said he told her that he would be a support in the background when she needed it, and could help her with her studies. Ms A decided to look around the university campus to see whether she wanted to live there.

79. In contrast, Dr C stated that he told Ms A about his new job and that he intended to go there to register with the Medical Council. He recalls that Ms A responded that she had searched the internet and thought the area had good nursing opportunities due to a shortage of nurses. Dr C said that Ms A requested his assistance, as she planned to travel there to "see the place" before enrolling at the university.

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[7] Ms A advised HDC that she had started a nursing degree in her home town in 2008, but became sick and did not complete it.



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80. Dr C said that Ms A travelled there of her own volition, at her own cost, and with "no coercion" from him. In a statement to the Medical Council he advised that, once there, Ms A "was on her own".

81. On 28 September 2008, Dr C left. Ms A said that she remained for three further days to look around the university campus.

82. Ms A said that Dr C picked her up from the airport when she returned to New Zealand and they went to his apartment, where they had sexual intercourse. Dr C drove her home at around 2am.

*October–November 2008*

83. Ms A said that she had intermittent contact with Dr C in October, and the sexual relationship continued into November.

84. Ms A enrolled to study nursing at the university, and planned to travel there at around the same time as Dr C. Ms A said that Dr C told her that his wife would be there with him, but he would help Ms A get settled and would be in the background to support her whenever she needed help.

*New country*

85. On 25 November 2008, Ms A flew to the new country and spent the first night at a backpackers' hostel. Dr C arrived the next day. Ms A said that for the first ten days she stayed with Dr C at his residence, and they continued to have sexual intercourse. She said that Dr C then helped her to move and get settled into her university accommodation.

86. In contrast, Dr C said that Ms A contacted him in late November as she did not know anyone else there, and told him that she needed interim accommodation until her university accommodation became available. Dr C said that he talked to his wife and they agreed to allow Ms A to stay in the spare room of his apartment until her university accommodation was ready. Dr C said that he allowed Ms A to use his computer and internet facilities to apply for part-time jobs, and for her correspondence with the university, and took Ms A to two job interviews because she had no car.

87. Mrs C said that, in December 2008, Dr C told her that Ms A had arrived to study nursing and had contacted him because she was alone and waiting for her university residence to become available. Mrs C said that "being a mother to a university student studying away from home … I felt compassion and understood that it might be difficult for her to be alone in a new place". She said she suggested that Dr C allow Ms A to stay in the spare room for a few days.

88. Ms A said that after she moved into her accommodation, Dr C visited her two to three times a week at the end of the day, and also on Saturday mornings. He sometimes brought her groceries or takeaway food, and they would have sexual intercourse. Ms A recalls that Dr C led her to believe that he was going to step away from having sex with her, but this didn't happen and he continued coming to visit her.



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89. Ms A provided HDC with a birthday card that Dr C gave her on her birthday, in December 2008. Dr C concedes that he "allowed a friendship and dependence to develop" and said he accepts full responsibility for this.

90. Mrs C advised HDC that during Ms A's stay, she and her husband assisted Ms A with material support, including the purchase of groceries while Ms A was living at the university.

91. Ms A said that she stayed with Dr C for two weeks in the New Year when Mrs C travelled back to New Zealand to see their children. Ms A said that she also spent two days with him in February when his wife was away.

*February 2009*

92. Ms A said that Mrs C found out about "the affair" on 14 February 2009.

93. Ms A said that she met with Dr C and Mrs C that morning at her university accommodation, and Mrs C asked about Ms A's relationship with Dr C.

94. Ms A said that she apologised, and told Mrs C that she had been having an affair with Dr C, which had started in Town 2.

95. Ms A said that Dr C and his wife then left, but they returned at midday. Ms A said that she was "hysterical", and Mrs C tried to comfort her. Ms A said that Mrs C told her that she (Ms A) needed to go home to New Zealand to start her life afresh, and they would pay for her ticket. All three of them then drove to Dr C's workplace, where they booked Ms A's flight home.

96. Ms A recalls that Dr C later contacted her to say that he was sorry and that he would return her books.[8] Ms A advised HDC that she was "in shock" and just wanted to return home. She packed her belongings and left early the next morning.

97. In contrast, Dr C advised that in mid-February he came home to find Ms A waiting on the front steps in a distressed state. He said that she told him that she had developed an emotional attachment to him and wanted more than a friendship. Dr C said that he reminded Ms A that that would be inappropriate and not something he could reciprocate. Dr C said that he informed his wife of the incident, and they decided to meet with Ms A to discuss the issue. He said that Ms A became upset and angry at the meeting, and stated that she wanted to go back to New Zealand, but had little financial means. Dr C said that he and his wife offered to pay for Ms A's ticket, and gave her $900 to "tide her over".

98. Mrs C advised HDC that on 11 February, Dr C informed her that Ms A had been waiting outside for him when he returned from another city two days earlier. Dr C told his wife that he had allowed Ms A into their home, and that Ms A had advised him that she had developed an emotional attachment to him. Mrs C said that she asked her husband to call Ms A and arrange to meet to discuss "this issue". They met on 14

[8] Dr C later sent Ms A a package containing 33 books.



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February 2009 in front of Ms A's university residence. Mrs C said that Ms A told her that it was best for her to leave. Mrs C said that she agreed that this would be best for everyone, and she and her husband then left.

99. Mrs C said that she later called Ms A to see how she was. Mrs C recalls that Ms A was "still very distressed", and Mrs C and Dr C returned to see Ms A, who told them that she had nothing, had lost a lot when she moved there, and wanted to return to New Zealand as soon as possible.

100. Mrs C said that she offered to pay for Ms A's ticket home and asked her husband to withdraw $900 from an ATM to give to Ms A. Mrs C said that they then booked Ms A a flight home the next day "at her request". Mrs C said that she consoled Ms A, who was "very tearful and distressed".

*Return to New Zealand*

101. On 15 February 2009, Ms A returned to New Zealand. She recalls that she was "hysterical" and kept leaving messages on Dr C's cell phone because she needed support. She received a telephone call from Mrs C, who told her to stop contacting her husband or Mrs C would contact the Medical Council. Ms A said that she responded that she would report Dr C to the Medical Council herself.

102. Ms A said that Dr C called her on 16 February and left two messages on her phone begging her not to tell anyone about the relationship, because his wife had threatened to end his career by reporting him to the Medical Council. He later called her, wishing her well with her nursing studies.

103. Ms A said that on 17 February Dr C left two messages on her phone telling her not to do anything silly. She said that Dr C then called her and told her that his daughter was upset with the situation and had emailed Ms A. Ms A said that she deleted the email before reading it.

104. Ms A said that Dr C told her to keep calm, and that he would keep in contact with her on a second phone. Ms A said that the contact continued for a time, but later ceased.

*Doctor's consultation*

105. On 19 February 2009 Ms A consulted physician Dr F. The notes from this consultation read:

> "Patient revealed that [she] has just returned from [overseas] allegedly following an affair with her psychiatrist. His wife became aware of their relationship and intervened."

106. On 5 March 2009, HDC received a complaint from Dr F about an inappropriate relationship between Ms A and her psychiatrist.

*Money*

107. Ms A said that before she left, Dr C promised to give her approximately $5,000 to help pay for her expenses, but did not do so.



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108. Ms A said that after she returned to New Zealand she had "nothing", because she had sold everything to move overseas. Ms A advised HDC that, for over a month, she kept asking Dr C for the money he had promised her.

