General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 03HDC11070)

Parties involved

Mrs A	Consumer / Complainant
Dr B	Provider / General Practitioner
Dr C	Neurologist
Dr D	Cardiologist
Dr E	Cardiac Surgeon
Dr F	General Practitioner

Complaint

On 25 July 2003 the Commissioner received a complaint from Mrs A about general practitioner Dr B. The following issues were identified for investigation:

- *The appropriateness and adequacy of Dr B's care and treatment of Mrs A's chest and cardiac symptoms in 2000 and early 2001, prior to referral to Dr C, neurologist.*
- *Whether Dr B met appropriate ethical standards when entering into a sexual relationship with Mrs A in 2001.*
- *Whether Dr B met appropriate ethical standards when he treated his wife (Mrs A) between March 2002 and May 2002.*

An investigation was commenced on 13 November 2003.

Information reviewed

- Mrs A's medical records
- Information from neurologist Dr C, cardiologist Dr D, and cardiac surgeon Dr E
- Independent expert advice from Dr Ian St George, a general practitioner.

Information gathered during investigation

Mrs A had been a patient at a medical clinic (the clinic) for many years. She became a patient of Dr B in 1974, when he joined the practice. She did not attend the clinic very often. Dr B's records indicate that she attended the clinic three times between 1999 and 2001.

Mrs A considered herself a fit woman. She swam 70 laps of an 18 metre pool, three mornings a week before work. However, from the late 1980s she suffered from migraine

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headaches, which she treated with "over the counter medication". By 1990 the migraines were becoming debilitating and affecting her work. Mrs A was assaulted in 1989 and Dr B suspected that the migraine headaches were a result of the assault. When she had a migraine she also suffered other symptoms – her pulse would flutter, she would become breathless, and she would experience pain in her chest. In early 2001 she developed significant congestion in her lungs. The migraines and breathlessness prevented her from swimming. She could not swim the length of the pool. Mrs A said that during visits to Dr B she recounted the rapid rush in her pulse for no apparent reason, and dizziness that would make her lose her balance. Dr B replied "on numerous occasions" that everyone lived with a heart murmur and dismissed her worries with "You are ok". He prescribed Digesic and Panadol. There is no record of these consultations.

According to Mrs A's records, on 12 March 2001 (her previous consultations being in August 2000) she consulted Dr B with shortness of breath, a productive cough and right-sided chest pain. He noted that Mrs A had stopped smoking about one year previously, and that her blood pressure was 125/85. She also had a heart murmur, which he thought was from the aortic valve. He arranged for her to have a chest X-ray, which indicated the following:

> "FINDINGS: Cardiac diameter is normal. CTR13/30. No valvular calcifications are seen. Pulmonary vascularity is within normal range. The lung fields are clear with no evidence of failure. Minor bronchial abnormalities are noted and suggest some bronchitis. No more specific abnormality or cause for SOB [shortness of breath] is seen."

Dr B said that he noted the heart murmur "which had possibly been there before but was now significant in that it was certainly louder. She had no cardiac symptoms." He diagnosed bronchitis and prescribed Ceclor (an antibiotic).

On 14 May Mrs A returned to see Dr B. Her main complaint was a fairly severe migraine, which had increased in severity. She also described "buzzing in her head". As her migraines were becoming increasingly debilitating, Dr B referred her to a neurologist, Dr C, for further investigation and treatment. Mrs A also complained of chest pain and a heart murmur. Dr B advised me that he and Mrs A discussed a referral to a cardiologist, but she decided that she wanted to have her headaches investigated first. Treatment for her migraines was her main concern. Mrs A cannot recall any discussion about her cardiac symptoms.

Dr B's referral letter included the following:

> "On clinical examination she has an aortic systolic murmur which radiates up into her neck and is probably non relevant, clinical exam apart from this is normal. …"

Dr B advised me that he is well aware of the dangers of aortic stenosis and of the use of ultrasound for diagnostic purposes. However, there was no private ultrasound available in the city at the time.

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Mrs A consulted Dr C, neurologist, on 22 May 2001. She complained of migraines, lung congestion and breathlessness, and shoulder pain. Dr C agreed that her migraines could be associated with the assault and adjusted her medication. He noted Mrs A's heart murmur and considered that she had a "significant aortic stenosis", but could find no signs of heart failure. Mrs A told him that she was so breathless she had difficulty climbing the two flights of stairs to his rooms. Dr C considered the stenosis so severe that he referred Mrs A for an urgent consultation at the cardiology clinic at a public hospital.

Mrs A consulted cardiologist Dr D at the public hospital on 13 June. Dr D noted that her symptoms included "angina, exertional breathlessness, syncope [fainting]". He confirmed Dr C's suspicion of severe aortic stenosis and advised Mrs A that she required an aortic valve replacement urgently.

Mrs A underwent cardiac angiography, which confirmed the diagnosis, and she was referred to a cardiac surgeon, Dr E. She decided to have the surgery privately and underwent aortic valve replacement at a private hospital.

Postoperative care
Mrs A was discharged from hospital and referred back to Dr B for general practitioner care. Dr E informed Dr B about the operation and advised him that he wanted to see Mrs A for a postoperative check on 9 August. In the meantime he advised that Mrs A, who had been discharged on warfarin, should be reviewed and her INR (test for blood clotting) kept "around 2.5" (the therapeutic level determined by her cardiac surgeon).

