Sports Doctor, Dr B

A Report by the
Health and Disability Commissioner

(Case 09HDC01403)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

The report considers the evidence that sports doctor Dr B entered into concurrent professional and sexual relationships with his patient, Ms A, and measures his conduct against professional standards set by the Medical Council of New Zealand. The findings highlight the need for more education of medical students, trainee doctors and practising doctors about professional boundaries, including the steps needed to terminate a professional relationship with a current patient, and the inappropriateness of providing medical services to a doctor's friends or family.

Complaint and investigation

On 26 June 2009 the Health and Disability Commissioner (HDC) received a complaint from Mr A about the relationship between his wife, Ms A, and Dr B. The following issue was identified for investigation:

- *Whether Dr B provided services to Ms A in accordance with professional and ethical standards from 2008 to June 2009, during which period it is alleged Dr B had a sexual relationship with Ms A.*

An investigation was commenced on 15 July 2009.

Information was received from:

Ms A	Consumer
Mr A	Complainant/Consumer's husband
Dr B	Provider/Sports doctor
Dr C	Sports doctor

Information gathered during investigation

Initial meeting
In August 2007, Ms A met sports doctor Dr B at a sporting event. She was acting as an official, and he was working as the doctor covering the event. They were seated together and struck up a conversation. Ms A gave Dr B her business card, and asked him to telephone her.

Dr B did not contact Ms A.

Professional relationship commences — 22 February 2008
On 22 February 2008, Ms A attended an appointment with Dr B for ongoing pain in both of her Achilles tendons.[1] She was referred by a physiotherapist who had been treating her for the past six months. Dr B assessed Ms A and diagnosed Achilles tendonosis. Ms A agreed with Dr B to follow a conservative treatment plan, and a follow-up appointment was booked for six weeks' time.

During the appointment, Ms A told Dr B that she was still interested in meeting him about a business-related matter. Dr B told Ms A that he had been busy, but was interested in meeting her, and would call her to arrange a time.

Again, Dr B did not contact Ms A.

On 4 April, Ms A attended a follow-up appointment with Dr B. Ms A felt that, although her right Achilles tendon was stable, her left Achilles tendon had deteriorated. She and Dr B discussed treatments, including injection of cortisone[2] or polidocanol.[3] However, Ms A decided to continue with conservative management.

Personal relationship commences — 4 April 2008
During the 4 April appointment, Ms A reminded Dr B of her interest in meeting about a business-related matter. He invited her to meet that night, and Ms A accepted the invitation.

During her visit that evening, Dr B asked Ms A if she would like to hear a presentation he had prepared. Ms A agreed, and invited Dr B to her flat to give the presentation.

On 13 April, Ms A sent a text message to Dr B's personal mobile telephone.

One evening between 15 and 17 April, Dr B visited Ms A's flat to give his presentation and discuss his business-related plans. Dr B recalls that he spent three hours with Ms A, but only discussed the business matter during that time.

On 24 April, Ms A attended a further appointment with Dr B. Both of her Achilles tendons had become increasingly painful and Dr B discussed treatment options with her. Although Dr B recommended continued conservative management, Ms A was dissatisfied with her response to conservative treatment and opted to undergo ultrasound guided injection of cortisone around both Achilles tendons. Dr B referred Ms A to a radiologist for injection of the cortisone, and this occurred on 1 May.

Following the appointment on 24 April, Ms A invited Dr B to visit her workplace during the weekend to obtain materials for a business-related meeting.

[1] At this time Ms A was living in a city where Dr B also lived and practised as a sports doctor.
[2] Steroid injections may directly reduce inflammation of the tendon.
[3] Sclerosants irritate the lining of blood vessels, causing them to close. Polidocanol is injected into blood vessels outside the Achilles tendon, which reduces blood flow to the tendon, lowering metabolic rate and hence reducing swelling and inflammation.

On 25 April, Dr B went to Ms A's workplace, and they discussed the business-related matter. She also said that she was moving to another city soon. Dr B recalls that during the discussion, Ms A asked him "out of the blue" if he was happy in his marriage. He recalls that Ms A "volunteered that she was unhappy in her marriage of two years" and told him that she had "shagged a workmate on [her] worktable".