109. Ms A advised HDC that after a month or more of Dr C telling her "it was coming", she began calling him at his work.

110. Dr C said that a few weeks after Ms A left, she called him and stated that he was the cause of her leaving her nursing career and that she had lost financially. Dr C said that Ms A was angry and demanded that he pay her $5,000 to get back all that she had lost as he "owed" her. Dr C said that Ms A abused him for rejecting her and threatened that she was in a position of advantage if he did not agree to compensate her.

111. Dr C said that he was reluctant to pay any money and discussed the matter with members of his family, and they "pondered the situation for a while". He said that during this time, he received another telephone call from Ms A, who was "in an angry state", and advised him that she had gone to her GP and insinuated that she had had a relationship with her psychiatrist. Dr C said that Ms A stated that she could easily deny it as long as he paid the money.

*Consultation with doctor*

112. On 9 March 2009 Ms A again consulted Dr F. The notes from this consultation refer to her relationship with an "ex [partner]". Dr F discussed with Ms A "putting forward [the] complaint".

*Communication with HDC*

113. On 23 March 2009, HDC contacted Ms A asking her to call or email HDC in relation to the complaint made by Dr F on 5 March.

114. On 30 March 2009, Ms A emailed HDC. She stated that she had been "involved emotionally" with Dr C, but there was no "sexual element" to the relationship.

115. On 24 August 2010, Ms A advised HDC that at the time she wrote that email she was in a difficult financial situation and waiting for money from Dr C. She said she told Dr C about the letter from HDC and Dr C said that if she stayed quiet about the affair, his wife would agree to his paying her the money. Ms A said that Dr C wanted to know how she was going to respond to HDC's letter, and told her what she should put in her statement. She said he told her to say that there had been a friendship, but no sexual relationship, and that he and his wife had been giving Ms A moral support. Ms A recalls that Dr C told her that it was very important for her to say that their relationship had been "non-sexual".

116. Ms A also said that she lied in her response to HDC because Dr C told her that he would strip her of her character, and do everything in his power to make her look unstable. He also told her that if she pursued her complaint she would receive no compensation for what had happened.



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117. On 31 March 2009, Ms A sent Dr C a copy of HDC's letter to her asking her to contact HDC about the allegations, together with her response to HDC of 30 March 2009.

118. On 1 April 2009, Dr C deposited $5,000 into Ms A's bank account, and on 8 April 2009 Dr C responded to HDC, denying that he had had an inappropriate relationship with Ms A.

119. On 20 April 2009, HDC referred Dr C to the Medical Council of New Zealand.

120. On 1 July 2009, the Medical Council of New Zealand wrote to Dr C and advised him that it was unwise to provide moral support and material assistance to a person whom he had been treating.

*Request for compensation*

121. Ms A said that at about the same time as the $5,000 was paid she asked Dr C for more money to enable her to study, buy a car, and pay rent and other expenses. Ms A recalls that Dr C told her that she could "dob him in" but, if she did, she would not get any compensation, and her situation would be exactly the same. He told her that she would be better off long term to take the money and be quiet. Ms A recalls that they agreed on the sum of $35,000.

122. Ms A said that she asked Dr C to stay in touch for "moral support", and he continued to communicate with her through a separate email account he had set up.

123. Ms A said that she also maintained telephone contact with Dr C.

124. Dr C said that he received a phone call from Ms A on 30 March demanding compensation for her "destitute situation", and asking him for $35,000 to cover the expenses of her studies, rental of a flat, and the cost of a car, as she felt that he and his wife were responsible for her departure and withdrawal from her nursing studies. Dr C said that Ms A told him that she had studied the HDC and Medical Council websites and believed that she was in a good position to get "proper compensation".

125. Dr C said that when he refused to pay Ms A any money, she became hysterical and threatened to destroy his future career and his family. Dr C said that Ms A then told him that she had been contacted by HDC and that she "had been honest in her response" and would send him a copy as proof, but that she "could change it to anything she desired" as she was of the view that she could convince anyone that she had had a sexual relationship with him.

126. Dr C advised HDC that he accepted that he had "inadvertently allowed [Ms A] to become dependent on [him], which caused her great distress when [he] rejected her advances". Dr C advised HDC of the reasons why he felt he had "no choice but to pay [Ms A]". Dr C further advised, "I am not proud of this as I take pride in my honesty. However, I acted as a father protecting his family, and a provider protecting his livelihood".



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127. Dr C added that he "felt obliged to assist" Ms A as the circumstances under which she left had been stressful and he may have contributed to her developing an attachment, by providing her with support over time.

128. Mrs C said that she and her husband decided to give money to Ms A because Mrs C felt that she had in some way contributed to Ms A's sudden decision to withdraw from her studies and return to New Zealand.

129. On 4 May 2009, Dr C deposited $15,000 into Ms A's bank account.

*False statement*

130. Ms A advised HDC that Dr C contacted her in May 2009 and said he did not think her initial response to HDC was "full enough" and asked if they could meet to discuss a more detailed response. Ms A said that she told Dr C that she did not want to see him, so he asked her if he could send her a response he had drafted, and she agreed.

131. Ms A provided HDC with a copy of the statement she alleges that Dr C sent her, together with the envelope in which it arrived. The New Zealand Police document examination report states that the handwritten address on the envelope has indications that suggest it was written by Dr C. The envelope is post marked 7 May 2009. The letter reads:

> "I wish to add to my statement that I made to the Health and Disability Commissioner to clarify any misunderstanding about my relationship with [Dr C].
>
> I was assessed by him and referred on to a psychologist. Thereafter I called him for some advice as I was having some difficulties at home. I wanted to have another consultation with him but he indicated that he had discharged me and suggested I talk to my psychologist. I wanted advice about my medication and suggested we meet at a café close to the hospital to which he agreed. The next time I met him was in early October at [a] shopping centre, and talked to him for a brief period.
>
> I had researched doing nursing training overseas so that I could get away from [Town 2]. I decided to enrol for nursing [overseas] as they had a shortage of nurses there. I also wanted to travel.
>
> [Once there] I needed some support and contacted called [sic] [Dr C] at the hospital as I was aware that he was working there. I received encouragement and moral support from both the doctor and his wife. However I started becoming attracted to him, but he felt this inappropriate. He discussed this with his wife and me. She became upset. I also was upset and distressed, so I made the decision to come back to New Zealand.
>
> I was angry, confused and felt rejected. I believe that I may have given my GP the wrong impression about my relationship with [Dr C]. I wish to make it clear that there was no intimate or sexual relationship between us.



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I am now fine and have enrolled for nursing at the Polytech. I would like this matter closed, so that I can get on with my life."

132. The letter, which is typed, has Dr C's name obscured by black ink, but the name is nonetheless legible.

133. Ms A advised HDC that she found this statement to be "weird" and told Dr C that she would not send it to HDC.

*Correspondence with Ms A's parents*

134. In early June 2009, Ms A's parents wrote to Dr C about his actions and the effect they had had on Ms A, noting that he had betrayed Ms A's "total trust" in him, his profession, and ultimately himself in what he had done.

135. Mr and Mrs B's letter stated that they feared "greatly for [her] mental health as well as her ability to cope with everyday life now and in the future" and noted that Dr C had not accepted that he was the main protagonist in the affair and held the power in the relationship. They advised Dr C that Ms A needed to hear from him "an unequivocal statement saying it was you at fault, that you held the power and you are so very sorry for the hurt you have caused her".