On 31 July Mrs A consulted Dr B complaining of right-sided chest pain and a productive cough, which she had had for two days. He thought that she had pneumonia, "which is not surprising following cardiac surgery". He referred her for a chest X-ray, which confirmed his diagnosis.

Mrs A's records note that she saw Dr B on 7 August, 3 September and 9 October 2001. Mrs A received phone calls from the clinic, advising her of the INR results on 21 August, and 4 and 15 October.

Mrs A had postoperative consultations with Dr E on 9 August and Dr D on 31 October 2001.

Intimate relationship
Mrs A claims that at one of her postoperative visits to Dr B when she complained of a sore chest, Dr B made a comment (while she was lying on the examination couch) that she understood to be in reference to her breasts. He said "gorgeous, just gorgeous". Her breasts were exposed at the time. She was shocked and asked him whether he made such comments to all his patients; he replied, "No, just to certain ones."

Dr B denies that he used the word "gorgeous", which is not a word he uses in consultations, and claims that he was referring not to her breasts, but to the neatness of the scar, and meant that it was healing well.

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In October 2001, Mrs A organised a postgraduate dinner at her place of work, and Dr B attended. (Mrs A claimed that the dinner occurred in September but Dr B confirmed, from a diary entry, that the postgraduate dinner was held on 11 October.) Mrs A recalled that Dr B arrived before the other doctors. He appeared at the door to her office, and after some hesitation he said he was attracted to her and would like to take her out. When the dinner guests had left, Dr B was waiting by her car and kissed her goodnight. Dr B advised me that the dinner was his first non-professional contact with Mrs A, and that he realised he had "feelings" for her.

Mrs A claims that from that moment Dr B was "full on". He would be at her door when she returned from swimming at 7am in the morning (this is denied by Dr B), and showered her with flowers and wine. She was confused by Dr B's attention because she still considered him her doctor. On one occasion he made sexual advances towards her and she questioned him about being her doctor. She said that Dr B told her that he could keep the professional relationship separate from the personal one.

Dr B claims that he and Mrs A developed a mutual attraction and "far from breaching the ethical requirements, in this situation, I did all I could (certainly took all reasonable steps) to ensure I followed the appropriate ethical steps". Once Dr B ascertained that Mrs A reciprocated his feelings, with her consent he took immediate action by telephoning Dr F, general practitioner, and explaining the situation. He arranged to have Mrs A's care transferred to Dr F on 25 October 2001, which was before they started "dating". Dr B's practice manager confirmed that on 25 October he told her that he had telephoned Dr F, who had agreed to take Mrs A as her patient. She immediately printed Mrs A's medical records. Dr B attended a clinic opening on 1 November and took the records to Dr F personally. Dr B also forwarded Mrs A's cardiology report to Dr F on 1 November.

Dr B considers that he was not Mrs A's doctor when they commenced socialising, and he did not "actively" manage her medical problems after he had transferred her records. The last entry in Dr B's records is 15 October 2001. Dr B advised me that the first sexual contact took place in the last weekend of November (24-25 November), about three weeks after he transferred her notes. At the time Mrs A was still under the care of the hospital.

Dr B denies that any behaviour of an intimate nature took place before he transferred Mrs A's notes to Dr F. Mrs A claims that their sexual relationship commenced before her records were transferred, and that Dr B asked her out before her 50th birthday, on 5 October 2001. Mrs A stated that on the weekend of 16 October they went to Auckland and stayed overnight with her daughter. She stated that although they slept in single beds in her grandson's room, Dr B made sexual advances towards her. Dr B responded that the weekend night occurred in mid-November and that there was no sexual contact.

In November 2001 Dr B asked Mrs A to live with him but she thought it was too soon. She moved into Dr B's house on 22 December 2001 and they were married on 30 March 2002. The marriage was of short duration and they separated on 17 October 2002.

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Prescriptions
While they were married Dr B arranged Mrs A's repeat prescriptions for her, including a prescription for vaginal thrush, warfarin and atenolol. He denies any impropriety because "most doctors do this for their wives and family". She did not first consult Dr F until May 2002 and did not attend another GP from October 2001 until May 2002. Mrs A provided me with the following medication containers: warfarin 8 January, 11 April and 4 December 2002; Micreme vaginal cream 7 May 2002; atenolol 17 July; Paradex 22 August, and amoxycillin 8 September 2002. Mrs A had blood tests taken every month or so. The INR results would be sent to Dr B, who would adjust Mrs A's warfarin dose according to the results.

Independent advice to Commissioner

The following expert advice was received from Dr Ian St George, an independent general practitioner:

"A. I respond to your letter of 26 February 2004 seeking advice in relation to [Mrs A's] complaints against [Dr B].

B. You have supplied me with the following information:

Purpose Whether [Mrs A] received an appropriate standard of general practitioner care from [Dr B].

Background [Mrs A] had been a patient of [Dr B] since 1974. In March 2001 she consulted [Dr B] about her chest symptoms, including chest pain, breathlessness and a marked reduction exercise tolerance. [Dr B] diagnosed bronchitis and prescribed amoxicillin.

[Mrs A] had also been suffering with migraine headaches as a result of an assault in 1989. The migraines were becoming more frequent and debilitating and she still had chest pain. She saw [Dr B] again on 14 May and he referred her to neurologist, [Dr C].

