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File No: **1078/Med 19/445P**

UNDER The Health Practitioners Competence Assurance Act 2003 ("the HPCA Act")

IN THE MATTER of a disciplinary charge laid against a health practitioner under Part 4 of the Act.

BETWEEN **A PROFESSIONAL CONDUCT COMMITTEE** appointed by the **MEDICAL COUNCIL**
Applicant

AND **DR RAN BEN-DOM** of Waikanae, registered medical practitioner
Practitioner

HEARING held at Wellington on 11 – 15, 18 – 22 November 2019

TRIBUNAL: Mr D M Carden (Chair)
Dr B Bond, Dr B Krause, Dr L Wilson ONZM and Mr C Nichol (Members)
Ms D Gainey (Executive Officer)

APPEARANCES: Ms A Miller and Ms H Goodhew for the Professional Conduct Committee

Dr D Stevens QC for the practitioner

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Introduction

[1] Between June 2011 and May 2017 Dr Ben-Dom was consulted as a medical practitioner by 9 female patients. In respect of 7 of these occasions Dr Ben-Dom raised with the respective patients the topic of breast health. This led, in respect of some of those, to a breast examination by him. The patients had consulted him concerning other issues, namely a consultation concerning the [young]- son of one of the patients, a throat complaint, an upper respiratory tract infection and repeat prescriptions, blistered eczema to the hand, stress, diarrhoea and a urinary tract infection, asthma, and a repeat prescription for venlafaxine.

[2] In respect of one patient, a [under 16 year old], Dr Ben-Dom raised certain [ ] matters when she was consulting about a throat infection. In respect of another patient, in addition to raising the topic of breast health and performing a breast examination, it is alleged that Dr Ben-Dom offered to perform a cervical smear test on her.

[3] Following complaints received, these consultations were investigated by a Professional Conduct Committee (PCC) of the Medical Council of New Zealand (the MCNZ) and it laid a charge against Dr Ben-Dom under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act). The full text of the Charge (after amendment by deletion of 2 particulars) is set out in the Schedule to this decision. The Charge was fully defended by Dr Ben-Dom and heard by the Tribunal over 10 days of hearing.

[4] Permanent orders for non-publication of the names or identifying details of the respective patients were made and are confirmed by this decision. The decision also deals with other non-publication applications made.

The hearing

[5] Before the hearing there had been objections to the proposed evidence to be advanced by both parties and these were dealt with at the hearing. The practitioner had applied for some evidence to be taken by telephone conference which was declined. An agreed bundle of documents was prepared and presented to the Tribunal on the basis that had been canvassed at a preliminary conference namely that each document in the bundle:

(a) is what it purports to be on its face;
(b) was signed by any purported signatory shown on its face;
(c) was sent by any purported author to, and was received by, any purported addressee on its face;

(d) was produced from the custody of the party indicated in the index;
(e) is admissible evidence; and
(f) is received into evidence as soon as referred to by a witness in evidence, or by counsel in submissions, but not otherwise.

[6] At the hearing some of the witnesses sought to give their evidence in private under section 97 of the HPCA Act and this was ordered.

[7] The PCC called evidence from each of the respective patients in question; the person who had been practice manager at the Health Centre in question, the Waikanae Health Centre, at relevant times, and two general practitioners who had been managing partners at the Waikanae Health Centre from time to time and are both still currently partners in the practice. The PCC also called evidence from an expert, Professor Bruce Arroll.

[8] During the course of the hearing counsel for the PCC was asked about whether there was any suggestion of prurience on Dr Ben-Dom's part in its prosecution of the charges and the transcript reads:

> *"**CHAIR:** There is some suggestion in the paperwork that there might be some prurience involved in this and some completely wrongful behaviour. I am wondering whether the PCC is asking us to go down that track or not?*
> ***MS MILLER:** The position is that - the PCC hasn't advanced this case on the basis that it was sexually motivated, so we're not seeking any particular finding with respect to motive, Sir".*

[9] The practitioner called evidence from himself, his wife, and two nurses who had worked from time to time at relevant times at the Waikanae Health Centre but were no longer there. He also called evidence from two experts, Dr Eletha Taylor, and Dr James Stewart Reid.

Background

[10] Dr Ben-Dom migrated from Israel to New Zealand in 2009. He is now aged 61 years. He had completed a medical degree in Israel in 1988 and obtained a licence to practise medicine in 1989. He completed a four-year residency in family medicine in Israel giving him a specialist qualification in family medicine. Having migrated to New Zealand, he became vocationally registered with the Royal New Zealand College of General Practitioners in 2014. He has been a part time lecturer in Israel and has co-authored an article for a European journal.

[11] Dr Ben-Dom said that his training emphasised the importance of using time that remained in a consultation and that prevention and health promotion have always played

a significant part in his approach to his patients. He said that, after he had used the necessary time for the presenting problem, he would seek to look at other matters and generally update the patient's "*dashboard*" and deal with other issues "*before moving on to prostate and breast health matters*". Dr Ben-Dom said that he found that this approach did not fit easily with what he described as "*the commercial model used in New Zealand*".

[12] Dr Ben-Dom said that his regular patients were "*very comfortable and happy with his proactive approach to their health*". He said that in the 8 years that he was at Waikanae Health Centre he had in the vicinity of 20,000 female consultations. He produced a bundle of statements which he said were "*provided by patients in [his] support*", but the PCC was critical of these in that they did not refer to the authors' awareness of the issues raised by the Charge. The Tribunal has considered those statements in the context of that objection. These refer to satisfaction of many of the women patients with Dr Ben-Dom's approach to introducing breast health and encouraging breast self-examination. The basis of Dr Ben-Dom's approach to breast health promotion is explored further below in the context of his defence to the Charge.

[13] The detail concerning the patients referred to in the Charge is considered below. Essentially, on [ ] 2011 one patient, Ms N, had brought her [young] son for consultation and during that consultation Dr Ben-Dom raised the topic of breast health with Ms N.

[14] On [ ] 2012 Ms E consulted with Dr Ben-Dom concerning a throat complaint and Dr Ben-Dom raised the topic of breast health and performed a breast examination.

[15] On [ ] 2012 Ms S consulted with him about an upper respiratory tract infection and repeat prescriptions when again Dr Ben-Dom raised the topic of breast health and performed a breast examination.

[16] On [ ] 2014 Ms D consulted with Dr Ben-Dom about blistered eczema on her hand and Dr Ben-Dom raised the topic of breast self-examination.

[17] On [ ] 2014 Ms N consulted with Dr Ben-Dom again, this time about her own health, namely stresses she was under, and Dr Ben-Dom raised the topic of breast health with her and performed a breast examination.

[18] On [ ] 2015 Ms S consulted Dr Ben-Dom about diarrhoea and a urinary tract infection and Dr Ben-Dom raised the topic of breast health and offered to perform a breast examination for her.

[19] On [ ] Miss Y, then a [under 16]-year-old, consulted Dr Ben-Dom about a throat infection, this being the first time she had seen a doctor on her own; and Dr Ben-Dom raised certain [ ] matters with her.

[20] In April 2015 the Waikanae Health Centre amended its Sensitive Examinations Protocol and Consultations Expectations following complaints that had been made concerning Dr Ben-Dom.