136. Dr C responded to Mr and Mrs B in an undated letter in which he expressed his "sincere and unmitigated apology to [their] family and [Ms A] in particular for the distress and pain that [his] lapse in judgement has caused".

137. Dr C went on to say that:

> "I however take full responsibility for my error and lapse of judgement and assure that I will never again place anyone at risk under my care … I am grateful for the outcome, not so much for me, but for all other innocent people that will have suffered as a result of my actions.
>
> I thank you on behalf of my family and all those that rely on my expertise, for your magnanimous decision regarding the future."

*Subsequent events*

138. Ms A provided HDC with email correspondence between herself and Dr C.

139. On 6 January 2010, Dr C emailed Ms A and advised that he was "doing a locum in [a rural area]" and would be able to deposit the final payment into her account in the second week of February, when he got paid.

140. On 13 January 2010, Ms A wrote an email to Dr C. The email referred to sexual relations, and the detrimental impact that his actions had had on her.

141. Dr C responded the same day:



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"I have read what you said and will contact you next week. Please do not say anything else in your email. I have lost a lot but do not resent you, even getting the money. I will survive. But for the sake of my family do not let your hate for me destroy others. Pleaseee [sic]."

142. Dr C sent Ms A the following email on 13 January 2010:

"Please do me a favour without asking a reason. Things are getting better and I need your help. Please send the following email to my work account. You have no idea how this will help me. I know you are angry. But this will help bring closure.

*Hi [Dr C]*

*How are you? I have had some ill health. What is happening about the money? Please contact me.*

*[Ms A]*

PS I will ever be grateful. This is for you know who. It will settle a few issues for me. Please put aside your anger and do this for me. Thanks"

143. On 15 February 2010, Dr C deposited $4,985 into Ms A's bank account.

144. On 16 February 2010, Dr C deposited $9,985 into Ms A's bank account and emailed Ms A the following:

"You should have all the money by now. That brings it to a total of about $42,200.00. I just want you to know that I have no anger towards you. I still believe you are a good person at heart."

145. On 28 July 2010, Ms A complained to HDC, alleging that she had had a sexual relationship with Dr C, commencing on 15 June 2008.

146. On 4 October 2010, Dr C emailed the following to Ms A's father:

"You are aware that [Ms A] has lodged a complaint with the HDC. I wish to communicate with you regarding the issue that has arisen. I am prepared to take the full consequences of my actions, but I believe that you (as [her] father) need to know some details that may be detrimental to all of us.

Please confirm that I am able to use this email. You may wish not to respond, and I will respect that.

[Dr C]"

147. Mr B responded the next day advising that it was best that they did not correspond as he did not wish to prejudice HDC's inquiry.

*Dr C's response to provisional opinion*



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148. In response to my provisional opinion, Dr C reiterated that he had not entered into a sexual relationship with Ms A, stating the following:

> "I was very disappointed to read that you have concluded in your opinion I did enter into a sexual relationship with [Ms A]. This is simply not so and as I have previously made clear, such a finding or opinion is incorrect."

---

## Relevant professional standards

149. The Medical Council of New Zealand's *Sexual Boundaries in the Doctor–Patient Relationship: A resource for doctors* (October 2006)[9] states:

> "The Council has a zero-tolerance position on doctors who breach sexual boundaries with a current patient. In the Council's view it is also wrong for a doctor to enter into a relationship with a former patient or a close relative of a patient if this breaches the trust the patient placed in the doctor.
>
> …
> A breach of sexual boundaries comprises any words, behaviour or actions designed or intended to arouse or gratify sexual desires … It incorporates any words, actions or behaviour that could reasonably be interpreted as sexually inappropriate or unprofessional.
>
> …
> It is difficult for any professional to objectively assess the appropriate action when he or she is attracted to a client. By recognising the danger signs you can consciously avoid any improper behaviour before any damage is done.
>
> …
> If you … feel attracted to a patient ask for help and advice from a respected peer who can help you decide the appropriate and ethical course of action.
>
> …
> 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."

150. The New Zealand Medical Association's Code of Ethics (2008) recommends:

> "Doctors, like a number of other professionals, are involved in relationships in which there is a potential or actual imbalance of power. Sexual relationships between doctors and their patients or students fall within this category. The

[9] In October 2009, the Medical Council issued a revised statement on *Sexual Boundaries in the Doctor–Patient relationship: A resource for doctors*. This statement postdates these events but, in any event, it would not have affected the outcome in this case.



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NZMA is mindful of Medical Council policy in relation to sexual relationships with present and former patients or their family members, and expects doctors to be familiar with this. The NZMA considers that a sexual relationship with a current patient is unethical and that, in most cases, sexual relations with a former patient would be regarded as unethical, particularly where exploitation of patient vulnerability occurs. It is acknowledged that in some cases the patient–doctor relationship may be brief, minor in nature, or in the distant past. In such circumstances and where the sexual relationship has developed from social contact away from the professional environment, impropriety would not necessarily be inferred. Any complaints about a sexual relationship with a former patient therefore need to be considered on an individual basis before being considered as unethical."

151. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) ethical guideline *Sexual Relationships with Patients*[10] provides:

"1. Psychiatrists, like other medical practitioners, are required to adhere strictly to their ethical obligations. In psychiatry there is an even stronger obligation to avoid exploitation because of the more intensive therapeutic relationship with patients, and the powerful emotional forces often released during treatment.

2. Psychiatrists face certain inescapable duties. They must be competent technically and watchful to ensure that whatever happens in therapy is in the patient's best interests. Psychiatrists should be aware of the need to monitor not only the patient's emotions but their own, in the interests of the therapeutic process and for the patient's benefit. This firmly excludes any exploitation of the patient sexually, financially or in any other way.

3. Sexual relationships between current and former patients and their psychiatrists are never acceptable and constitute unethical behaviour. The term 'sexual relationship' is not restricted to sexual intercourse. In this guideline, sexual relationship includes: any behaviour, including discussion, which has as its purpose some form of sexual gratification, or which might reasonably be construed as having that purpose."

152. The *RANZCP Code of Ethics*[11] provides:

"3. Psychiatrists shall provide the best possible psychiatric care for their patients.

3.1 Psychiatrists shall serve the best interests of their patients by engendering mutual trust and therapeutic partnership, avoiding intentional or foreseeable harm and treating patients under the best possible conditions."

153. *Cole's Medical Practice in New Zealand* (2009) provides:

[10] February 1990, amended August 2005.
[11] October 1998.



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> "81. You must cooperate fully with any formal inquiry into the treatment of a patient and any complaints procedure that applies to your work. Disclose to the appropriate authority any information relevant to an investigation into your own or a colleague's conduct, performance or health.
>
> 82. If you are asked to give evidence or act as a witness in litigation or formal proceedings, be honest in all your written and spoken statements. Make clear the limits of your knowledge or competence."

## Opinion: Breach — Dr C

*Introduction*

154. This case relates to the relationship between a psychiatrist and his patient both during the therapeutic relationship and after it ended. In this case, I must determine several key issues of fact:

1) During what period was Ms A a patient of Dr C?

2) Did Dr C have a sexual relationship with Ms A while she was his patient?

3) Did Dr C have a sexual relationship with Ms A after the therapeutic relationship ended?

155. I note that "sexual relationship" includes any behaviour, including discussion, which has as its purpose some form of sexual gratification, or which might reasonably be construed as having that purpose.