When [Mrs A] saw [Dr C] on 22 May she asked him about her breathlessness and exercise intolerance, including that she had had difficulty walking up the two flights of stairs to his rooms. On auscultation, [Dr C] detected noticeable heart murmur, which [Dr B] had detected earlier, and referred her to the cardiology department at [the public hospital].

On 13 June cardiologist [Dr D] diagnosed severe aortic stenosis (confirmed by angiography …) and advised her that she should have the valve replaced urgently. As a result [Mrs A] underwent cardiac surgery for aortic valve replacement by [Dr E] … She was discharged on warfarin (and other medication) and referred back to [Dr B], who was advised to keep her INR around 2.5.

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Towards the end of October ([Mrs A] later confirmed that it was mid/late September,) [Dr B] declared his attraction for [Mrs A], although before that time there is some suggestion that he made improper statements of a sexual nature.

[Dr B] arranged to have [Mrs A's] records transferred to [Dr F] on 25 October 2001 and he claims that he had no active medical management from that date. Their sexual relationship began at about that time. [Mrs A] moved in with [Dr B] in December 2001 and they married on 30 March 2002. The marriage was of short duration and they separated on 17 October 2002.

Between November 2001 and October 2002, [Dr B] continued to prescribe [Mrs A] medication including warfarin and atenolol.

[Mrs A] did not see her new general practitioner, [Dr F] until May 2002 and did not see any other doctor in the interim.

Complaint [Mrs A's] complaint is summarised in her complaint letter to the Commissioner who is investigating the following:

- *The appropriateness and adequacy of [Dr B's] care and treatment of [Mrs A's] chest and cardiac symptoms in 2000 and early 2001, prior to referral to [Dr C], Neurologist.*
- *Whether [Dr B] met appropriate ethical standards when entering into a sexual relationship with [Mrs A] in 2001.*
- *Whether [Dr B] met appropriate ethical standards when he treated his wife ([Mrs A]) between January 2002 and September 2002.*

Supporting Information

- [Mrs A's] letter to the Commissioner dated 21 July 2003 and records of telephone conversations (pages 1-19) marked 'A'
- The Commissioner's notification letter to [Dr B] dated 13 November 2003 (pages 20-21) marked 'B'
- [Dr B's] response to the Commissioner's letter dated 19 November 2003 and accompanying information (pages 22-32) marked 'C'
- [Mrs A's] medical records transferred to [Dr F] dated 25 October 2001 (pages 33-52) marked 'D'
- Telephone conversation with [Dr F's] nurse on 17 February 2004 (page 53) marked 'E'
- Relevant medical records from [the public hospital's] cardiology outpatients (pages 54-56) marked 'F'

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- List of medications [Dr B] prescribed for [Mrs A] (page 57) marked 'G'.

Expert Advice Required To advise the Commissioner whether [Dr B] provided general practitioner services of an appropriate standard to [Mrs A] and, in addition, to answer the following questions;

1. What particular standards apply in this case?

2. Did [Dr B's] management of [Mrs A's] chest symptoms meet these standards?

3. Whether a general practitioner could have detected the severity of [Mrs A's] aortic stenosis and, if so, what was the appropriate course of treatment?

4. Whether, in your opinion, [Dr B] was actively treating [Mrs A's] medical care, by prescribing warfarin etc, after he transferred her records to [Dr F] on 24 October 2001?

5. Is the Medical Council's statement 2001 *Statement Of Self Care And Family Care* applicable in this case? Please explain.

6. Would you consider [Dr B's] prescribing 'minor'?

7. From the evidence available, was [Mrs A's] overall medical care being monitored by another doctor?

8. Is the *Policy Statement On Sexual Relationships With Former Patients* (effective from 12 December 1996) published by the Medical Council applicable in this case?

9. Has the statement (as cited in question 8 above) been replaced with the 1999 *Policy Statement On Sexual Abuse In The Doctor/Patient Relationship*?

10. Was [Mrs A] [Dr B's] former patient after he sent her records to [Dr F]?

Are there any other matters about [Dr B's] relationship with [Mrs A] that, in your opinion, should be brought to the Commissioner's attention?

C. In my opinion

   1. The standards that apply with respect to her heart disease are those of a clinically competent medical graduate: aortic stenosis is one of the iconic conditions in medicine – classic symptoms and signs, a condition which, if left untreated, can lead to sudden death. The standards that applied in 2001-2 with respect to their relationship are those traversed in the Medical Council of New Zealand's *Policy statement on sexual abuse in the doctor/patient relationship* (1999) and *Statement on self care and family care* (2001).

   2. When [Mrs A] presented with breathlessness [Dr B] diagnosed acute bronchitis, but noted the aortic systolic murmur, and ordered a chest Xray. The diagnosis of

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aortic stenosis is made not on chest Xray but either *clinically* (on the classic triad of symptoms – breathlessness, chest pain and dizziness – and the classic triad of signs – the murmur, slow-rising pulse, and left ventricular hypertrophic apical impulse), or by *echocardiogram*. It is confirmed by cardiac catheterisation. He made clinical records of chest pain and breathlessness on 12 March 2001 and noted the murmur, and on 14 May 2001. There is no record of questioning the nature of the pain or asking about dizziness or examining for the other signs. On 29 May 2001 he entered important extracts from [Dr C's] letter in his clinical record, including breathlessness on exertion, and the conclusion 'I suspect she has significant aortic stenosis'. He writes now that 'she had no cardiac symptoms', and later 'as she was still asymptomatic' he (with her agreement) intended to follow up the murmur after the neurological appointment.