Following this discussion, Dr B decided to leave Ms A's workplace and return home and, as he was leaving, said to Ms A, "It is just as well you are leaving [the city] as we could both get ourselves in trouble."

Sexual relationship commences — 25 April 2008
Later that evening, Ms A and Dr B sent sexually suggestive text messages back and forth — Ms A sent 15 text messages to Dr B between 4.50pm on 25 April and 1.42am on 26 April 2008. Dr B eventually telephoned Ms A. He recalls: "[I]t was during that conversation in which we both expressed a mutual attraction for each other that I invited her to visit me at a flat we have attached to the end of our house."

Ms A immediately drove to Dr B's house and met him at the attached flat, and they had sexual intercourse. Dr B admits that "it was at that stage that our relationship became sexual". Ms A stated that she and Dr B met at his flat the following two nights and had sexual intercourse.

Ms A and Dr B were in frequent text message, telephone, and email contact from 25 April onwards.

Professional and personal/sexual relationships continue
On 8 May, Ms A attended an appointment with Dr B, for follow-up after receiving cortisone injections into both Achilles tendons on 1 May. Dr B noted that Ms A's Achilles tendon pain was significantly improved, and recommended that she avoid high-impact exercise for another week.

Dr B advised HDC that he "pointed out to [Ms A] very clearly that I thought it was now inappropriate that I continue to treat her Achilles tendon problem because of our relationship". Dr B recalls that Ms A objected to this, but he did not make a follow-up appointment with her. Conversely, Ms A advised HDC that Dr B never told her that it was inappropriate to continue treating her while they were in a relationship and, in fact, wanted to keep treating her so that they would have a legitimate reason to see each other.

On 16 May, Ms A attended an appointment with Dr B. He stated that she "turned up unannounced for an unscheduled appointment", and his appointment schedule shows that Ms A was seen after his booked appointments for the day. However, Ms A does not recall ever attending an unscheduled appointment.

In any event, Dr B examined Ms A and documented that although both Achilles tendons were pain free, she had some discomfort in the right tendon. He booked a follow-up appointment for three weeks' time. During that time they saw each other frequently.

Ms A did not attend the follow-up appointment, and Dr B explained that "we had begun to see each other more frequently and both agreed that it was unwise for me to continue seeing her as a patient". Ms A disputes this claim by Dr B.

Around 3 June, Ms A provided Dr B with a new pre-pay mobile phone, for which she arranged a "best mate" call plan on 31 August. Dr B explained:

> "[T]he use of a number of cellphone numbers eventuated because my wife found some suggestive texts (between [Ms A] and myself) on my phone very early on in the relationship. [Ms A] therefore supplied me with one of her old mobile phones for me to use. She set us up on a [scheme through a telephone company] so that we were able to stay in regular contact by texting and phoning."

In June, Ms A moved to the new city. However, she and Dr B remained in frequent text message and telephone contact, and spoke with each other daily.

Ms A revealed significant personal information to Dr B on 25 July, during a car trip together. Ms A told Dr B that she had a history of depression and was taking antidepressants, which she found beneficial. She recalls that he told her that she was not suffering from depression and should not be taking antidepressants, and that as a result she ceased taking antidepressant medication.

In contrast, while Dr B recalls discussing the topic of antidepressants with Ms A, he explained that this was in the context of a discussion about a recent study which compared the use of antidepressants and placebo for treating depression. He stated that he "did not advise her to stop her antidepressant medication. She made that decision herself."

Blood tests

In early October 2008, Ms A told Dr B that she had athletic amenorrhea[4] during one of their daily telephone conversations. Dr B states that he advised Ms A that the condition could affect her long-term bone health, and recommended that she consult another sports doctor, Dr C, based in the city she had moved to. Dr B recalls that he telephoned Dr C to discuss Ms A's condition but she refused to see another doctor, citing cost and her preference to see Dr B for the problem. He further recalls:

> "I explained to her once again that while athletic amenorrhoea was within my specialty field as a sports [doctor], because of our relationship, it was inappropriate for me to advise her on this matter ... I faxed a blood test request form to [Dr C's clinic] but took no further part in the management of this problem. In a follow-up phone call I once again urged her to see either [Dr C] or her own GP about it."