156. The professional and ethical standard expected of a medical practitioner is set out in the Medical Council's publication *Sexual Boundaries in the Doctor–Patient Relationship*. The standard is non-negotiable. The Council will not tolerate sexual activity with a current patient by a doctor. Any doctor–patient sexual activity is considered a most serious transgression from the doctor's professional standards, irrespective of consent on the part of the patient.

157. As stated above (see paragraph 151), in psychiatry there is an even stronger obligation to avoid exploitation, because of the more intensive therapeutic relationship with patients, and the powerful emotional forces often released during treatment. Sexual relationships between current and former patients and their psychiatrists are never acceptable and constitute unethical behaviour.

158. Dr C was aware that Ms A was vulnerable.

*Therapeutic relationship*

159. When Dr C saw Ms A on 13 June 2008, he recorded that he planned to see her again on his return from leave in five weeks' time. Following a telephone conversation with Ms A on 18 August, Dr C took steps to discharge her to the care of her GP. I conclude



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that Dr C was in a therapeutic relationship with Ms A from 18 April 2008 until 18 August 2008.

*Sexual relationship*

160. I am satisfied that, on the balance of probabilities, Dr C and Ms A had a sexual relationship between 15 June 2008 and mid February 2009. My reasons for this conclusion are as follows.

161. Ms A alleged that on 13 June 2008, Dr C suggested that she come to his flat to discuss her issues, and gave her his cell phone number. Ms A said that, on 15 June 2008, when she was unable to contact Dr C because the number was incorrect, she went to the apartment and the receptionist directed her to Dr C's apartment.

162. Ms A stated that she had not previously experienced sexual intercourse. She claimed that this was the first occasion on which she and Dr C had sexual relations and that she stayed the night at his apartment.

163. Ms A's parents stated that Ms A told them on 15 June that Dr C had invited her to his residence for a meal, and they told her that they thought such contact was inappropriate. Mr B recorded his concerns in his diary. Mrs B said that she and her husband spoke to their daughter on the afternoon of 16 June, and Ms A admitted that she had spent the night at Dr C's apartment, and that sexual relations had taken place.

164. On 17 June 2008, Ms A consulted a doctor and stated that she had just become sexually active and asked for advice about the contraceptive pill.

165. In contrast, Dr C denied that he invited Ms A to his flat and claimed that she "pitched up at the door of [his] flat unannounced on a Sunday after asking to be let in by security". Dr C acknowledged that Ms A visited him on a few occasions thereafter "on her own volition".

166. I note that Ms A's account of events has not been entirely consistent. Following the complaint to HDC made by Dr F, Ms A advised HDC on 30 March 2009 that she had become "emotionally attached for a period, but there was no sexual element to the relationship".

167. Ms A explained this statement by saying that she was in financial difficulties and waiting for Dr C to pay her the money he had agreed to pay, and that he said that if Ms A stayed quiet, his wife would agree to pay money to her. Ms A stated that she knew that if she acknowledged that relationship she could not backtrack, and that Dr C said that if she told HDC that they had had a sexual relationship he would be "finished". Ms A stated that Dr C told her what to say in her response to HDC.

168. Ms A said that she sent Dr C a copy of her response to HDC, and he subsequently sent her the text of a further statement that he wanted her to send to HDC. Ms A said that she refused to do so.



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169. Ms A provided two handwritten notes that she says Dr C wrote to her. The expert opinion is that there are indications that this is the handwriting of Dr C. The notes were personal in nature and referred to sexual relations. I find that it is more likely than not that those notes were written by Dr C. In my view, the content of these notes alone is sufficient to amount to a breach of sexual boundaries.

170. On 26 September 2008, Ms A and Dr C travelled overseas. On the flight they sat in adjoining seats. Ms A advised HDC that she paid for her own flights, but Dr C paid for their accommodation.

171. Ms A asserts that she and Dr C stayed together at a hotel. Ms A said that they had dinner at a restaurant and the next day he bought her a "nice dress/top" to wear out to dinner that evening and he took her to a "really nice restaurant by the waterfront". Dr C has not denied these statements. Accordingly, I accept Ms A's evidence.

172. Ms A said that on 25 November 2008 she again flew there, and Dr C arrived the following day. Ms A said that they stayed together at Dr C's residence for the following ten days, and the sexual relationship continued. Dr C then helped her to move to her university accommodation. In contrast, Dr C said that Ms A contacted him saying she needed interim accommodation and he agreed to allow her to stay in the spare room of his apartment until her university accommodation was ready, and that he took Ms A to two job interviews because she had no car. However, both Ms A and Dr C agree that they stayed together in his apartment for ten days in late November/early December 2008.

173. Ms A alleges that once she moved to her university accommodation Dr C would visit her two or three times a week and on Saturday mornings, and a sexual relationship continued. Although Dr C denies having a sexual relationship with Ms A, he concedes that he "allowed a friendship and dependence to develop". Ms A said that she stayed with Dr C for two weeks when Dr C's wife travelled back to New Zealand, and for two further days in February when his wife was away. Dr C has not denied these allegations. I accept Ms A's evidence that she stayed with Dr C on these occasions and that the sexual relationship continued during this period.

174. In early June 2009, Ms A's parents wrote to Dr C about his actions and the effect they had had on Ms A. Dr C's response contained an apology and the statement: "I however take full responsibility for my error and lapse of judgement and assure that I will never again place anyone at risk under my care."

175. On 13 January 2010, Ms A wrote to Dr C referring to the sexual relationship and the detrimental impact that his actions had had on her. Dr C responded the same day: "I have read what you said and will contact you next week. Please do not say anything else in your email." He did not assert that the statements about a sexual relationship were untrue.

176. In light of the contemporaneous consistent information provided by Ms A to her parents on 15 and 16 June 2008, to her GP on 17 June 2008, the nature of the



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correspondence between Dr C and Ms A, and the subsequent events, including during the trips overseas, I am satisfied that Dr C had an inappropriate relationship with Ms A, and that it is more likely than not that the relationship was of a sexual nature.

177. Dr C must have been aware that his relationship with Ms A was unethical. The strict prohibition on a sexual relationship between doctors and their patients exists for the protection of the individual patient, who is actually or potentially vulnerable in what is an unequal relationship. The prohibition is so essential for the maintenance of public trust in the medical profession that it is deeply embedded in medical ethics and professional guidelines.

178. The Health Practitioners Disciplinary Tribunal has reiterated the prohibition on doctors entering into sexual relationships with their patients. In *Nuttall* a general practitioner entered into a long-term sexual relationship with his patient when he was aware that she was in a vulnerable state. The Tribunal stated that Dr Nuttall's conduct "constituted gross negligence, malpractice and brought the medical profession into discredit. His actions justify a severe disciplinary sanction for the purposes of protecting the public, maintaining professional standards, and to punish him."[12]

179. In *Patel*, a general practitioner was found guilty of professional misconduct because he had a sexual relationship with a current patient. The Tribunal referred to the Medical Council's policy paper "Sexual Conduct With Patients" and its zero tolerance of doctors who breach sexual boundaries with a current patient.[13]

180. In this case, the inequality of the relationship was accentuated by the fact that Dr C was Ms A's psychiatrist and knew her history and the extent of her vulnerability. It is irrelevant that the sexual relationship was consensual or that Dr C paid money to Ms A. It is the responsibility of the medical practitioner to maintain professional boundaries and ethical standards. Dr C seriously abused Ms A's trust.