3. The severity of aortic stenosis is assessed at echocardiogram, but it can be estimated on the symptoms and signs: by the time [Mrs A] saw the cardiologist she was breathless and was having chest pain and dizziness. If she had had these symptoms earlier she should have been referred urgently for cardiological intervention. [Dr B] was in some difficulty however; her major symptom appears to have been her migraine, and he writes she 'was asymptomatic' at that time, presumably meaning he interpreted her chest pain and breathlessness as resulting from bronchitis. He decided to sort out her migraine first, with the decision that cardiological referral could wait, and at that stage the referral for her heart disease was taken out of his hands. On 20 June 2001 [Dr D] was in no doubt her chest pain was angina, and noted her exertional breathlessness and 'syncope', with the murmur and slow-rising pulse, so the classic triads were there. It is difficult to understand how [Dr B] could have thought her asymptomatic, and how in the presence of a murmur he could attribute her chest pain and breathlessness to bronchitis. If, as he would have noted from [Dr C's] letter on 29 May, he was aware she may have a significant aortic stenosis, he should have made the cardiological referral a priority. In my opinion he gives no evidence that he is aware of the symptoms and signs of severe aortic stenosis, nor of the need for urgent referral because of the danger of sudden death that this condition carries.

4. By prescribing for his wife [Dr B] was treating her. He had passed her records on to [Dr F], but effectively continued as her general practitioner while she was attending cardiology outpatients. It has to be said that the Council statement is only a guideline as to what a wise doctor should do, and many doctors regard the prescription of drugs (provided they are not mind-altering) to spouses and family as reasonable. Nonetheless, [Mrs A] had been quite unambiguously his patient when they started a relationship outside the professional one, they had started a sexual relationship before they were married, and he should have been scrupulous in not continuing to treat her.

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5. The Council's statement on self and family care thus applies strictly only to the period following his marriage, and it is only a guideline.

6. His prescribing was major, for a chronic condition, and entailed drugs with important adverse effects and interactions.

7. [Mrs A] continued to attend cardiology outpatients, and was not receiving general practice care other than that provided by [Dr B].

8. The Council's *Policy statement on sexual relationships with former patients* (1996) applies only marginally here (it was replaced in 2003, after these events, so applied in 2001) as she was not a former patient: [Dr B] and [Mrs A] began their relationship while she was a current patient; [Dr B] should have ensured [Mrs A] became a 'former patient' by properly and fully handing over her care.

9. The Medical Council's *Policy statement on sexual abuse in the doctor/patient relationship* (1999) applies here. It deals with separate issues from those covered in the *Policy statement on sexual relationships with former patients.* While the words he is said to have used ('Gorgeous, just gorgeous') could have been meant for her surgical scar, they are at best ambiguous, and they do suggest sexual impropriety, which is how [Mrs A] understood them. The subsequent courting behaviour tends to confirm that, and it occurred while [Mrs A] was still his patient. Although the exact date of transfer of her records is uncertain, as I have said above, I believe he did continue to act as her general practitioner throughout this period. His reported comments, if true ('he kept reassuring me it was alright') suggest he was aware of the impropriety.

10. [Mrs A] remained [Dr B's] patient; his passing her records to [Dr F] was not a proper handover, and he continued to prescribe for her. His contention that this was at her request does not exonerate the behaviour.

I note there is a difference between [Mrs A's] and [Dr B's] accounts of these events, and I note her reference to 'a hostile and very difficult marital break-up', and his to an 'extremely acrimonious marriage break up'. I am of course unable to judge the credibility of these written statements. …"

Response to Provisional Opinion

In response to my provisional opinion, Dr B stated the following:

"Thank you for the opportunity to comment on your provisional opinion and the advice from Dr St George as to the complaint between myself and my former wife, [Mrs A]. I will address each of the three aspects of [Mrs A's] complaint, and your factual findings and recommendations in relation to the same.

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Care and Treatment of Chest and Cardiac Symptoms Prior to Referral

First, in respect of my treatment of [Mrs A] prior to her referral to [Dr C]. I note the finding that [Mrs A] presented with 'classic symptoms' of Aortic Stenosis, and that as such it is your view that I should have made that diagnosis and actioned an earlier referral. With respect, I do not agree.

[Mrs A's] original complaint was a fairly severe migraine, increasing in severity. She also described buzzing in her head in relation to those migraines. On 12 March, I did make a diagnosis of aortic stenosis, and I did advise [Mrs A] that a cardiology appointment would be required. However, in discussion with [Mrs A] at that consultation, it was her election to have the migraines addressed first as these were debilitating and interfering with her work. She wished to have her migraines assessed privately, as she was well aware of the time constraints that can exist in the public hospital system, and she advised that she had significant work commitments. Whilst she did complain of some right sided chest pain at that time, this was the first consultation in which she had made that complaint. Because of its relationship to the lung congestion, I considered it appropriate that the first step would be a chest x-ray. You will note the findings on that chest x-ray supported a diagnosis of bronchitis. This was not inconsistent with the pain that was described.