Dr C recalls discussing Ms A's condition with Dr B in a telephone conversation in October 2008. The discussion related to her bone health and organising blood tests.

[4] Cessation of menstruation due to decreased estrogen, which may be caused by low body weight, inadequate nutrition, excessive exercise, or a combination of these factors.

However, he never received a blood request form. Dr C advised that he did not discuss her Achilles tendon problem with Dr B. The only time he saw Ms A was much later, on 4 August 2009.

The blood test request form was faxed to the medical laboratory on 6 October, although the destination number is not documented. Dr B signed as the requesting clinician, and requested a copy of the results to be sent to him. Ms A's work facsimile number is documented as the primary number to transmit results to.

Ms A denies that Dr B encouraged her to see Dr C. She recalls asking Dr B to refer her to Dr C several times from May 2008 to January 2009, but that he would not agree to do so. Ms A advised HDC that after her relationship with Dr B broke down, she immediately transferred her care to Dr C, and he is her current sports doctor.

Ms A attended the medical laboratory on 8 October 2008 to have blood drawn. Laboratory records show that a hard copy of the results was posted to Dr B on 9 October. This appears to contradict Dr B's statement that he did not know whether Ms A had blood taken until 23 July 2009, when he requested the results for purposes of the HDC investigation. However, Dr B submits that "if these results had been in [Ms A's] file I would not have had to ring the lab. I state once again that I did not offer her any advice on this issue but do remember saying to her to see her own GP if she did not want to see [Dr C]."

Ms A and Dr B's sexual relationship continued, and she accompanied him to a sports medicine conference in Australia in October 2008.

Polidocanol injections

In December 2008, Ms A was still experiencing Achilles tendon pain, and during a telephone call to Dr B, she requested ultrasound-guided polidocanol injections. Dr B recalled: "Because we were in daily contact with each other, she kept me informed of her Achilles tendons progress. When they continued to bother her she enquired about Polidocanol injections which ... I had discussed with her thoroughly on [4 April]."

Dr B states that he once again offered to refer Ms A to Dr C, but she refused. Dr B did not examine Ms A, but made arrangements for the radiologist to administer ultrasound-guided polidocanol injections around both Achilles tendons. To make the arrangements, Dr B ensured that an appointment was made for Ms A to see the radiologist, telephoned the pharmacy to order polidocanol and wrote a prescription for it, and completed the necessary ACC documentation. Dr B stated:

> "I did not see her in my rooms for any scheduled appointment in regard to this. Instead I asked my receptionist to organise the injections ... to maintain my professional distance. ... From my point of view, these injections were arranged as a friend (not her [doctor]) to continue a course of treatment I had discussed with her ... before our sexual relationship began."

The radiologist completed the procedure on 22 December.

On 30 January 2009, Ms A told Dr B that both of her Achilles tendons were still painful, and he agreed to refer her to the radiologist for further polidocanol injections. Dr B arranged the injections as he had previously done in December.

On 5 February 2009, the radiologist completed the procedure. Ms A recalls that Dr B attended the procedure, so that he could ensure that the radiologist was placing the polidocanol in the correct site.

On 9 April 2009, Ms A reported to Dr B that her left Achilles tendon was pain free, but her right tendon was still painful. Dr B referred her to the radiologist for another polidocanol injection around her right Achilles tendon, and arranged the procedure as he had in the past.

The radiologist injected polidocanol near Ms A's right Achilles tendon on 2 May 2009.

Ms A said that she had wanted to get the polidocanol injections in her home town but Dr B persuaded her to have them done in his home town so they would have an excuse to spend time together.

Sexual relationship ends

Ms A said that from around May 2009, her depression returned and her personal relationship with Dr B deteriorated significantly, although they continued to maintain regular text, telephone and email contact. She stated: "Looking back, I think I became co-dependant on him and him on me."

Ms A became increasingly depressed and guilty: "My illness became too much for me … I wanted to self destruct. I had continuous thoughts of suicide and I wanted to come clean and tell my husband what was going on."