181. I conclude that Dr C had a sexual relationship with Ms A while she was his patient, between June 2008 and August 2008. The sexual relationship continued after the therapeutic relationship ended in August 2008 until February 2009. In these circumstances, Dr C sexually exploited Ms A and breached professional and ethical standards. Accordingly, I find that Dr C breached Rights 2 and 4(2) of the Code.

*Statements to HDC*

182. In March 2009, Dr C persuaded Ms A to provide misinformation to HDC by making threats and attempting to gain her sympathy. In May 2009, Dr C sent the text of further misinformation he wished her to send to this Office.

183. *Cole's Medical Practice in New Zealand* (2009) provides: "You must cooperate fully with any formal inquiry into the treatment of a patient and any complaints procedure that applies to your work." I view Dr C's attempts to induce Ms A to mislead this

[12] *Professional Conduct Committee v Nuttall* (8/Med04/03P), para 75.

[13] *Director of Proceedings v Patel* (59/Med06/36D), paras 57–60.



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Office very seriously, and consider that they damage Dr C's credibility. Dr C's actions were unprofessional, unethical and a breach of legal and professional standards and, accordingly, he breached Right 4(2) of the Code.

*Standard of treatment and discharge*

184. As Ms A's psychiatrist, Dr C had a duty to serve Ms A's best interests, provide services with reasonable care and skill, and avoid doing any harm to her. By entering into a sexual relationship with Ms A — a patient who was seeking psychiatric treatment including for issues relating to a fear of separation and discomfort with intimate relationships— Dr C not only acted unethically, but also failed to provide services of an appropriate standard.

185. Furthermore, Dr C advised HDC that, during the last consultation with her, Ms A enquired if she could contact him if she needed further advice about her treatment, and he told her that this was not possible as he had discharged her. However, he said he "agreed that she could call [him] if she had side-effects from her medication".

186. In giving this advice Dr C provided mixed messages to Ms A. Advice about side effects could reasonably be construed to be advice about treatment, even though Dr C had said he would not be involved in further treatment decisions because he had discharged Ms A.

187. As advised by Dr Patton, "for someone in whom difficulty and understanding of relationships had been clearly identified as an important contributor to their mental health problems, unambiguous advice about professional roles was important. I do not think this was acting with reasonable care and this was not consistent with [Ms A's] needs, for roles to be clearly defined and unambiguous."

188. The records of the consultation of 13 June 2008 state that Dr C planned to see Ms A in five weeks' time. The only subsequent record is of a telephone call with Ms A on 18 August 2008, at which time Dr C indicated that he would be discharging Ms A to the care of her GP.

189. Dr C was aware of Ms A's fear of separation and being alone, and that she turned to others for support and security. As advised by Dr Patton, all these factors point to the need for particular care in the arrangements for discharge. I agree with Dr Patton that Dr C's decision to discharge Ms A by way of a telephone conversation in these circumstances was seriously inadequate, and fell well short of a reasonable standard of care.

190. In my view, Dr C did not provide services to Ms A with reasonable care and skill because he formed an inappropriate relationship with her during the course of the therapeutic relationship, discharged her by way of a telephone conversation, and told her she could call him if she had side effects from her medication after discharge. These actions were inconsistent with Ms A's need for roles and relationships to be clearly defined. In my view, Dr C breached Right 4(1) of the Code.



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*Boundaries and peer support*

191. It is undisputed that Ms A visited Dr C's apartment on more than one occasion. Ms A alleges that she was invited there by Dr C, while Dr C alleges that Ms A "pitched up" uninvited. Ms A recalls Dr C commenting during the consultation on 13 June 2008 that they had "such limited time" in the session to discuss her issues. She said that "he wanted to know if I would like to come around to his flat and have some time to just ask any questions I wanted to".

192. In light of Ms A's conversation with her parents, which was contemporaneously recorded by Mr B in his diary, I consider that it is more likely than not that Dr C invited Ms A to visit his apartment. Dr Patton has commented that "it is hard to identify a circumstance where it would be appropriate for the psychiatrist to invite a patient to his or her own home for something that might be framed as therapeutic intervention".

193. Following the consultation on 13 June, Dr C should have realised that the invitation he had issued was inappropriate. Dr Patton considers that, at the very least, Dr C should have sought support and guidance from colleagues and supervisors who were experienced in managing such difficulties, with consideration being given to transferring Ms A's care to another practitioner.

194. It is also undisputed that Dr C drove Ms A to the hospital on 25 June 2008. As advised by Dr Patton, "in any circumstance, the maintenance of professional boundaries between a psychiatrist and a patient is of central importance to the therapeutic relationship. Therapeutic work should be confined to the context of clearly defined therapeutic encounters, in a clinical context … providing transport to a meeting unrelated to the purpose of the professional relationship would serve only to further blur the nature of the relationship and the boundary between professional and personal roles. At best this would be unwise."

195. I agree with Dr Patton that having not discussed these issues with his psychiatric peers following the appointment on 13 June 2008 was a significant lapse of judgement on Dr C's part. He had a responsibility to be explicit about boundaries and what was appropriate or inappropriate contact. His failure to take appropriate steps following the consultation on 13 June meant he did not provide services in a manner that minimised the potential harm to Ms A. Accordingly, I find that Dr C breached Right 4(4) of the Code.

*Payments*

196. In February 2009, Dr and Mrs C paid for Ms A's return ticket to New Zealand. Subsequently, Dr C made additional payments to Ms A amounting in total to approximately $42,000. At least one payment was made after Dr C had advised HDC that he had had no inappropriate relationship with Ms A. As stated by Dr Patton, an exchange of any sort between practitioner and patient, other than appropriate payment for professional advice, is hazardous. Dr Patton advised that "to offer payment to [Ms A] for her ticket would in my view undermine the message that a personal relationship was not appropriate".



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197. Further payments were made in February 2010, despite the Medical Council of New Zealand having written to Dr C advising him that it was unwise to provide moral support and material assistance to a person whom he had been treating. Dr Patton advised that "to continue to make such payments after receipt of such a letter from a regulatory body suggests a serious lack of judgement and would be viewed with serious disapproval by peers". I agree with Dr Patton's advice.

*Summary*

198. Dr C must have been aware that his relationship with Ms A was unethical. The strict prohibition on the sexual relationship between doctors and their patients exists for the protection of the individual patient. In this case, Ms A was particularly vulnerable, in what was an unequal relationship.

199. The *RANZCP Code of Ethics* and ethical guideline *Sexual relationships with patients* requires a higher standard for psychiatrists entering into relationships with their patients than for other doctors. The prohibition on such relationships extends to both current patients and former patients. It is irrelevant that the sexual relationship was consensual, or that Dr C paid money to Ms A to compensate her for the financial difficulties she experienced as a result of his actions. It is the responsibility of the medical practitioner to maintain professional boundaries and ethical standards. I consider that Dr C abused the trust of his patient.

200. Dr C had a sexual relationship with Ms A while she was his patient between June 2008 and August 2008. That relationship continued, after the therapeutic relationship had terminated, until February 2009 and, in these circumstances, Dr C breached Rights 2 and 4(2) of the Code.

201. Dr C failed to be explicit about boundaries and what was appropriate and inappropriate contact, and did not seek peer support following his consultation with Ms A on 13 June 2008. Accordingly, he failed to provide Ms A with services in a manner that minimised the potential harm to her, and breached Right 4(4) of the Code.