At the next consultation on 14 May, the decision for referral was made because of continued chest pain and breathlessness. I consider that it was necessary at that time to further investigate those signs, and that they were not adequately explained by ongoing bronchitis. You will note from my referral letter to [Dr C] that the presenting complaint is identified as *'severe persistent headaches'*. This is in accordance with [Mrs A's] main concerns at the time of seeing me. I did however also refer to the aortic systolic murmur in anticipation [Dr C] would investigate that further.

Accordingly, I do not accept there was any unnecessary delay in referral. [Mrs A's] primary concern was that her migraines be addressed. While her right sided chest pain was obviously of concern, at the consultation in March the murmur was faint, and the breathlessness complained of was wholly consistent with the diagnosis of bronchitis.

[Dr C] referred [Mrs A] to [Dr D] at the Public Hospital, a referral made more rapid by origin from a Consultant. As documented in the notes, urgent referral for cardiac surgery was made. I note from the reporting letter by [Dr D] that [Mrs A] was allowed to return to work, provided that she did not engage in heavy lifting. The fact that she was allowed to return to work and to continue to drive illustrates that [Dr D] did not consider her symptoms were critical. Having said that, I acknowledge that urgent surgery was required.

I am well aware of the dangers of aortic stenosis, and I am also well aware of that diagnosis using Ultrasound. There was not private ultrasound available in [the city] at that time (although there is now). Had I written a letter in March as suggested by Dr St George detailing the symptoms [Mrs A] complained of at that time, I am confident she would not have been placed on the urgent list for initial assessment.

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Ethical Standards When Entering Sexual Relationship with [Mrs A]

I refer to your provisional breach finding in respect of this aspect of the complaint, and in particular, the reliance on the timing of my transfer of [Mrs A's] notes to [Dr F].

With regard to my transfer of the notes, I do consider my actions were adequate. [Mrs A] has stated and it appears that both you and Dr St George accept that my first non-professional contact with [Mrs A] was at her post-graduate dinner. By non-professional, I do not mean 'intimate'.

This was our first meeting that was not a consultation. However the date of this dinner was definitely 11 October and not in September. [Mrs A's] complaints as to my actions in September are plainly incorrect. I certainly did not attend her 50th Birthday party.

On recognising my feelings for [Mrs A] on 11 October at her post-graduate dinner, that is that I wished to form a relationship with her, and upon ascertaining [Mrs A] was receptive to this I immediately took the actions I considered appropriate. I contacted [Dr F] on 25 October and explained the situation to her. I transferred [Mrs A's] notes on that same date (with her consent). At this time I reiterate that the relationship was non sexual. I refute all allegations that any behaviour of an intimate nature took place before the transfer of [Mrs A's] notes. It is absolutely not correct.

With reference to the weekend in [the city], this was in mid-November. We did stay with [Mrs A's] daughter. However, there was no sexual contact at this time. The first sexual contact between us occurred on the last weekend of November, that is, some 3½ weeks after the transfer of notes. At this time, [Mrs A] was still under the care of the Hospital.

[Mrs A] has stated that I made comments of an inappropriate sexual nature, namely *'gorgeous, just gorgeous'*. In my original response to this complaint, I stated that any comments I made whilst examining [Mrs A] were in relation to the healing of her scar. I realise I did not make it clear that I certainly did not use the word *'gorgeous'* at this time, or indeed at any other time that I can recall in relation to [Mrs A]. It is not a word I use and it is certainly not a word I would have used in the context of a consultation.

[Mrs A] has also asserted that I pursued her, for example by appearing on her doorstep in the mornings. I did not do this; I never waited for her on her doorstep in the morning for her to return from swimming as she states.

I note your comment that the fact I married [Mrs A] does not detract from the alleged inappropriate nature of my behaviour. Given my belief I had terminated the doctor/patient relationship by transferring her notes before embarking on an intimate relationship with her, and by ensuring that the attraction was mutual, I do not accept this. I certainly do not accept that [Mrs A] was particularly vulnerable, or that my embarking on a relationship with her was abusive. In my view it is wrong to assume the relationship must have been abusive; it was not. While I do not wish to detail the steps taken by [Mrs A], it was very clear to me that she was equally keen on a relationship and she was active in pursuing that.

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Finally, I note Dr St George's comment that both [Mrs A] and I have referred to the acrimonious nature of our matrimonial split. Dr St George correctly comments that he is unable to judge the credibility (on the papers) of our accounts. However, the findings of Dr St George, and the provisional opinion, plainly indicate that [Mrs A's] assertions have been accepted, when many are factually incorrect. There was no intimate relationship prior to the transfer of her notes. I did not make any inappropriate sexual comments during the course of any consultation.

Ethical Standards When Prescribing for [Mrs A] during the Course of our Marriage

I accept it may appear unwise to prescribe medicine but I agree this should not constitute a breach. I did not have an active medical management of [Mrs A] after the transfer of her records. The medications I prescribed were simply repeat medications, and were in accordance with what was prescribed by the Hospital.

The fact that [Mrs A] did not see any other general practitioner namely [Dr F] until May 2002, is simply because she did not require GP care for that period of time. She was being followed up by the Hospital. Other than the prescriptions of which you are aware, I did not otherwise treat her at this time.