In June, Ms A's husband became aware of her affair with Dr B. He confronted Dr B, who did not deny the affair. On 9 June, Mr A initiated a family conference, where he confronted his wife about her affair, and she admitted having an emotional and sexual relationship with Dr B.

Ms A subsequently needed inpatient psychiatric care. She is now recovering with support from her family. Her marriage has broken down.

Complaint to HDC

On 26 June 2009, Mr A complained to HDC about Dr B's conduct. Mr A states that Dr B's relationship with Ms A was an "abuse of power", particularly in light of his knowledge of her psychologically dependant background and history of depression.

Mr A expressed concern about Dr B's apparent lack of recognition of the "severe inappropriateness, and implications of his actions". He does not want any other patients "to suffer similar circumstances".

Dr B's response

Dr B admits that he had a sexual relationship with Ms A. Dr B advised HDC that he had not placed any pressure on Ms A to enter into, or remain in, a relationship with him:

> "I refute completely however that this was a one-sided 'abuse of power' in which I coerced her to engage in sexual activity by using information from her past ... She was a more than willing participant."

Dr B also stated:

> "As a confident, strong willed […]/professional woman, she is of equal social and community standing as myself. This was not a lopsided abuse of power. Both of us were in a position to say yes or no to the other's advances."

Dr B accepts that he provided medical services to Ms A after he entered into a sexual relationship with her, when he saw her twice in his rooms as follow-up for her Achilles tendon problem, and later when he organised polidocanol injections for her.

Dr B denies using his doctor–patient relationship to "procure and maintain" his relationship with Ms A: "There was simply no need to do that. … Our continuing to see each other was not dependent on me arranging Polidocanol injections. It would have occurred without them."

Dr B notes that the first appointment (on 8 May 2008) was a follow-up appointment booked prior to the commencement of the sexual relationship. The second consultation (on 16 May 2008) was an unscheduled appointment when Ms A turned up at his rooms. In relation to the polidocanol injections, Dr B submits that they were done as a "friendly gesture" and "an act of goodwill", just as he would do for a family member or friend. He states that he was not unaware of the New Zealand Medical Council requirements for ending a professional relationship. At no time during medical school or his subsequent vocational training programme was Dr B taught about this information. However, he accepts that he had a responsibility to find out the requirements, once the sexual relationship commenced.

Dr B is "deeply regretful for any emotional turmoil [Ms A] has sustained", and "truly sorry for the grief" he has caused Mr A.

Dr B states that he too has suffered both personally and professionally from this experience:

> "… I have learned a very hard but valuable lesson in all this and while I am confident I will never let myself be put in this position again, if it should occur I now know the necessary steps I must take."

Dr B advised that he has entered into a mentoring relationship with two other doctors working in sports medicine and that they will oversee his medical practice from now on.

Relevant professional standards

The New Zealand Medical Council's *Statement on sexual abuse in the doctor–patient relationship (June 1994)* states:

> "Sexual behavior in a professional context is abusive.
>
> …
>
> The Council condemns all forms of sexual abuse in the doctor/patient relationship for the following reasons:
>
> …
>
> - The onus is on the doctor to behave in a professional manner … it is not acceptable to blame the patient for the sexual misconduct.
>
> …
>
> - Sexual misconduct by a doctor risks causing psychological damage to the patient.
> - The doctor/patient relationship is not equal. In seeking assistance, guidance and treatment, the patient is vulnerable. Exploitation of the patient is therefore an abuse of power and patient consent can not be a defense in disciplinary hearings of sexual abuse.
> - Sexual involvement with a patient impairs clinical judgment in the medical management of that patient.
>
> The Council will not tolerate sexual activity with a current patient by a doctor.
>
> …
>
> The Council rejects the view that changing social standards require a less stringent approach. The professional doctor/patient relationship must be one of absolute confidence and trust ..."

Opinion: Breach — Dr B

Sexual relationship
There is no dispute that Dr B and Ms A engaged in a sexual relationship from 26 April 2008 to June 2009.