202. Dr C entered into a sexual relationship with Ms A while in a therapeutic relationship with her, discharged her by way of a telephone conversation, and told her that she could call him if she had side effects from her medication after discharge. Accordingly, Dr C did not provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

203. Dr C breached legal and professional standards by inducing Ms A to provide false information to this Office. Accordingly, Dr C breached Right 4(2) of the Code.

## Recommendations

204. I recommend that Dr C:



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- apologise to Ms A for his breaches of the Code. The apology is to be sent to HDC by **10 December 2012**.

205. Dr C is currently practising overseas and does not hold a current practising certificate in New Zealand. However, should Dr C decide to return to practice in New Zealand, I recommend that:

- the Medical Council of New Zealand undertake a competency review before issuing a practising certificate to Dr C. Dr C must report back to HDC on the outcome of any review before recommencing practice in New Zealand.

- he enter into a mentoring relationship for two years with two senior psychiatrists (including at least three face-to-face meetings with each mentor each year), and that both mentors provide written confirmation to the Royal Australian and New Zealand College of Psychiatrists that the mentoring has occurred and that Dr C appears to be continuing to maintain appropriate professional boundaries with patients.

## Follow-up actions

- Dr 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 will be sent to the DHB.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, the regulation agency and the medical board in the country of Dr C's new position, and the Royal Australian and New Zealand College of Psychiatrists, and they will be advised of Dr 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 disciplinary proceeding. The Health Practitioners Disciplinary Tribunal's decisions finding professional misconduct established and cancelling the doctor's registration are available at http://hpdt.org.nz/Default.aspx?Tabid=379



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## Appendix A — Independent expert advice to Commissioner

The following expert advice was obtained from: Dr Murray Patton FRANZCP.

"I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP, or 'the College') and have had vocational registration (Medical Council of New Zealand) in psychiatry for just over 20 years. I have worked at a senior clinical level within public sector mental health services in Australia and New Zealand for many years and have maintained a small private consulting practice. I have additionally been actively involved with committees of the RANZCP over many years, including in recent years holding the positions of deputy Chair of the Board of Practice Standards, Chair of the Board of Practice and Partnerships and I presently hold the office of President. Please note that my comments should not be regarded as reflecting any opinion of the RANZCP, but simply that my experience with College matters contributes to my views on this matter along with the variety of other professional roles I have had over my years of practice as a psychiatrist.

I am not aware of any conflict of interest in this matter.

You have asked three questions:

1. What standards apply in this case?

2. Was there a departure from any of these standards by [Dr C] (and if so, in what way)?

3. Are there any aspects of the care provided by [Dr C] that I consider warrant additional comment?

I shall address each of these below.

You have noted that there are disputed facts in respect of this complaint. I shall not attempt to determine which elements of the reports from [Dr C] or [Ms A] are true but instead base my comments upon the standards that are required of practitioners by regulation and formal guidelines as well as by commonly expected levels of expertise within the psychiatric profession.

**What standards apply?**

There are a number of sets of standards that apply to the practice of a psychiatrist working in the public sector mental health services in this country. Most relevant of these in respect of the performance of an individual medical practitioner and psychiatrist and to the issues of concern in this complaint are:

• Medical Council of New Zealand standards for all doctors registered with the Council, as detailed in the publication 'Good Medical Practice' (June 2008)



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• RANZCP Code of Ethics (latest revision 2010, although the version of relevance in the period of concern was issued in 2004). [Dr C] as a Fellow of the College is expected to practise in accord with these standards

• RANZCP Ethical Guideline #8 'Sexual relationships with patients' (amended August 2005)

In addition, a document oriented toward providing guidance for patients also helps define the behavior and standards expected of medical practitioners in New Zealand. This document, 'The importance of clear sexual boundaries in the patient–doctor relationship', was updated by the Medical Council of New Zealand in 2006 and mirrors in a resource document for doctors, 'Sexual boundaries in the doctor–patient relationship' published by the Council in 2004 and reprinted in 2009.

Further, a general standard is set by Health and Disability Commissioner Code of Rights (1996, revised 2004).

**Was there a departure from any of these standards by [Dr C]?**

[Dr C], in his letter (dictated 23 April 2008) to Dr D following his second appointment with [Ms A], had identified that [Ms A] had [certain issues].

Earlier records from 2005 had noted that [Ms A] appeared to have a fear of separation (file discharge note of 14 February 2005, written by [a psychologist]).

In a further letter dictated on 2 May 2008 [Dr C] noted that [certain issues would be addressed] in the therapeutic interactions with [Ms A].

[Dr C] saw [Ms A] on 13 June at which time he planned to see her again on his return from leave in 5 weeks. A further letter following a telephone discussion with [Ms A] on 18 August indicates that [Dr C] was discharging her to the care of the GP. Continuation with [her medication] indefinitely was recommended by [Dr C]. The letter noted continued clinical involvement with two therapists in respect of cognitive behavioural therapy.

In a letter to [Dr C] dated 1 August 2008, the psychologist who saw [Ms A] in June of that year confirmed the psychological difficulties noted by [Dr C] in his reports.

This is the background against which the various allegations of [Ms A] and responses from [Dr C] should be considered.

[Ms A] alleges that in June 2008, in the context of a clinical appointment with [Dr C], he invited her to his apartment on Sunday 15 June to help with [a certain issue] and that he offered her 'extra support outside normal hours'. At this time [Dr C] had been the psychiatrist providing treatment to [Ms A] since April of that year. He was still the treating psychiatrist.



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In any circumstance, the maintenance of professional boundaries between a psychiatrist and a patient is of central importance to the therapeutic relationship. Therapeutic work should be confined to the context of clearly defined therapeutic encounters, in a clinical context. Whilst in some circumstances this might include visits to the home of a patient, it is hard to identify a circumstance where it would be appropriate for a psychiatrist to invite a patient to his or her own home for something that might be framed as a therapeutic intervention.[14]

This issue is flagged[15] by the Medical Council as a danger sign pointing to possible threat to the maintenance of proper professional boundaries. Danger signs are noted to include seeing patients at unusual hours, especially in the absence of other staff; and giving or accepting social invitations from a patient.

[Ms A] advised the HDC that she went to [Dr C's] apartment on 15 June and had dinner with him, subsequently staying the night and that a sexual encounter took place. She advises that she visited again the following night.

I note that since this initial allegation in respect of a sexual encounter, [Ms A's] accounts of whether or not there has been a sexual relationship with [Dr C] have varied.

If a sexual encounter did take place at this time, this would clearly have been in breach of the expected standards of the Medical Council and the RANZCP.

The Medical Council guidance notes for doctors[16] identify that the Council has a zero tolerance position on doctors who breach sexual boundaries with current patients. At this time in June, [Ms A] remained a patient of [Dr C].

The Medical Council position in respect of sexual relationships with former patients is less clear.

The RANZCP Code of Ethics[17] sets out to guide ethical professional conduct. The Code notes that it may be applied by other bodies as a benchmark of satisfactory ethical behavior in the conduct of psychiatry.

In 2004 the annotations to Principle 2 of the Code included:

• 2.4 Psychiatrists shall not engage in sexual exploitation, harassment or sexual contact of any kind with their patients

[14] This might only be acceptable if there was a clearly designated consulting space within the home, with appropriate separation of personal and professional spaces. There is no suggestion that Dr C in any context had such arrangement at his home.
[15] In 'Sexual Boundaries in the Doctor Relationship — a resource for doctors' Medical Council of New Zealand — March 2004, reprinted 2009.
[16] Ibid.
[17] The RANZCP Code of Ethics. Royal Australian and New Zealand College of Psychiatrists, October 2004. This code was revised in 2010.