[21] On [ ] 2016 Ms A consulted with Dr Ben-Dom about asthma and he raised the topic of breast health with her.

[22] In May 2016 the practice manager and the then managing partner met with Dr Ben-Dom and following this in May 2016 Dr Ben-Dom wrote to the Waikanae Health Centre followed in June 2016 with a signed written undertaking to the partners. Details are referred to below.

[23] On 24 May 2017 when Ms Kenny consulted with Dr Ben-Dom about a repeat prescription for venlafaxine, Dr Ben-Dom raised the topic of breast health with her and performed a breast examination. At that same consultation Dr Ben-Dom offered to perform a cervical smear test on Ms Kenny and the Charge allegation concerns an absence of chaperone offer and absence of record.

The Charge – the PCC position

[24] The PCC has advanced its presentation of the Charge on two bases:

a) First in respect of those patients with whom Dr Ben-Dom discussed breast health and for whom, in some instances, he performed a breast examination. The PCC's position is that in each case the circumstances did not clinically justify the discussion or examination. In respect of the [under 16]-year-old Ms Y, Dr Ben-Dom raised [ ] matters with her when that was not relevant to the consultation for a throat infection. In relation to the consultation on 24 May 2017 with Ms Kenny there is a further factor arising from a written undertaking that Dr Ben-Dom had given to Waikanae Health Centre on 1 June 2016.

b) Secondly in relation to all patients and particulars of the Charge that Dr Ben-Dom's raising of the topic of breast health or examination or his raising of [ ] matters with Ms Y or his offering to perform a cervical smear for Ms Kenny were in a manner that was inappropriate in the specifics referred to in the particulars of the Charge.

[25] Having outlined the purpose of disciplinary proceedings and referred to other decisions of the Tribunal said to be relevant and similar, the PCC referred to certain relevant standards and guidelines including *Good Medical Practice* (2008, 2013, June 2016 and December 2016 editions), *Sexual Boundaries in Doctor-Patient Relationship* (October 2009), *The Maintenance and Retention of Patient Records* (August 2008), and the *Statement on Cultural Competence* (August 2006).

[26] It also relied on certain publications referred to in the evidence of Professor Arroll namely, "Breastscreen Aotearoa; More about screening and Breastscreen Aotearoa" (Ministry of Health 2007); "Standards of Service Provision for Breast Cancer Patients in New Zealand" (Ministry of Health 2013); "Information on Breast Awareness" (published by National Screening Unit, Cancer Society, and the New Zealand Breast Cancer Foundation); and "American Cancer Society Recommendations for the Early Detection of Breast Cancer".

[27] Having then referred to the evidence particularly of Professor Arroll, Dr Reid, and Dr Taylor, the PCC also referred to evidence of the two general practitioners who had practised with Dr Ben-Dom, Dr Edwards and Dr O'Connor. It submitted that there was no sound body of medical opinion supporting the practice by Dr Ben-Dom of regularly and repeatedly raising breast examinations (whether clinical or self) when this was not the patient's presenting concern.

[28] Dr Ben-Dom's approach, it was submitted, was not consistent with relevant guidelines or the practice of professional peers but rather indicating that he allowed his own singular agenda or "*logical*" views to override the wishes of the patient to the point he was intrusive and insensitive. The PCC did not accept Dr Ben-Dom's position that his practice of routinely asking female patients about breast examinations was in the best interests of his patients. Dr Ben-Dom's actions should, it was said, be viewed in light of concerns raised with him by his professional peers and by his employer during the time he was at Waikanae Health Centre.

[29] The submissions then addressed the individual patients and are referred to further below. It is the PCC's case that Dr Ben-Dom's conduct, both separately and cumulatively, amounts to a departure from acceptable standards sufficiently serious to warrant disciplinary sanction for the purposes of maintaining professional standards and protecting the public. The breaches were serious; the conduct demonstrated a pattern of behaviour over a lengthy period of time; and the conduct requires a clear message to be

sent through the imposition of a penalty not only to protect the public but to prevent Dr Ben-Dom from continuing with this inappropriate conduct.

The Charge – Dr Ben-Dom's position

[30] The defence by Dr Ben-Dom to the Charge addressed two main fronts:

a) The specific allegations in relation to the individual consultations, details of which were denied by Dr Ben-Dom. No undue pressure was placed on patients to have examinations and all were complete professional examinations with the duration not having been excessive, with an offer routinely of a chaperone, an opportunity for privacy and without inappropriate comments about the patient's breasts, any comment having been clinically appropriate. Evidence from nurses who worked with Dr Ben-Dom was called to confirm that examinations were always clinical and professional and respectful of privacy issues and the sensitive nature of those examinations.

b) The appropriateness of breast awareness advice, breast self-examination advice and clinical breast examinations, Dr Ben-Dom's position being that these were entirely appropriate and justified. Dr Ben-Dom's behaviour in this respect was, it was submitted, influenced by his training and practice in Israel and reflected both his proactive approach to health and prevention of disease and early diagnosis. Dr Ben-Dom sought to increase his female patients' awareness of the risk of breast cancer which he considered to be important. Clinical breast examination played a valuable part in the detection of breast cancer and Dr Ben-Dom sought to encourage women to have these examinations.

[31] Any omission to record required matters in the patient notes were the result of pressure of work but not sufficient to amount to a departure from acceptable standards and only an oversight not warranting disciplinary sanction.

[32] The submissions for Dr Ben-Dom relied on his evidence and that of his wife that the approach in Israel to medical practice was more direct than he had perceived to be the case in New Zealand. Dr Ben-Dom's proactive approach to medicine and high level of patient care was, it was submitted, very favourably received by a great majority of his patients and reliance was placed on the written references were provided. There were cultural and language considerations in respect of the very small number of patients who were unhappy about his approach and there were sometimes communication issues as a result of English having been Dr Ben-Dom's second language and his "*heavy accent*".

[33] Specifically in relation to the second category of defence, namely the appropriateness of breast awareness and breast self-examination, Dr Ben-Dom relied on section 100(4) of the HPCA Act which is discussed below. He acted, it was said, honestly and in good faith and he adopted and practised a theory of medicine.

The Charge: general principles

[34] The Charges are laid under section 100(1)(a) and/or (b) of the HPCA Act. These provide that orders can be made by the Tribunal if, after conducting a hearing, it finds that the practitioner has been guilty of professional misconduct because of any act or omission that amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time of the conduct or because of any act or omission that has brought or was likely to bring discredit to the profession in which the practitioner practised at the time of the conduct.

[35] If negligence or malpractice is alleged that must be established as behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error or oversight or even carelessness.

[36] Discredit to the profession involves a breach of an objective standard with the question to be asked being whether reasonable members of the public informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the profession in question was lowered by the behaviour of the practitioner.[1]

[37] In considering any charge of misconduct under the HPCA Act the Tribunal must, having found the acts or omissions in question which were misconduct or likely to bring discredit to the relevant professional, also consider whether the acts or omissions in question are of such severity as to warrant a disciplinary sanction for the purpose of maintaining standards, protecting the public, or punishing the practitioner.[2]

[38] The onus of proving the Charges lies on the PCC. The standard is the balance of probabilities. The more serious the allegation, the higher the level of proof required.

[39] The Tribunal can gain some guidance from the previous decisions of the Tribunal referred to it by the PCC. Those are referred to below[3].