Professional relationship
Both parties agree that the professional doctor–patient relationship commenced on 22 February 2008. After they commenced a sexual relationship on 26 April 2008, Dr B provided Ms A with medical treatment on several occasions:

1. He saw Ms A for two medical consultations at his office on 8 and 16 May 2008 (and booked a follow-up appointment after the second consultation).
2. He ordered blood tests on 6 October 2008 to investigate Ms A's complaint of athletic amenorrhea.
3. He referred Ms A to a radiologist for ultrasound-guided injections of polidocanol in December 2008, 30 January 2009, and 9 April 2009, and prescribed the polidocanol used on each occasion.

Dr B's final episode of care for Ms A was on 9 April 2009, when he referred her for a final polidocanol injection.

Dr B accepts that he saw Ms A for two medical consultations, on 8 and 16 May, after their sexual relationship commenced. He knew that it would be wrong to continue to be Ms A's sports doctor, and told her at the 8 May appointment that he could not continue to treat her Achilles tendon problem (although she disputes that he said this).

The Medical Council of New Zealand's statement "Ending a professional relationship"[5] requires a doctor to complete all of the following steps:

- Tell the patient that the professional relationship is ended.
- Note this termination in the patient's records.
- Refer the patient to another doctor of the patient's choice (or in the case of a specialist, back to the usual general practitioner).
- Send a letter of referral (or reporting letter) and all relevant information about that patient to the new doctor or general practitioner.

Only after all these steps have been completed does the Council consider the doctor–patient relationship to be properly terminated.

In the *Wiles* case, when referring to a situation similar to that faced by Dr B, in April 2008 the District Court held that "… the transfer of Mrs Y's medical notes was a necessary step in ending her doctor/patient relationship with Dr Wiles. Dr Wiles knew that relationship was being taken into dangerous waters and it was his professional

[5] See http://www.mcnz.org.nz/portals/0/guidance/endingdoctorpatientrelationship.pdf, March 2004.

duty to take clear and positive steps to end it."[6] The decision was upheld on appeal by the High Court.[7]

Dr B did not take "clear and positive steps" to end the professional relationship with Ms A when intimacies began to develop in April 2008. He did not undertake all the steps required by the Medical Council. Accordingly, the professional relationship had not been properly terminated. Even though Dr B was apparently unaware of the Medical Council's requirements for ending a professional relationship, he had an obligation to find out this information (as he himself accepts).

Whatever his good intentions, I do not accept Dr B's characterisation of his medical services for Ms A post 16 May 2008 as non-professional. The medical care he provided after commencing the sexual relationship — ordering blood tests, completing ACC documentation, prescribing medicines, and referring Ms A to a radiologist for ultrasound-guided injections of polidocanol — could only be provided by a doctor acting in his professional capacity. Nor is the position altered by the fact that Dr B did not see Ms A in his rooms for a scheduled appointment after 16 May and involved his secretary in organising her treatment.

I conclude that Dr B provided all the listed medical services to Ms A in his professional capacity as a doctor, and that he engaged in simultaneous sexual and professional relationships with her from 26 April 2008 until the referral of 9 April 2009.

Appropriateness of simultaneous professional and sexual relationships
The Medical Council of New Zealand (the Medical Council) has a policy of "zero tolerance" for concurrent professional and sexual relationships between a doctor and patient. The Council describes sexual behaviour in a professional context as "abusive" and notes that it "risks causing psychological damage to the patient".

As the medical professional, the onus was on Dr B to maintain professional boundaries. It is not an excuse that Dr B first met Ms A in a social setting. He knew that having an affair with a patient could get himself "in trouble".

I repeat what I stated in case 06HDC01330:[8]

> "Any sexual relationship between a patient and her doctor involves a breach of trust. A doctor is required to have the patient's best interests at heart. That is the fundamental contract that allows patients to trust the doctor with intimate physical and psychological matters.
>
> The strict prohibition on sexual relationships between doctors and their patients exists both for the protection of the individual patient (who, by virtue of the doctor's social status and the exposure of the patient's body and

[6] *Director of Proceedings v Medical Practitioners Disciplinary Tribunal* (DC, Wellington 24 January 2002, Judge Lee, MA 69/01) at [32].