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• 2.5 Sexual relationships between psychiatrists and their patients are always unethical

• 2.6 Sexual relationships between psychiatrists and their former patients are always unethical

This is in accord with the Ethical Guideline No 8 of the RANZCP ‘Sexual Relationships with Patients’ dated 1990, which notes ‘Sexual relationships between current and former patients and their psychiatrists are never acceptable and constitute unethical behavior’. In this guideline, sexual relationship includes any behavior that has as its purpose some form of sexual gratification, or which might reasonably be construed as having that purpose.

In this respect in relation to former patients, the RANZCP is much clearer than the Medical Council about the standards expected in respect of former patients.

[Dr C] advises that [Ms A] arrived unannounced at his apartment on 15 June. He also reports that [Ms A] visited him on a few further occasions of her own volition, although the timing of these further visits is not clear to me. He notes that he thought [Ms A] was looking for someone to talk to.

On 25 June [Dr C] drove [Ms A] to [a] Hospital. Unlike the matters identified above, this provision of transport to the meeting is not something that is disputed by either [Ms A] or [Dr C].

[Dr C] in his reports to [Ms A’s] GP had identified [certain issues]. In such circumstances, actions should be taken to ensure that risks of blurring professional and personal relationships are reduced. If there was additional evidence that boundaries between these roles were becoming further blurred, such as uninvited visits to one’s home, then it would be important to take steps to clarify the nature of the relationship and roles. Providing transport to a meeting unrelated to the purpose of the professional relationship would serve only to further blur the nature of the relationship and the boundary between professional and personal roles. At best this would be unwise. [Dr C] had a responsibility, given the nature of the therapeutic work required by [Ms A] (to help define and clarify relationship issues, amongst other things), to be explicit about boundaries and what was appropriate or inappropriate contact.

It is alleged that during his subsequent period of leave [Dr C] was in contact with [Ms A] by cell phone and text messaging and that upon his return, [Dr C] provided gifts to [Ms A]. The content of these alleged messages is not clear, but there would usually be little justification for a therapist to maintain contact with a patient while on a period of leave. There is no evidence that these were necessary as part of the ongoing review of progress of treatment. To signal that one was on leave only then to continue contact would further blur the professional boundary. If this was not contact in respect of the professional relationship, then to do so for personal reasons clearly fits within the domain that the Medical Council identifies as risky.



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[Ms A] reports that over the period of September 2008 to February 2009 there were a series of contacts with [Dr C], including a period in which she stayed in a spare room at his home. All of the contacts alleged over this period of time, if they did take place as reported, appear to be highly inappropriate given the manner in which the relationship commenced, in a professional context, and the vulnerability [Ms A] had to difficulties in defining relationships.

[Dr C] describes finding [Ms A] in a distressed state at his home in February 2009 and that she advised she had become emotionally attached to him and wanted more than friendship. [Dr C] notes that he told [Ms A] that such relationship would be inappropriate.

It would be highly inappropriate for such a relationship to be fostered by [Dr C]. His responsibility was to define the boundaries of the relationship, with the aim of facilitating [Ms A's] understanding that it was unethical and improper for him to allow her to believe that a relationship of that nature was possible. [Dr C] had a responsibility to ensure, in the face of what appears to have been such a clearly stated wish of [Ms A], that no further actions on his part might blur the boundary of the relationship and be seen as offering the slightest possibility that [Ms A] might feel her wishes were reciprocated. A message of the sort [Dr C] has indicated would be a necessary part of clarifying the relationship.

The RANZCP notes in Ethical Guideline #8[18] that psychiatrists face certain inescapable duties. The guideline notes: 'They [psychiatrists] must be technically competent and watchful to ensure that whatever happens in therapy is in the patient's best interests. Psychiatrists should be aware of the need to monitor not only the patient's emotions but their own, in the interests of the therapeutic process and for the patient's benefit. This firmly excludes any exploitation of the patient sexually, financially or in any other way.'

There appears to be no suggestion of [Dr C] receiving payment or other gifts from [Ms A]. The standards and guidelines to which I have referred are all silent in that regard. In my view however the principles behind the standards are clear and signal that exchange of any sort between a patient and practitioner, other than appropriate payment for professional advice, is hazardous.

A message such as that which [Dr C] has identified he gave [Ms A] should be supported by all other actions in order that there was no ambiguity about the intention. To offer payment to [Ms A] for her ticket would in my view undermine the message that a personal relationship was not appropriate.

Subsequently [Dr C] appears to have made additional payments to [Ms A]. Although [Dr C] appears to have discussed earlier payments with his wife and brother, there is no evidence that these payments or the request for compensation or that these further greater payments were discussed with any appropriate peer or other professional body

[18] Ethical Guideline #8 'Sexual relationships with patients' RANCP updated 2005.



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in a manner that could give sound and objective advice about the propriety of such payments. [Dr C] reports that informal advice was sought by and provided to him. Whilst I accept that such advice may be an understandable part of the process of considering how to address this situation, it is my view that in these circumstances it should have been clear that advice founded upon a professional and objective relationship was required.

At least one payment, on 4 May 2009, appears to have been made at a time when it would have been evident to [Dr C] that there were concerns about the nature of the relationship with [Ms A]. He had in a letter to the HDC on 8 April denied that there was an inappropriate relationship. It seems to me that it should have been clear that this situation was becoming extremely hazardous for his professional reputation and that clear, objective advice was required. At the very least, advice on how to manage what may have been unwanted approaches from [Ms A] would have been wise.

Such circumstances are difficult for therapists. It is not unknown for patients to develop feelings of attraction for their therapists. Even in the absence of a reciprocal attraction on the part of the therapist, these are potentially difficult situations to navigate. It is important that the therapist takes great care to avoid perpetuating any blurring between the professional and personal roles.

This may mean that the professional relationship, if still current, should end and that there be transfer of care to another practitioner. At the very least, seeking support and guidance from colleagues and supervisors with experience in managing such difficulties is helpful and should be considered. To do so would be in accord with the general right to services of an appropriate standard, set out in Right 4 of the Code of Health and Disability Services Consumers' Rights.

This Code sets out that services will be provided with reasonable care and skill. In a situation as that which prevailed in June 2008 in which [Dr C], by his account, found himself subject to uninvited visits from [Ms A], a discussion with peers or a supervisor or senior colleague about the difficulties this could cause would have been in accord with reasonable care in the professional role. Certainly by the time [Ms A] was staying in his home and requesting financial support, such advice was clearly indicated.

I have no evidence that [Dr C] discussed these problems with psychiatrist peers, more senior staff, or with legal or other practitioners with expertise in considering ethical or other professional boundary issues. In my view, and I think this would be the view of most psychiatrist colleagues, this was a significant lapse of judgement on his part.

In October 2010 [Dr C] emailed [Ms A's] father, advising him that as her father he needed to know 'some details that may be detrimental to all of us'.

At this time there was no professional relationship between [Dr C] and [Ms A]. Whilst in the context of a professional relationship it may be important to discuss matters with family, this would usually be with the consent of the patient. There is no



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evidence that [Dr C] discussed the proposed release of information with [Ms A]. In some circumstances, usually involving significant risk concerns, disclosure without the consent of the patient may be appropriate. However, there was no current professional relationship between [Ms A] and [Dr C] at the time of this correspondence.