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1 *Collie v Nursing Council of New Zealand;* [2001] NZAR 74 at [28].
2 *PCC v Nuttall;* 8/Med04/03P.
3 Paragraph 334

Absence of clinical justification or relevance

[40] An issue common to all particulars 1-11 (excluding 5 and 7 deleted) was the allegation of the absence of clinical justification for the actions taken by Dr Ben-Dom in relation to the respective patients in the circumstances or, in the case of the [under 16]-year-old referred to in particular 9, [ ] matters raised which were not relevant or were inappropriate. It is the case for the PCC that in the respective circumstances of each patient there was no clinical justification for the steps taken. This related to allegations of his having raised the topic of breast health, having performed a breast examination in some cases, having raised the topic of breast self-examination, having offered to perform a breast examination, and having raised [ ] matters with the then [under 16]-year-old patient. Different allegations were made in respect of the different patients.

Clinical justification – the PCC position

[41] The PCC urged that any consideration of an absence of clinical justification must be taken in the context of the individual patients and factors surrounding them.

[42] It adduced evidence from Professor Arroll who dealt specifically with the individual patients but in general terms in the context of breast health in New Zealand referred to a number of relevant guidelines; but said there were no national guidelines. Reference was made to the Standards of Service Provision for Breast Cancer Patients in New Zealand – Provisional of the National Breast Cancer Tumour Standards Working Group (2013) which made reference to three risk categories namely "*At or slightly above average population risk*", "*Moderately increased risk*" and "*High risk*".

[43] Professor Arroll referred to a publication titled "*Breast-screen Aotearoa More About Breast Screening and BreastScreen Aotearoa*" (Ministry of Health 2007) which includes[4]:

> "*In the past, some women were taught a formal technique of breast self-examination. This recommendation is no longer made as there is no evidence that this formal self-examination will reduce a woman's chances of dying from breast cancer. It can also increase a woman's risk of having unnecessary biopsies*".

[44] A Ministry of Health – Standards of Service document referred to by Professor Arroll included reference to screening surveillance of women at moderately increased risk with "*good practice points*" and advice for women at high risk; but Professor Arroll said that

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those standards do not provide advice on clinical breast examinations for women at average risk.

[45] Attention was drawn to a Cancer Society of NZ advice (online):

> "*When cancer is detected early, people have a much greater chance of being treated successfully. It is important to know your body and to be aware of any changes that are out of the ordinary for you. If you notice something different or unusual for you, please see a health professional as soon as possible to discuss what these changes may mean*".

[46] Professor Arroll also drew attention to a 2015 Article from the New England Journal of Medicine discussing the findings of an IARC Working Group on breast-cancer screening (2015) where the Working Group had evaluated the evidence regarding the beneficial and adverse effects of different methods of screening for breast cancer in the general population and high risk women. The findings with respect to clinical breast examination and breast self-examination were that there was "*inadequate evidence*" that clinical breast examination reduced breast-cancer mortality, but "*sufficient evidence*" that that examination shifted the stage distribution of tumours detected toward a lower stage. In respect of breast self-examination the Working Group found that there was "*inadequate evidence*" of any reduction in breast-cancer mortality when taught, any reduction in the rate of interval cancer when taught, or any reduction in breast-cancer mortality when practised competently and regularly.

[47] Professor Arroll concluded that, taking that guidance into account, the circumstances in which a clinical breast examination is done in primary care would be when a woman presents with a lump in her breast or breast pain or other breast symptoms, such as nipple discharge or skin rash on the breast(s). "*If a female patient presented with breast symptoms the doctor would conduct an examination of the breasts*". Women at moderately increased or high risk are generally referred to a high-risk breast clinic, Professor Arroll said.

[48] In the context of the Breastscreen Aotearoa statement that breast self-examination is no longer recommended, Professor Arroll drew attention to this extract from the American Cancer Society website:

> "*Research has not shown a clear benefit of regular physical breast exams done by either a health professional (clinical breast exams) or by oneself (breast self-exams). There is very little evidence that these tests help find breast cancer early when women also get screening mammograms. Most often when breast cancer is detected because of symptoms (such as a lump), a woman discovers the symptom during usual activities such as bathing or dressing. Women should be*

> *familiar with how the breasts normally look and feel and report any changes to a health care provider right away*".

[49] In his evidence Professor Arroll came to certain conclusions. Objection was taken to this evidence being given by him by counsel for Dr Ben-Dom. That objection was not accepted by the Tribunal at the hearing, primarily because of the provisions of clause 6(1), Schedule 1 of the HPCA Act which reads:

> (1) The Tribunal may receive as evidence any statement, document, information, or matter that may in its opinion assist it to deal effectively with the matters before it, whether or not that statement, document, information, or matter would be admissible in a court of law.

The Tribunal formed the opinion that Professor Arroll's evidence in these conclusions might assist it to deal effectively with the matters before it.

[50] One of those conclusions was that there having been no clinical justification for a clinical breast examination based on patient risk or symptoms indicated a breach of a reasonable standard of practice by Dr Ben-Dom.

[51] In evidence in reply to the proposed evidence from witnesses for Dr Ben-Dom, Professor Arroll said that he did not consider that Dr Ben-Dom's view of the New Zealand model of general practice is accurate when described as a "*reactive*" "*commercial model*" where a doctor is only able to react to the presenting issue. He said that he considered Dr Ben-Dom's own practice described as "*proactive*" is an example of "*over-servicing*" which runs the risk of over-diagnosis.

[52] He agreed with Dr Ben-Dom that the majority of women in New Zealand do not have the skills required to undertake a breast self-examination or to achieve breast awareness; firstly because of a lack of training when this was introduced some 29 years earlier and secondly because it is now not actively promoted. He said that "*[i]nformal examination, such as checking when in the shower, is considered to be sufficient to detect lumps of concern*" which would be considered to be breast awareness in normal risk women. Further, he said that in primary care, examination of the breasts should be restricted to women (or men) with symptoms and that higher risk women should be seen at the secondary care breast clinic.

[53] The PCC also relied on evidence from Dr Reid, an expert witness called by Dr Ben-Dom, that breast self-examination and clinical breast examination are not routinely recommended in New Zealand although women at moderate and high risk are

recommended to have a clinical breast examination by an experienced breast clinician annually from 10 years prior to onset of disease in the youngest affected relative; and that, although breast self-examination is not recommended, women should be encouraged to report promptly any breast changes to their clinician.

[54] Attention was drawn to the evidence from Dr Taylor that the current accepted body of medical opinion in New Zealand and other similar environments such as Australia and the United Kingdom is that the evidence does not support a routine self-examination by patients. She referred in evidence to the accepted practice being to check under a woman's arms and that the breast tissue itself extends quite high laterally in the axillary tail for certain women; and that she examines the axillary nodes as part of a breast examination. She said that there can also be breast tissue under the armpit.