In summary, on the basis of the above, I do not accept that this matter warrants a referral to the Director of Proceedings. In my view, other than the issue as to the referral for specialist treatment, the matters the subject of this complaint stem from the break up of our marriage. I regret that the Commissioner has had to become involved in this, and I do not consider it is appropriate that these issues are being dealt with in this way.

I am aware of the Medical Council guidelines and to *'sexual abuse in the doctor/patient relationship'*. I reiterate yet again that I did not have any intimate relationship with [Mrs A] until after 25 October 2001 that being the date on which her medical records were transferred. I am aware that there are also boundaries in relation to a former patient, however the fact that this relationship was mutually serious is evidenced by the fact we were married. The fact the marriage was of short duration is of absolutely no consequence in that respect. I remain of the view that the complaint has been motivated not by any genuine concern on [Mrs A's] part that I acted inappropriately but rather as a consequence of the unhappy nature of our relationship breakup. It is telling in my view that this complaint was not lodged until July 2003, that being shortly after a matrimonial settlement was reached."

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Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

Professional Standards

The Medical Council of New Zealand *Statement on Sexual Abuse in the Doctor–Patient Relationship* (1999) states:

"Sexual behaviour in a professional context is abusive. Sexual behaviour comprises any words or actions designed or intended to arouse or gratify sexual desires.

…

The Council condemns all forms of sexual abuse in the doctor/patient relationship for the following reasons:

- The ethical doctor/patient relationship depends upon the doctor creating an environment of mutual respect and trust in which the patient can have confidence and safety

- The onus is on the doctor to behave in a professional manner. Total integrity of doctors is the proper expectation of the community and of the profession. The community must be confident that personal boundaries will be maintained and that as patients they will not be at risk. It is not acceptable to blame the patient for the sexual misconduct.

- The doctor is in a privileged position which requires physical and emotional proximity to the patient. This may increase the risk of boundaries being broken.

…

- 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

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of power and patient consent can not be a defence in disciplinary hearings of sexual abuse

- Sexual involvement with a patient impairs clinical judgement in the medical management of that patient.

Definitions

For the purposes of disciplinary action, the Council has defined sexual abuse under three categories:

- Sexual impropriety
- Sexual transgression
- Sexual violation."

The Medical Council's *Policy Statement on Sexual Relationships with Former Patients* (1996) states:

"Any complaint that a doctor entered into a sexual relationship with a former patient will be considered individually …

In every case a sexual relationship between a doctor and a former patient will be deemed unethical if it can be shown that the doctor exploited any power imbalance, or exploited any knowledge and influence gained within the professional relationship."

The Medical Council's *Statement of Self Care and Family Care* (2001) states:

"It is generally unwise for medical practitioners to care for themselves or family members in all but minor matters and emergency health matters. Self care and family care is neither prudent nor practical due to lack of objectivity and discontinuity of care. The Medical Council recognises that there are some situations where family treatment may occur but maintain that this should only occur when overall management of patient care is being monitored by the family's practitioner."

Opinion: No breach – Dr B

Chest / cardiac symptoms
Aortic stenosis can be diagnosed by a general practitioner. Classically patients complain of breathlessness, chest pain and dizziness, accompanied by signs of heart murmur, slow-rising pulse and enlarged left ventricle. Confirmation of aortic stenosis is by clinical assessment, echocardiogram, or cardiac catheterisation.

Dr B recorded Mrs A's chest pain and heart murmur in March and May 2001 but did not record whether he explored the nature of the chest pain and dizziness or examined her for

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other cardiac signs. Following the 12 March consultation he ordered a chest X-ray, which revealed some chest congestion. Following the 14 May consultation he referred Mrs A to Dr C and advised that she had an "aortic systolic murmur which radiates up into her neck and is probably non relevant …". On 29 May he recorded Dr C's findings (from his consultation with Mrs A on 22 May) that the aortic stenosis was severe.

Mrs A had reported to Dr B significant deterioration in her ability to exercise, and dizziness to the point of falling down. Upon seeing Dr C eight days after Dr B's referral she had difficulty climbing two flights of stairs. Dr C immediately referred her for a cardiac assessment. The cardiologist who saw Mrs A on 13 June reported severe valve disease and recommended urgent valve replacement, which was carried out in a private hospital.

My advisor believed that Dr B's difficulty diagnosing Mrs A's cardiac symptoms was because her main symptoms were migraine headaches. He initially diagnosed bronchitis and treated her accordingly. At the 14 May consultation he considered that investigation of her migraines took priority over the heart murmur because she was asymptomatic. My advisor found it difficult to understand why Dr B would report her as "asymptomatic" in the presence of a heart murmur, and why he would attribute her chest pain and breathlessness to bronchitis. In my expert's view the cardiac referral should have taken priority, particularly as Mrs A's bronchitis had not responded to antibiotics.

Dr B advised me that he is "well aware of the dangers of aortic stenosis" and anticipated that the neurologist to whom he was referring Mrs A would investigate further, as indeed occurred. Dr B focused on Mrs A's presenting complaint of persistent migraines. He did not consider that an urgent referral to a cardiologist was warranted.

Patients rely on their GP to be alert to serious problems that, because of their potential consequences (eg, risk of sudden death from aortic stenosis), are far more pressing than the presenting complaint. This is an aspect of the doctor's duty to provide services with reasonable care and skill, under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). I have some concerns about Dr B's response to Mrs A's condition at the 12 May consultation. However, on balance, I accept that Dr B has given a credible explanation for his failure to make an urgent referral to a cardiologist and that, in the circumstances, he did not breach Right 4(1) of the Code.