[7] *Director of Proceedings v Medical Practitioners Disciplinary Tribunal* [2003] NZAR 250 (HC).

[8] See www.hdc.org.nz (06HDC01330) pp15-20.

> feelings, is vulnerable to a romantic attraction to his or her doctor) and of the doctor (in whom the prohibition is deeply embedded by medical ethics and professional guidelines, reinforcing the concept of an inviolate boundary that must never be crossed). The prohibition is also essential for the maintenance of public trust in the medical profession.
>
> Proper adherence to professional boundaries is important in any doctor–patient relationship … While the relationship was consensual, it is the responsibility of the medical practitioner to maintain the appropriate professional boundaries and ethical standards. The responsibility in this regard rested on [the doctor] alone."

Dr B breached the Medical Council's "zero tolerance" guidelines in relation to a doctor's sexual involvement with a current patient, and must be held accountable for his breach of standards.

Provision of medical services to friends or family

As explained above, I do not accept that Ms A was merely a friend (as opposed to a pre-existing patient) when Dr B provided her with medical services over the period May 2008 to April 2009. However, even if Ms A had not been a pre-existing patient, I note the Medical Council's advice that it is unwise for doctors to provide medical services for family or friends. In its "Statement on providing care to yourself and those close to you" (June 2007), the Council notes:

> "It is generally unwise for medical practitioners to treat people with whom they have a personal relationship rather than a professional relationship. Providing care to yourself or those close to you is neither prudent nor practical due to the lack of objectivity and discontinuity of care. The Medical Council recognises that there are some situations where treatment of those close to you may occur but maintain that this should only occur when overall management of patient care is being monitored by an independent practitioner."

Doctors are frequently pressured by family and friends to provide minor medical services — for reasons of convenience and to save costs. A wise doctor will resist such pressure and gently advise the family member or friend to consult their regular doctor or an after-hours clinic. Providing medical services to a family member or friend is risky because the doctor may cut corners or overlook a feature of the presentation because his or her normal judgement is clouded by the informal nature of the consultation.[9]

Summary

Dr B continued to provide care to Ms A in his capacity as a doctor, after commencing a sexual relationship with her. His decision to commence and maintain concurrent professional and sexual relationships with Ms A was contrary to professional and ethical standards.

[9] See also case 06HDC14100, at page 14.

I conclude that Dr B breached Right 4(2)[10] of the Code of Health and Disability Services Consumers' Rights (the Code).

Non-referral to Director of Proceedings

A health professional found in breach of the Code by virtue of a sexual relationship with a current patient is likely to be referred to the Director of Proceedings for potential disciplinary proceedings. However, I see no public interest in such a referral in this case, taking into account the following factors:

1. The medical services provided by Dr B after the sexual relationship commenced were few and of a relatively minor nature. Although his conduct was wrong, there is no evidence of exploitative or predatory behaviour on his part.

2. Dr B has admitted the sexual relationship and cooperated fully in the HDC investigation. He accepts that he acted wrongly and breached the Code.

3. Dr B has entered into a mentoring relationship with two senior doctors working in sports medicine. I have recommended below that they continue to oversee his practice for two years. This should provide a "safety net".

4. In my view the breach finding and notification to the Medical Council and the Australasian College of Sports Physicians is sufficient punishment of Dr B for purposes of accountability.

Recommendations

I recommend that Dr B:

- Remain in a mentoring relationship with the two senior doctors in sports medicine (including at least three face-to-face meetings with each mentor each year) until **31 December 2011,** and that both mentors provide written confirmation to the Australasian College of Sports Physicians that the mentoring has occurred and that Dr B appears to be continuing to maintain appropriate professional boundaries with patients.
- Review his willingness to provide medical services for family or friends, in light of this report.

[10] Right 4(2) of the Health and Disability Services Consumers' Rights states that "every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards".

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- A copy of this report with details identifying the parties removed, except the name of Dr B, will be sent to the Australasian College of Sports Physicians, and to Dr B's mentors.

- A copy of this report, with details identifying the parties removed, will be sent to the Deans of the Medical Schools of the Universities of Auckland and Otago, the Council of Medical Colleges, and the Medical Protection Society and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.