[55] Reliance was placed on the evidence of Dr O'Connor, then currently a partner at the Waikanae Health Centre, who had worked there for 30 years and had been managing partner on several occasions. He was Dr Ben-Dom's clinical supervisor when Dr Ben-Dom first started at the Waikanae Health Centre. Part of this supervision involved ensuring that Dr Ben-Dom was comfortable with the New Zealand system and "*way of doing things*" and he said that a considerable amount of effort had been put into this. He spoke about having given Dr Ben-Dom feedback about his practice on a one-to-one basis and at peer review meetings monthly. He said that Dr Ben-Dom's spoken and written English was good but that he was occasionally left in some doubt as to whether Dr Ben-Dom was fully in agreement and understood what had been said to him. Dr O'Connor spoke about an event concerning three young women who had presented to Dr Ben-Dom with breast cancer and Dr Ben-Dom's apparent view that the New Zealand system was wrong. He had general discussions with Dr Ben-Dom about patient rights which left him with the impression that the Israeli system was more directive and patients had less input into treatment decisions.

[56] Dr O'Connor's evidence referred to the Waikanae Health Centre practices and policies which included a Sensitive Examinations Protocol and Consultation Expectations. The Sensitive Examinations Protocol was amended as a result of a review following complaints received about Dr Ben-Dom's breast examination practices and was discussed at a peer review meeting (or perhaps several meetings). One requirement was that, for sensitive examinations of the opposite sex such as breast or pelvis, a chaperone would be present.

[57] Dr O'Connor said that as a practice, the Waikanae Health Centre moved away from encouraging breast self-examination and doctor examination about 10 years ago to breast awareness where patients were encouraged to be aware of their breasts and familiar with changes, reporting changes to the general practitioner.

[58] Breast awareness, Dr O'Connor said, is a more inclusive approach than just an examination and breast self-examination was never shown to help reduce breast cancer rates in the long term.

[59] Dr O'Connor said that he found Dr Ben-Dom to be a caring, hard-working and valued part of the team; but he became concerned when the Waikanae Health Centre began receiving complaints about Dr Ben-Dom. Following a complaint from Ms A, the patient referred to in particular 10, in May 2016, a meeting was arranged with Dr Ben-Dom to discuss issues raised by her complaint and previous complaints. Dr O'Connor outlined the discussion held at a meeting on 27 May 2016 and said that Dr Ben-Dom said something like "*it was a clash of agendas*" in that what he wanted to achieve during the consultation was different from what the patient wanted from the consultation; and it was reiterated to him that the patient's "*agenda*" must always come first. Dr O'Connor said that he raised with Dr Ben-Dom that Waikanae Health Centre looked at the Protocol for Sensitive Examinations in April 2015 specifically to deal with this concern.

[60] On 29 May 2016 Dr Ben-Dom wrote to the partners at the Waikanae Health Centre promising to "*utterly avoid raising [breast cancer prevention] during [his] consultations with patients from [then] on*" and that the subject of breast cancer prevention would "*only be discussed if it is brought up by the patient herself and even then, I will first ensure that the patient is willing to further discuss this issue with me*".

[61] On 1 June 2016 Dr Ben-Dom wrote again to the partners at the Waikanae Health Centre to reinforce his commitment earlier made stating that the subject of breast cancer prevention would only be discussed if this were brought up by the patient herself and even then, he would first ensure that the patient was willing to further discuss that issue with him. The undertaking referred to the "*rare circumstance*" where there might be a clear or plain clinical indication warranting a discussion about the topic of breast cancer prevention but in that circumstance Dr Ben-Dom said he would "*tread very cautiously making quite sure that the patient was wanting to review that issue with [him]*". A chaperone nurse would be offered to be present during the discussion and always present during the physical examination and the patient would be offered the choice to deal with this issue only with a female general practitioner or a nurse. The undertaking referred

to Dr Ben-Dom's intention to improve on his physical examination performances and reporting as well as improving his notes.

[62] The reply dated 1 June 2016 from Dr O'Connor on behalf of the Waikanae Health Centre referred to concerns with the quality of Dr Ben-Dom's note-keeping, regular monthly reviews and the requirement to attend communications training by end of June 2016.

[63] The PCC also relied on evidence from Dr Edwards, a general practitioner then currently a partner at the Waikanae Health Centre, having been managing partner on several occasions. He referred to having worked with Dr Ben-Dom there, training in breast examinations, and performing breast examinations. He said that, from discussions with Dr Ben-Dom, Dr Ben-Dom indicated that he thought he had obtained a better way of detecting breast cancer than the mammography service and the breast examination concept (which Dr Edwards referred to as "*(self-examination)*") could achieve. Dr Edwards said that Dr Ben-Dom was a strong advocate for doing breast examinations and it appeared from the complaints that he would often steer the consultation around to this issue, regardless of the patient's presenting problem.

[64] Dr Edwards did refer to having recalled one woman as supportive of Dr Ben-Dom's approach to breast examination who had had breast cancer but had detected it herself whilst showering.

[65] Submissions for the PCC referred to a number of relevant standards and guidelines. The first was Good Medical Practice (June 2008) of the MCNZ. This is described as the foundation document for standards of ethical conduct and included reference to establishment and maintenance of trust, listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences. It said that doctors should make sure that they respected a patient's privacy and dignity and the right of patients to be fully involved in decisions about their care; and that the patient agrees before treatment is provided or a condition is investigated, with respect being given to the patient's right to decline treatment. It required that doctors keep their knowledge and skills up to date and stated that integrity (honesty and trustworthiness) is at the heart of medical professionalism. Good Medical Practice (April 2013) of the MCNZ made similar provisions as did Good Medical Practice (June 2016) and Good Medical Practice (December 2016) all of the MCNZ and all applicable during the period covered by the Charge.

[66] Sexual Boundaries in the Doctor-Patient Relationship (October 2009) identified that trust is the basis of the doctor-patient relationship which is not equal with reference to

the vulnerability of a patient and the often subconscious power imbalance. The major reasons for the latter are said to include that close physical contact that occurs in a consultation and that the doctor determines the level of physical contact through the examination. Sexual impropriety is defined as

> "*any behaviours, such as gestures or expressions, that are sexually demeaning to a patient, or that demonstrate a lack of respect for the patient's privacy …[including] … making inappropriate comments about, or to, the patient…*"

[67] The MCNZ Statement on Cultural Competence (August 2006) includes that

> "*… A culturally competent doctor will acknowledge …*
> - *That a doctor's culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship*".

[68] Based on those guidelines, the expert evidence, and the evidence of Dr Ben-Dom's former professional peers, the PCC submitted there was no sound body of medical opinion supporting Dr Ben-Dom's practice of regularly and repeatedly raising breast examination issues, whether clinical breast examination or breast self-examination, when this was not the patient's presenting concern. Dr Ben-Dom's approach was not consistent with relevant guidelines or the practice of professional peers; but rather he allowed his own singular agenda to override the wishes of the patient to the point where it might reasonably be regarded as intrusive and insensitive.

[69] Routinely asking female patients about breast examinations was not in the best interests of the patients. Rather, it was said, had Dr Ben-Dom intended to act in the best interests, he would have been familiar with relevant guidelines; he would have simply discussed the concept of breast awareness rather than encouraging breast self-examination or seeking to undertake clinical breast examination; he would have respected the patient's right not to undergo a breast examination or discuss the topic during an appointment when breast issues had not been raised by the patient; he would have carefully recorded every instance of an examination including findings. If he was being "*proactive*" he would also have recorded that he had raised the topic with the patient or that information had been given the patient so that there was a record of that discussion.