I note [Dr C] wrote to [Ms A's] parents in June 2009, apologizing for his lapse in judgement. It is not clear in what respect [Dr C] felt that his judgement had lapsed. I note however that there appear to have been subsequent payments to [Ms A] from [Dr C], in February 2010. These payments were also made following the Medical Council having written to [Dr C] advising that it was unwise to provide moral support and material assistance to a person with whom he had been the treating psychiatrist. To continue to make such payments after receipt of such a letter from a regulatory body suggests a serious lack of judgement and would be viewed with serious disapproval by peers.

[Dr C] notes in his letter of 29 October 2010 to the Health and Disability Commissioner that during his final appointment with [Ms A], she asked him if she could contact him if she needed further advice about her treatment. [Dr C] said this was not possible, as he had discharged her, although also advised that she could call him if she had side effects from medication.

There appears to be some lack of correlation between the timing of events as outlined by [Dr C] in this letter and that of the sequence of events as outlined elsewhere in the documentation. In particular, [Dr C] describes this conversation taking place before the visit to [the hospital], yet it is clear from other records that the therapeutic relationship continued well after that visit in June, as late as August of that year. This discrepancy may be related to [Dr C] not having access to the clinical records at the time of writing this letter. Nonetheless, [Dr C] seems clear that although he had discharged [Ms A], it would have been reasonable for him to be contacted directly by her about adverse effects of medication.

I believe this advice to be at least somewhat ambiguous. Advice about side effects could reasonably be construed to be advice about treatment, something with which [Dr C] had apparently said he would not be involved as he had discharged her. In my view it would have been much more appropriate to advise [Ms A] to initially discuss any concerns about adverse effects with her GP, as the treating practitioner. For someone in whom difficulty in understanding relationships had clearly been identified as an important contributor to their mental health problems, unambiguous advice about professional roles was important. I do not think this was acting with reasonable care and this was not consistent with [Ms A's] needs, for roles to be clearly defined and unambiguous.

The Medical Council document 'Good Medical Practice'[19] discusses accepting gifts from patients, but not the converse. It highlights the importance of maintaining trust

[19] New Zealand Medical Council, June 2008.



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of patients and acting with integrity and not becoming involved in a sexual or any improper emotional relationship with a patient. This document is silent about such issues in respect of former patients.

The guidance notes[20] offer advice on what to do if a patient acts inappropriately toward a doctor. The advice includes taking measures to put a stop to the behavior, including clear discussion with the patient about their feelings that explains the inappropriateness of the relationship. If this is not possible, transfer of care to another practitioner is advised.

[Dr C] notes that he did tell [Ms A] that a relationship was not appropriate, when she arrived [at his home]. In my view, it would have been appropriate for him to have been clear much earlier, when he was involved in her care in [Town 2], that contact outside of the bounds of the scheduled appointments was not acceptable or appropriate.

**Are there any aspects of the care provided by [Dr C] that I consider warrant additional comment?**

[Dr C] appears to have given reasonable attention to the assessment and formulation of the problems with which [Ms A] presented in 2008.

[Dr C] appears to have readily identified that [Ms A] had difficulties with relationships. It could reasonably have been anticipated that this might extend to the professional relationship.

The RANZCP Code of Ethics notes at Principle 3 that psychiatrists shall provide the best possible psychiatric care for their patients. At annotation 3.1 to this principle, the Code notes ‘Psychiatrists shall care for their patients by engendering mutual trust, developing a therapeutic partnership, avoiding intentional or foreseeable harm, and treating patients under the best possible conditions’.

In my view, given the apparently sophisticated understanding of [Ms A’s] psychological difficulties, there could have been foreseen some difficulty in the professional relationship.

It would have been prudent for a therapist in such situation to ensure the availability of supervision, or for the approach to treatment and its progress to have been discussed regularly with colleagues, to help provide further and independent perspectives on the care being provided and the dynamics of the relationship.

I am not clear about the pharmacologic management. A letter of 13 June notes that [Ms A] was on [medication] although there appears to be no reference to this in prior letters. She had been on [a different medication] at the point of referral. The rationale for the prescribing of [medication] is not clear to me, particularly as in a letter of 2

[20] ‘Sexual Boundaries in the Doctor–Patient Relationship. A resource for doctors’ Medical Council of New Zealand March 2004.



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May [Dr C] noted that he emphasized to [Ms A] that he did not feel she had [a certain condition]. I cannot find an entry in the clinical record of the assessment on 21 May at which time it appears this medication was prescribed, other than a brief note entered by […] on that occasion. I cannot find a letter corresponding to that appointment on 21 May 2008.

In other respects however there appears to have been some effort to ensure that [Ms A's] GP was kept up to date with the thinking about her presentation and the treatment planned for her.

The only other area of care for which arrangements seem somewhat unclear is with respect to discharge. The information available does not clearly set out the series of events. The information available appears to suggest that on 13 June 2008 [Dr C] planned to see [Ms A] again. I cannot see record of another appointment and the next interaction for which record is available appears to have been a telephone call on 18 August 2008, at which time [Dr C] indicated he would be discharging [Ms A] to the care of the GP.

It is not clear how the telephone call came to be made, nor whether there has been an intervening appointment following the June contact.

I accept that it is possible that some information is missing. However, on the basis of what is available there does appear some reason for concern. It was clear that on a previous episode of involvement with the mental health service there were difficulties with the arrangements for discharge. In February 2005 in a file discharge note [a psychologist] noted that [Ms A] had not attended the last appointment, which appeared to reflect her fear of separation. [Dr C] himself had noted [Ms A's] fear of being alone. The psychological assessment had suggested, amongst other things, that [Ms A] turned to others for support and security. All these factors point to the need for particular care in the arrangements for discharge. A decision to discharge made in the context of a telephone conversation would be seriously inadequate and in my view falls well short of the standard of reasonable care in the discharge arrangements for [Ms A].

**Summary**

Overall, the care provided to [Ms A] that was clearly provided in the context of his scheduled outpatient appointments in the period from June to August 2008 appears to have been of a reasonable standard, although there is some lack of clarity about the prescription of antidepressant medication. The failure to clearly identify the rationale for such treatment and the implications of this for future monitoring of progress would be viewed by most psychiatrist peers, in my opinion, with at least mild disapproval.

Of much greater significance is the ongoing contact with [Ms A] outside of the context of standard outpatient appointments, and apparently after transfer of care to [Ms A's] General Practitioner.



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This is however an area for which standards are less clearly defined. Given though the nature of the personality characteristics and vulnerabilities identified by [Dr C] and confirmed to him by the psychologist during the period in which [Dr C] was involved in care, particular caution was needed to ensure that roles were clear and boundaries respected. Contact of a social nature, which may be arguably acceptable in the absence of such difficulties, becomes much more clearly inappropriate when these vulnerabilities in the patient (or former patient) are present. Contact of this nature would be viewed with at least moderate disapproval by peers.

There appears to be no dispute about [Ms A] having stayed in [Dr C's] accommodation [overseas]. At the least, this suggests a significant lapse of judgement that would in my opinion be viewed with serious disapproval by most peers.

If a sexual relationship did occur at any time, this would clearly have been a breach of the ethical standards of the RANZCP. If such a relationship took place during [Dr C's] involvement in care, this would also clearly have been a breach of the standards expected by the Medical Council. There is no doubt this would be viewed with the very highest level of disapproval.

Yours sincerely

M D Patton"



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