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Opinion: Breach – Dr B

Relationship with patient
Right 4(2) of the Code states that patients have a right to services provided that comply with professional and ethical standards. The Medical Council of New Zealand (the Council) has published a number of guidelines on relationships between patients and their doctors. In its 1996 statement on sexual relationships with former patients, the Council stated that in every case a sexual relationship between a doctor and a former patient will be deemed unethical if it can be shown that the doctor exploited a power imbalance. The Council's 1999 statement condemns all sexual behaviour in a professional context as abusive.

Dr B was aware that a sexual relationship with a current patient was inappropriate. He transferred Mrs A's care to another doctor before they started dating. Although Dr B considers that the transfer was effective on the date he telephoned Dr F (25 October), in my view the transfer was not complete until he handed over Mrs A's records on 1 November.

Mrs A claims that Dr B first made sexual advances on the weekend of 16 October, while she was still his patient. However, that is denied by Dr B, and there is insufficient evidence for me to conclude that sexual contact began at that time. I note that 16 October 2001 was a Tuesday. I consider that Dr B's statement that the weekend visit occurred in mid-November is likely to be accurate, and am not convinced that any sexual contact occurred. Both parties agree that a sexual relationship had commenced by the last weekend in November. I find that Dr B and Mrs A began a sexual relationship around 24-25 November, approximately three weeks after Dr B transferred Mrs A's records.

It may be argued that Mrs A was technically no longer Dr B's patient when their sexual relationship began. As a matter of law, a doctor's professional relationship with a patient will usually be terminated by the transfer of medical records to another practitioner. However, I note my advisor's comment that Dr B should have ensured Mrs A became a former patient by "properly and fully handing over her care". Judge Lee in *Director of Proceedings v MPDT* stated that "the action required of the doctor is to terminate the doctor–patient relationship and to *ensure that another doctor takes over the care of the patient*" (emphasis added).[1]

Dr B said that he no longer had active medical management of Mrs A after he transferred her records, yet he continued to prescribe repeat medications for her after she became his wife. She saw no other doctor until May 2002.

I agree with my advisor's view that "by prescribing for his wife [Dr B] was treating her". Effectively he was still her general practitioner. Dr B's prescribing was "major, for a chronic condition, and entailed drugs with important adverse effects and interactions". He crossed the line beyond occasional, minor prescribing for a family member. For any doctor to undertake major prescribing for a family member is unwise. Dr B, who had embarked on a

[1] Wellington District Court, MA No 69/01, 24 January 2002, para 77.

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relationship with a woman who until very recently had been his long-time patient, and whose justification for the propriety of his actions was that he had transferred her care, should (as Dr St George noted) "have been scrupulous in not continuing to treat her". He failed to ensure that another doctor actively took over her medical care.

For all practical purposes, Dr B continued to act as Mrs A's GP after they began a sexual relationship, despite the transfer of her records. However, even if it is accepted that Dr B's professional relationship with Mrs A ended on 1 November 2001, when he transferred her records to Dr F, and that she became a former patient from that date, Dr B still had ethical responsibilities towards her. According to the Medical Council's *Policy Statement on Sexual Relationships with Former Patients* (1996), "In every case a sexual relationship between a doctor and a former patient will be deemed unethical if it can be shown that the doctor exploited any power imbalance, or exploited any knowledge and influence gained within the professional relationship." I accept that there was no element of exploitation in the relationship Dr B began with Mrs A. Nevertheless, he was privy to a great deal of information as her GP for 27 years, and some element of influence and power imbalance must have endured. In my view, the longer the doctor–patient relationship the less appropriate an intimate relationship is, because the power imbalance from the professional relationship is more firmly entrenched. It was extremely unwise for Dr B to begin a sexual relationship barely three weeks after his professional relationship with Mrs A officially ended.

Even if Dr B did not breach the professional standards laid down by the Medical Council, the question remains whether he complied with ethical standards. Under Right 4(2) of the Code, a doctor is required to comply with professional *and* ethical standards. The profession is not the final arbiter of ethical behaviour. As Commissioner, I am required "to promote and protect the rights of health consumers"[2] and to form *my own opinion* about the extent of a health professional's ethical responsibilities. I find it artificial to suggest that doctors who become attracted to a patient can simply discharge the patient from their books and commence a sexual relationship shortly afterwards, so long as there is no element of exploitation. I consider it unacceptable for a doctor to end a doctor–patient relationship for the sole purpose of starting a sexual relationship. The reasons were well articulated by a Dr Robin Briant, former Chair of the Medical Council, in 1994:[3]

> "The doctor–patient interaction is for the patient's benefit and there is no place in it for a sexual liaison. It would do immense harm to the quality of doctor–patient interactions generally if it were even suspected that intimate or sexual relationships may evolve from medical consultations. Only when people feel safe in a professional relationship can they entrust it with their most private emotional, psychological and physical secrets."

Doctors owe their patients a fiduciary duty not to allow a conflict of interest between their professional duty and their personal interest. Whenever a doctor commences an intimate relationship with a patient to whom he owes an ongoing professional duty (for example, to

[2] Health and Disability Commissioner Act 1994, s 6.
[3] Medical Council newsletter, March 1994.