Clinical justification – Dr Ben-Dom's position

Evidence

[70] Various witnesses for Dr Ben-Dom gave evidence on the subject of clinical justification for breast examination. For his part Dr Ben-Dom referred to his qualifications and work experience, teaching responsibilities and publications. He spoke about his approach to practice which included the importance of using any time that remained in consultation; and in some cases, even if the presenting issue took longer, he would seek to look at other matters. He said that that approach "*did not fit easily with the commercial model used in New Zealand*". He said his regular patients were very comfortable with his approach and produced the bundle of statements mainly from former patients and referring to a more comprehensive consultation with Dr Ben-Dom. Dr Ben-Dom acknowledged, with hindsight, that the approach he took to proactive health was not a "*to everyone's taste*" and said that over the 8 years that he was at Waikanae Health Centre he had in the vicinity of 20,000 "*female consultations*" and there were only 8 patients whose consultations spanned a period of 6 years, who did not apparently welcome his proactive approach.

[71] Dr Ben-Dom's evidence canvassed his experiences in Israel and the practices there concerning breast health and prevention of breast cancer. He expressed the opinion that the New Zealand approach to detection of breast cancer was far from perfect and that "*one had to educate women about the disease, it risks and its prevention*". He sought to increase his female patients' awareness of the disease. He said that the "*overwhelming majority of [his] female patients welcomed and valued [his] proactive approach to the issue of breast health*".

[72] Dr Ben-Dom acknowledged that "*several recent studies showed that self-examination did not increase a woman's breast of cancer survival rates and called into question the previous 70 years of advice on the issue*"; but referred to a news media report in 2001 from Dr Ronald Kay which included that, whilst breast self-examination alone is not an effective method of reducing breast cancer mortality "*it would be a disservice to women to abandon the procedure entirely*"; and that that at the very least self-examination "*lifts women's awareness of breast health …*"

[73] Reference was made in Dr Ben-Dom's evidence to other professional disagreement on the subject of self-examination of breasts by women. Dr Ben-Dom produced a 2012 Women's magazine article written by a patient of his quoting comments from a Wellington breast surgeon which included that "*advising women that routine [breast*

self-examination] is of no benefit could be construed as removing empowerment from them …"

[74] The Tribunal notes that none of the persons whose views were expressed by Dr Ben-Dom in this way were called as witnesses or available to be cross-examined; and that questions could have been effectively asked of them concerning the distinctions between breast awareness and breast self-examination and, in the case of the Wellington breast surgeon, whether that was more an advocacy of women's rights than otherwise.

[75] Dr Ben-Dom expressed the view that the possibility of unnecessary anxiety and unnecessary invasive procedures is outweighed by the benefits of breast self-examination and the further view that that recommending that patients should not do monthly breast self-examinations is illogical that "*and does women a disservice*".

[76] Dr Ben-Dom then discussed breast awareness in his evidence and said that, "*where appropriate*," he raised the issue of breast cancer with the patient and provided the necessary guidance for checking the breasts. As to clinical breast examination Dr Ben-Dom said that he tried to make this a team effort asking nurses to help, chaperone and witness the examination.

[77] Dr Ben-Dom said that he considered that a clinical breast examination played a valuable part in the detection of breast cancer.

[78] Evidence was also called from Dr Ben-Dom's wife, Mrs Ben-Dom. She spoke of the differences between practice for a general practitioner in Israel compared with that in New Zealand. She said that a general practitioner is a "*family doctor*" which means that the practitioner" *may feel able to discuss a wider range of issues than a [general practitioner] in New Zealand*". Mrs Ben-Dom also spoke about what she called a "*cultural difference*" between Israelis who were "*accustomed to saying what they think and feel at the time they're thinking and feeling it*" and New Zealanders who are "*much less inclined to do this…*"

[79] Other evidence called for Dr Ben-Dom from Ms Crespin and Ms Goodwin dealt with several issues but on this topic referred in general terms to Dr Ben-Dom's encouragement of women to be proactive in their health. Ms Crespin said that she never saw Dr Ben-Dom pushing women into breast examinations, she referring to "*times when you try and seize an opportunity that is presented with a patient*." Ms Crespin said that Dr Ben-Dom would only teach people how to be breast aware and not teach them to do a full clinical breast examination and she spoke of Dr Ben-Dom's respect for patients' anxiety concerning sensitive examinations.

[80] Ms Goodwin referred to her having regularly acted as a chaperone where Dr Ben-Dom's breast examinations were clinical and professional, consistent and exemplary.

[81] The expert witnesses called for Dr Ben-Dom were first Dr Taylor who referred to the risk categories mentioned above. She said that the American Cancer Society and the Canadian Task Force on Preventative Health Care did not recommend clinical breast examination, with the National Comprehensive Cancer Network recommending a "*clinical encounter*" in average risk patients, described as including a "*completed medical history, followed by breast cancer assessment and a [clinical breast examination]*".

[82] As to breast self-examination, Dr Taylor said that the

> "*current accepted body of medical opinion in New Zealand and other similar environments, such as Australia and the United Kingdom, is that the evidence does not support a routine self-examination by patients*".

She interpreted this as referring to a mimicking of a clinical examination that a breast specialist or general practitioner would perform.

[83] Dr Taylor referred to the approach in the United States of America where there are those "*who advocated the merits of breast self-examination*". Dr Taylor spoke about the concept of breast awareness but said that there needed to be some form of education from a health professional on technique. She referred to various aspects which were reasonably specific such as a woman who "*examines her breast with a flatter hand and the surface of the [palmar] aspect of the fingers rather than a pinching motion…*"

[84] As to breast examinations Dr Taylor said, and this was emphasised and agreed with by Professor Arroll,:

> *"If, in the context of the discussion, the patient was aware of the issues relating to when a breast examination may be indicated, it would seem reasonable for this to be considered. I would counsel clear documentation of this, in order to protect the health professional. I would probably advocate limiting the bulk of the proactive health care approach to a discussion, rather than an examination, in the context of a consultation about an unrelated issue, unless the patient requested otherwise. This is my personal view, as I am not aware of a significant evidence base around this.*"

[85] The final witness for Dr Ben-Dom was another expert, Dr Reid, who limited his evidence to the general topic and did not express any opinion concerning the individual patients or clinical indications as raised in the Charge against Dr Ben-Dom.

[86] He expressed awareness that breast self-examination and a clinical breast examination are not routinely recommended in New Zealand. He referred to the recommendation that women should be encouraged to report any breast changes and the emphasis in a Breast Cancer Foundation of New Zealand article, apparently accessed September 2018, on having any changes to a breast or breasts properly checked.

[87] Dr Reid referred to international advice differing from that given in New Zealand concerning regular clinical breast examination; and referred to studies in Russia and China raising concern about the value of breast self-examination and noted that Dr Smith of the American Cancer Society in an article accessed August 2019 stated that breast self-examination is difficult to study because it is hard to monitor whether women actually do it.

[88] Dr Reid said that the difference between breast self-examination and breast awareness is not clear except that breast self-examination is a formal way of being breast aware. He expressed the opinion that the 2013 National Breast Cancer Tumour Standards Working Group New Zealand Government Article: The Standards of Provision for Breast Cancer Patients in New Zealand supported breast awareness without actually stating that it does.

[89] Dr Reid went on to give evidence about mammography and said that it was to fill in certain gaps in mammographic availability that breast self-examination and annual clinical breast examination are recommended.

[90] After discussing other expressions of opinion (which the Tribunal has noted), Dr Reid concluded:

> "*Any intimate examination involving breast and/or pelvic examination should be "offered" [*without explaining why that expression was in quotation marks*] and for male doctors, offering that a female colleague could do the examination may be appropriate. If the woman consents to the examination a chaperone* ***must be offered****, but the examination may proceed if this offer is declined. There should be appropriate screening for disrobing and only the relevant body part should be uncovered at one time*" (emphasis added).

[91] Also produced on which Dr Ben-Dom relied were some 25 documents or extracts concerning breast health, breast self-examination, and clinical breast examination. These were eventually admitted by consent of the parties on the basis that the documents were what they purported to be. There was significant criticism of some of these by Professor Arroll. The submissions for Dr Ben-Dom relied on the content of these reports as expressions of opinion on the topics raised by the Charge. None of the authors of the

reports were called as witnesses. There was some reference in the evidence of the experts for Dr Ben-Dom to these articles and there were questions addressed in examination to Dr Reid concerning these. To the extent that the content of these reports was referred to by witnesses or in submissions, they are taken into account.

[92] The bundle included a screen shot from an apparent website of the University of Texas MD Anderson Cancer Center. The opinion expressed there was otherwise not proven or indeed even authored. This recommended clinical breast examination in women aged 25 – 39 years every 1 – 3 years and for women 40 years and older every year with a mammogram every year. The recommendation included:

> "*Along with regular exams, practice awareness. This means you should stay familiar with your breasts. That way you'll notice changes, like a new lump or mass. Then report them to your doctor without delay*".

[93] By contrast in the Dana-Farber Cancer Institute Health Library website extract produced (undated and unauthored) the general recommendation was made that "*[r]egardless of risk, women of all ages should be seen by their physician on a regular basis as part of general screening*". A recommendation was made for women aged between 18 and 45 years for physical examination at an annual physical consultation without mammogram usually, aged 45 - 55 years annually with annual mammogram, and over 55 years annually with a mammogram every two years in certain circumstances. No evidence was given to the Tribunal about resourcing, or facilities, for checking of this kind but the report was tendered by Dr Ben-Dom as a basis for recommending consultations of the type he was giving.

[94] The extract from the International Journal of Surgical Oncology Research Article dated 2011 contained a table on which Dr Ben-Dom relied comparing younger and older breast cancer patients and the methods of discovery either by mammography, self-breast examination or clinical breast examination. Professor Arroll dismissed this article as a retrospective study with weak methodology that was probably not worth reading. That article concluded:

> "*In 2003, the American Cancer Society recommended that breast self-examination be optional primarily because of a lack of unequivocal supporting evidence of benefit. Hence, the only screening guideline currently suggested for women 18-40 years of age is a clinical breast examination every three years. However, for 5 – year survival among young women diagnosed with breast cancer is clearly related to the stage of the disease at the time of diagnosis… Thus, early diagnosis and treatment of breast carcinoma are essential for optimal prognosis. Breast self-examination has not been encouraged or recommended, in part, because it has not been consistently associated with a*

> *decrease in morbidity or mortality, and because it purportedly can cause increased patient anxiety, especially when biopsies of breast masses that are discovered on self-examination are performed. We propose that the anxiety can be dispelled or ameliorated by quality time spent properly counselling and supporting the patient.*
> *Our data confirm that young women with breast cancer are likely to present with a more advanced stage of the disease compared with older patients. In response to increasing breast cancer in young women under 41 years of age in recent years, further investigation focused on this age group is indicated, and encouragement of proper breast self-examination is warranted and should be advocated as a quality health maintenance practice*".

[95] Also referred to in evidence was a Breast Cancer Foundation NZ website document referring to breast awareness and breast checks and Professor Arroll agreed that there was a significant overlap between advice given concerning breast awareness and breast self-examination.

Submissions

[96] The first submission was that the onus on the PCC was to prove the Charge on the balance of probabilities required, in reliance on *Williams v A Professional Conduct Committee of the Medical Council*[5], that there be behaviour which falls seriously short of that which is considered acceptable by competent, ethical and responsible practitioners and not mere inadvertent error, oversight or carelessness. Any departure from acceptable standards must be significant enough to warrant a finding of professional misconduct against the practitioner, bearing in mind the stigma and very strong message that will be sent to the profession and felt keenly by the practitioner. It should be a matter reserved only for serious conduct.

[97] On the evidence Dr Ben-Dom was, it was submitted, not engaged in any structural breast self-examination advice but rather advice on breast awareness. In relation to the four particulars that involved clinical breast examination by Dr Ben-Dom, the question is whether that was appropriate. Given the state of this position internationally and given the advice from cancer organizations "*of very high standing*" in the USA, it was appropriate for Dr Ben-Dom to be giving this clinical breast examination.

[98] As to instruction on breast awareness it was submitted that "*virtually everyone agrees*" that it is appropriate to give instruction on breast awareness and the issue was whether there was undue pressure in the individual cases where this issue arose and whether it

[5] Auckland High Court; [2018] NZHC 2472

was appropriate for Dr Ben-Dom to have raised the issue. In that context the individual cases were analysed by submissions for Dr Ben-Dom.

[99] Criticism was made of the period of time that has elapsed in the reliance by the PCC on recollection of events from many years earlier. Memories of what was said and what occurred must be carefully assessed. Misunderstandings which arise from misreading body language, use of ambiguous words, and a lack of precision and expression can lead to misunderstandings. This is accentuated where there are differences of language and, in Dr Ben-Dom's case, English was his second language. There was also said to be a cultural difference but the only evidence advanced by Dr Ben-Dom on that topic was that of himself and his wife. Particularly reference was made to the fact that Israeli doctors tend to be more "*directive*" which is different, it was said, from the New Zealand approach which encourages patients to be more informed of their options and make their own decisions rather than be told what to do. It is a question of degree, it was said, as to how a doctor, and in this case Dr Ben-Dom, responded with the individual patients.

[100] Dealing then with the documents to which the evidence of Professor Arroll referred and on which the PCC relied, the submissions for Dr Ben-Dom included:

a) That the Ministry of Health Standards of Service Provision for Breast Cancer Patients in New Zealand – Provisional made no reference at all to the issue of breast self-examination.

b) That BreastScreen Aotearoa – More about breast screening and Breastscreen Aotearoa was designed to inform patients rather than health professionals.

c) That the recommendation in that document concerning breast self-examination which read:

> "*[The recommendation for a formal technique of breast self-examination] is no longer made as there is no evidence that this formal self-examination will reduce a woman's chances of dying from breast cancer. It can also increase a woman's risk of having unnecessary biopsies*"

does not say that there is opinion elsewhere to the contrary and certainly no recommendation against conducting breast self-examination.

d) That where that document says:

> "*However, there is limited evidence that breast examinations alone, carried out by doctors, reduce the chance of dying from breast cancer*"

there is in fact no recommendation against clinical breast examination.

e) That Professor Arroll is wrong in his evidence that research has shown that clinical breast examination and breast self-examination are not interventions in reducing mortality (where he relied on the New England Journal of Medicine (2015) above), where the research in fact has not shown that they are not effective interventions.