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ensure that repeat medication prescriptions are appropriate or that blood test results do not raise clinical concerns), there is a potential conflict between duty and interest – in the sense that emotional interests may cloud professional judgement.[4]

In my view, in addition to handing over Mrs A's records and ensuring that another doctor took over her care (and that he ceased to care for her), Dr B should have specifically recommended that she obtain independent advice (eg, from another doctor or a counsellor) about the risks of becoming emotionally involved with her former doctor,[5] and should have sought independent advice from a peer/mentor on the wisdom of his proposed course of action.

Prescribing for family members
The Medical Council's *Statement on Self Care and Family Care* (2001) notes that it is generally not wise or prudent for doctors to treat members of their own family. Patients are entitled to good medical care, which may be compromised if a doctor's lack of objectivity interferes with sound clinical judgement. The Council recognises that doctors treat family members for minor matters but recommends that this only occur under the oversight of another medical practitioner. In my view, Dr B's prescribing of significant medications for his sexual partner (and later wife) Mrs A was inappropriate.

Conclusion
In my opinion, Dr B did not fulfil his ethical responsibilities to Mrs A. The ethical situation is not changed by the fact that Dr B subsequently married his patient; nor by her motives in bringing this complaint after a bitter marital breakdown.

In these circumstances Dr B failed to comply with ethical standards and breached Right 4(2) of the Code.

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[4] Dr Robin Briant commented in a paper on 'Sexual Misconduct' (Medico-Legal Conference Auckland, 20 April 1994):

> "Another reason for prohibition is that emotional and sexual involvement with a patient leads to objectivity loss in managing their patient's medical problems; the therapist becomes impaired.
> The relatively common though generally unwise practice of doctors proving medical care for their own family members is a mirror image of this: lack of objectivity in that situation has been well recognised."

[5] See the similar comment of Judge Lee, in *Director of Proceedings v MPDT* (Wellington District Court, MA No 69/01, 24 January 2002), that the doctor's conduct "fell short in failing to warn [the patient] of the potential harm of becoming romantically involved with her former doctor and in failing to ensure as far as possible that she received independent counselling" (para 80).

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Other comments

Sexualisation of doctor–patient relationship

Dr B denies that he referred to Mrs A's breasts (when examining her operation scar at a consultation some time after her surgery in July 2001) as "gorgeous, just gorgeous". It is not possible to determine whether such a statement was made. If, as Dr B claims, he simply referred to the neatness of her scar and did not use the term "gorgeous", the misunderstanding highlights the need for care in making comments about a patient's anatomy. The consultation room is no place for ambiguous comments that risk misinterpretation and sexualisation of the doctor–patient relationship.

Need for clear guidelines

This case highlights the weakness of open-ended guidelines that regulate sexual relationships with former patients, and prescribing for family members, on a case-by-case basis. Although clear guidelines (such as a six-month stand-down period before a sexual relationship with a former patient is permitted[6]) may be criticised as rigid and inflexible, in my view patients and doctors would be better served by "bright lines" to proscribe unacceptable behaviour.

Non-referral to Director of Proceedings

I have decided not to refer this case to the Director of Proceedings. The Medical Practitioners Disciplinary Tribunal and the District Court have signalled that it is not a disciplinary offence for a doctor to commence a sexual relationship with a recently former long-term patient (after a brief period of intimacy while she was a current patient), if there is no evidence of exploitation.[7] As noted above, Dr B's conduct was not exploitative. In the present case, where (at least until 2001) there were relatively few professional consultations between the doctor and patient, and no element of counselling within the professional relationship, the case for discipline is even weaker – although Dr B's provision of ongoing medical care is a countervailing factor. On balance, I regard it as sufficient that Dr B's conduct is sanctioned by a finding of breach of the Code of Consumers' Rights, and that he undertake a review arranged by his College (see below).

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[6] I note that research undertaken by the Medical Council suggests that 60-80% of damaging relationships between doctors and their former patients occur within six months of termination of the professional relationship: Ontario Task Force on Sexual Abuse of Patients (1991), 137-138. 42 of 70 submissions (including 68% of consumer submissions) on the Medical Council's discussion document on 'Sexual Boundaries in the Doctor/Patient Relationship' (March 2001) suggested stricter controls on former doctor–patient relationships than the current case-by-case approach, according to the Council's 'Executive Summary of Submissions Report' (October 2001).

[7] *Director of Proceedings v Wiles* (MPDT, 155/00/65D, 5 March 2001) and *Director of Proceedings v MPDT* (Wellington District Court, MA No 69/01, 24 January 2002).

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Recommendations

- I recommend that Dr B review his practice in light of my report and meet with a colleague appointed by the Royal New Zealand College of General Practitioners, to discuss the lessons of this case and the implications for his future practice. I request that the College confirm that this meeting has occurred.
- I recommend that the Medical Council review its *Statement on Self Care and Family Care* (2001) in light of this report.[8]

Follow-up actions

- A copy of this report will be sent to the Medical Council and the Royal New Zealand College of General Practitioners.
- A copy of this report, with identifying details removed, will be sent to the New Zealand Medical Association, Women's Health Action, and the Federation of Women's Health Councils-Aotearoa and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[8] I have not recommended that the Council review its guidelines on sexual relationships with former patients as I am aware that the Council is shortly to publish a revised statement on *Sexual boundaries in the doctor–patient relationship* (2004).