f) That where the Breast-Cancer Screening – Viewpoint of the IARC Working Group (2015) document on which Professor Arroll relied referred to "*inadequate evidence*" that simply means that there is not adequate evidence one way or the other; and does not mean that there is evidence against the intervention.

g) That there must be reliance on the Australian Government document Early Detection of Breast Cancer (published 2004 revised 2015) which included:

> "*A firm recommendation regarding clinical breast examination is not possible as there is no evidence to either encourage or discourage the use of clinical breast examination as a screening method for women of any age*";

and that that too is not a recommendation one way or the other.

h) That where the New England Journal of Medicine refers to inadequate evidence that ultrasound and MRI are not recommended for breast cancer investigations because of inadequate evidence but are used nevertheless, the test of "*inadequate evidence*" is not a sufficient basis for any decision or judgment.

i) That in the individual cases where breast self-examination is alleged, this was in reality advice from Dr Ben-Dom to the respective patients on breast awareness; and that there is a significant overlap between the two concepts. In the context of the distinction between the two, Dr Ben-Dom did not refer to examination of the axilla nodes in the armpit because he was only encouraging them to be breast aware rather that carry out any formal breast self-examination.

j) That while it is impossible to say that recommendations for breast self-examination are inappropriate, it is even more impossible in respect of recommendations for breast awareness.

k) That although the risk of morbidity may not be reduced by a breast self-examination, there are other risks, such as the necessity for a mastectomy, that might be avoided by that process.

l) That the test is not whether breast self-examination is appropriately raised by a general practitioner but rather whether the raising of that issue is proven to be inappropriate.

m) That in respect of the entry in the MCNZ publication Sexual Boundaries in the Doctor – Patient Relationship[6]:

> "*Your actions and how you communicate them to the patient influence the patient's perception about what to do and the treatment he or she receives*",

is coloured by communication difficulties, cultural issues, and the like with the result that Dr Ben-Dom may not have been as receptive as he should have been to body language. The patients did not alert Dr Ben-Dom to their feelings as they should have.

[101] Concerning the individual allegations of conducting a clinical breast examination, the submissions for Dr Ben-Dom:

a) Referred to Table 1 in the New England Journal of Medicine article produced by Professor Arroll evaluating the evidence regarding the beneficial and adverse effects of different methods of screening and its reference in the context of clinical breast examination to there being **sufficient** evidence of a shift of the stage distribution of tumours detected towards a lower scale.

b) Referred to the evidence of Dr Taylor, an expert called by Dr Ben-Dom, to support the submission that authorities recommend, and continue to recommend, clinical breast examinations.

c) That a general practitioner in New Zealand cannot be criticised for following the recommendation to conduct clinical breast examinations.

[102] The submission for Dr Ben-Dom was that the test for the Tribunal in each of the particulars to which the Charge refers is whether it can be said that the topic of breast health, a breast examination, or the topic of breast self-examination, as the case may be was "*inappropriate*" as alleged; and that it could not be said that this is so, having regard to the evidence and the documents referred to.

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[6] Paragraph 28

Discussion

[103] The topic of clinical justification for the actions of Dr Ben-Dom in respect of the respective patients to which the Charge refers must be considered in the context of those consultations. There cannot be an overall generic statement of any principle which applies universally. The best that the Tribunal can do is to express its opinion on the general evidence and submissions of the parties.

[104] What is also important is that the Tribunal considers the question in the context of the position in New Zealand. Experts in other countries may have different views; the practice in other countries may be different; and the resources available for consultation and assessments may be different. This may well be the case in the United States of America where different views have been expressed even by the experts there and where the resources available to patients to have more regular clinical breast examinations or the like may be greater.

[105] Likewise, although Dr Ben-Dom has brought his learning, training and practice from Israel to New Zealand, he has practised as a general practitioner in New Zealand and must primarily apply its standards and concepts.

[106] In general terms, the Tribunal finds that Dr Ben-Dom has resisted change from what he says he had been used to in Israel. No expert evidence was called or adduced about the practices in fact in Israel or the extent of the differences in philosophical or professional approach to those in New Zealand. The Tribunal cannot attach significant weight to Dr Ben-Dom's own statement on the matter although that is noted; and the same applies to the evidence from his wife who is not an expert in the matter and does not practise as a medical practitioner.

[107] The Tribunal is more attracted to the evidence of the expert witnesses for the PCC. The starting point is the relevant Practice Guides issued by the MCNZ. While these do not have the obligation of a legal requirement, they are established by the MCNZ after appropriate consultations and discussions as the regulatory authority exercising the statutory functions under section 118 of the HPCA Act which include the setting of standards of clinical competence, cultural competence, and ethical conduct to be observed by medical practitioners.

[108] These are noted above and refer to establishment and maintenance of trust, listening to patients, asking for and respecting the views of patients about their health, and responding to their concerns and preferences. They require respect for a patient's privacy and dignity and acknowledge the right of patients to be fully involved in

decisions about their care. They require that patients be treated as individuals with respect to their dignity and privacy. They refer to the vulnerability of a patient seeking assistance, guidance and treatment and the (often subconscious) power imbalance between patient and doctor. Gestures or expressions that are sexually demeaning to a patient or demonstrate a lack of respect for the patient's privacy including the making of inappropriate comments is within the definition of "*sexual impropriety*".

[109] The Tribunal accepts Professor Arroll's evidence that from at least 2002 onwards there was published advice recommending that there were no benefits from breast self-examination or clinical breast examination. Also it accepts his evidence:

> "*The mammography is the major modality for screening in New Zealand and there are problems of screening in a low prevalence or diagnostic testing in a low prevalence setting. So, all screening is low prevalence, as opposed to somebody presenting with symptoms, which is a higher prevalence, and that causes issues in terms of false positives*."

[110] The Tribunal interprets that as meaning that screening examinations are different from clinical examinations for symptomatic patients.

[111] A careful distinction must be made between the relevant concepts involved, breast health, breast awareness, breast self-examination, and clinical breast examination by a professional. There seems to be overlap and confusion in the articles and references made between some of these concepts.

[112] In general terms the Tribunal endorses the importance of breast awareness amongst women (and indeed men). This is part of the broader importance that all New Zealanders take an active interest in their health and be aware of all facets relating to their health, whether this be diet, exercise, stress, and the other myriad of factors which make up a lifestyle. It also accentuates the importance of awareness of health issues and, when some bodily function gives rise for concern, taking appropriate advice on this.

[113] Breast awareness involves those things to which the documents referred to above and by Professor Arroll refer. It is not the function of this Tribunal to articulate what needs to be done to achieve breast awareness other than to endorse this as a concept that should be encouraged. Likewise with breast health, which is an aspect of breast awareness.

[114] As to breast self-examination, there is a significant overlap between the understanding of what this involves on the one hand and a sensible and realistic approach to breast awareness on the other. The Breast Cancer Foundation NZ website document produced

to the Tribunal has the subset "*Breast awareness*" and gave practical indication as to how this might be achieved. Some of that may be said to be part of a more formalised breast self-examination process.

[115] Some of the articles referred to at the hearing described techniques for breast awareness which could be said to have been closely describing breast self-examination. Again it is not for this Tribunal to articulate techniques, merits, the disadvantages, or otherwise so far as processes for breast awareness are concerned.

[116] What the Tribunal can say with some assurance, having heard the evidence at length and considered the documents that were presented by the parties, is that in New Zealand at least breast self-examination is no longer actively encouraged as such. The Information on Breast Awareness paper referred to endorses that the Cancer Society of New Zealand and the New Zealand Breast Cancer Foundation do not recommend the practice of regular breast self-examination, a formal and structured technique for feeling for breast changes. Part of the reason for this may be the absence of any clear articulation of what that self-examination should properly entail. There may be times, there may be occasions and there may be persons for whom breast self-examination is appropriately helpful but that is not for the Tribunal to say. Of note is the reference in information on breast awareness to reduction in mortality but other papers refer to reduction in morbidity and each individual case must be dealt with on its own merits. The Tribunal's comments must be limited to this practitioner in this setting with these patients.

[117] As to clinical breast examination the Tribunal is not in any position to say more about the appropriateness of this topic between a doctor and patient other than in the circumstances of the individual cases in question. There will be circumstances in which a clinical breast examination is appropriately undertaken by a medical practitioner for the patient; and one of the factors for the medical practitioner to take into account is the respective gender of doctor and patient. Then there are questions of privacy, dignity, and a chaperone.

[118] One of the significant factors common to all patients and particulars of the Charge is the question of initiation of the discussion about breast health, or breast self-examination or clinical breast examination. The Tribunal emphasises that in New Zealand the standard required is that the topics of breast self-examination or clinical breast examination are not initiated primarily by the medical practitioner but rather by the patient. If there is some reason why a medical practitioner needs or indeed wants to raise the topic, that must be carefully considered and sensitively approached having regard to the patient,

the sensitivities, the presenting issue, perhaps the medical history as known by the medical practitioner, and using appropriate language. Again questions of dignity and privacy arise along with the necessary discussion about the presence of a chaperone.

[119] The Tribunal has approached the allegations of absence of clinical justification in the respective particulars of the charge on those general bases, but having specific regard to the individuals and the particular facts of the consultation.

Theory of medicine defence – section 100(4) HPCA Act

[120] Amongst other matters raised by Dr Ben-Dom in his defence, there was also that section 100(4) of the HPCA Act applied which reads:

> (4) No person may be found guilty of a disciplinary offence under this Part merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith.

[121] Dr Ben-Dom's position is that he had adopted and was practising a theory of medicine and acted honestly and in good faith in doing what he did with the respective patients and therefore cannot be found guilty of any disciplinary offence as charged.

[122] Through counsel Dr Ben-Dom was asked what his theory of medicine was on which he relied in this context. He gave two answers, one in opening and one in closing namely:

Opening: "*that a more proactive approach needs to be taken in this country concerning the detection of breast cancer*"

Closing: "*that it was appropriate as a screening method to adopt [clinical breast examination and breast awareness or breast self-examination], whichever of those last two it was".*

[123] Submissions for Dr Ben-Dom relied on passages from the judgment in *Williams*[7]. That judgment referred to an earlier case of *Tizard v Medical Council of New Zealand*[8] . Submissions were that Dr Ben-Dom was acting honestly and in good faith in following the courses that he did with these patients. Reliance was placed on the evidence of Dr O'Connor when he said that Dr Ben-Dom was relying on the Israeli approach which he said was the correct one and he would be proven right. Reference was made to the evidence from Dr Edwards, called for the PCC, that Dr Ben-Dom had his own series of special interests and that he believed strongly that clinical breast examination could pick

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[7] See footnote 5

[8] Auckland High Court; No 2390/91; 10/12/92

up cancers that would otherwise be missed. Reference was also made to the evidence of Ms Parker that Dr Ben-Dom maintained that all doctors should be taking a proactive approach to breast health with the submission that this overwhelmingly established that Dr Ben-Dom was acting honestly and in good faith. His theory of medicine was not idiosyncratic but had international support, it was said. Other cases referred to in those judgments were said to be distinguishable on the facts.

[124] The reply submissions for the PCC included:

a) A discussion of the principles enunciated in *Tizard* including that, while an honest belief in a theory of medicine is necessary to invoke the defence, it is not sufficient to satisfy it.

b) Referred to other disciplinary Tribunal decisions and the *Williams* case, where the High Court confirmed that an honestly held belief in an alternative theory is not enough to exclude liability for what would otherwise be disgraceful conduct, saying that a theory of medicine defence is not properly available where the theory espoused is the idiosyncratic view of a single practitioner and referred to the need for a sound body of medical opinion to support the use of the compound in that case.

c) That Dr Ben-Dom's theory of adopting a more proactive approach is not a theory of medicine and Dr Ben-Dom's approach was merely medical practice with shortcomings coupled with an inability to follow clear guidelines and accepted practice.

d) Acceptance that doctors ought to be proactive concerning the detection of breast, or indeed any, cancer.

e) That what Dr Ben-Dom was doing was simply embarking upon a single-minded course of action of regularly and repeatedly raising breast examinations when this was not the patient's presenting concern.

f) That Dr Ben-Dom's approach to breast screening was not supported by the evidence tendered and the overseas sources relied on by Dr Ben-Dom were at variance with the available reputable evidence.

g) That Dr Ben-Dom was told by colleagues that he needed to stop pursuing his own agenda and Dr Ben-Dom refused to change its approach.

h) That the theory of medicine advocated by Dr Ben-Dom cannot be used as a shield or justification for his behaviour in the consultations at issue.

Theory of medicine defence – Discussion

[125] The Tribunal finds that this defence does not apply in this case. The theory of medicine, whichever way it is articulated, does not apply as a theory. A theory of medicine must be some structured approach to a medical process, treatment, or outcome based on some research and analysis. It must be in some way demonstrably different from what is already practised.

[126] In the *Williams* case the medical practitioner had combined two medications, betamethasone valerate and clomazol to create a medication which he named "*betaclom*". In the High Court these factors were identified:

a) That Dr Williams had never tested the potency of the cream he created and simply assumed that his mix was correctly diluted based on common-sense logic; but there was no scientific proof to support this view and Dr Williams accepted that his belief about potency was mistaken.

b) That Dr Williams did not consult with appropriate specialists about his theory but continued with it because it appeared effective for patients who used it.

c) That Dr Williams was aware of guidelines about the appropriate use of the steroid but preferred his own assumption about the dilution as opposed to published warnings and contraindications.

d) That the available evidence did not support the theory and although Dr Williams had researched the area he had not done so sufficiently.

e) That Dr Williams prescribed this cream on a one-size-fits-all approach and did not tailor the mix to the individual patient.

f) That Dr Williams had a casual approach to side-effects.

g) That when concerns were expressed about his practice by other professionals he did not change his approach and

h) That Dr Williams paid little attention to data sheets and guidelines, did not keep proper records and did not consult with others.

[127] In *Kapua*[9] a charge against a midwife included various allegations of failure to provide information, take care of the client, and recommend specialist assistance. One of the defences was that the midwife was acting as a traditional Maori birth practitioner; and the Tribunal of its own initiative considered whether section 100(4) applied. The Tribunal said this:

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[9] 227/Mid08/103D

> *"19. The Tribunal sees this section as providing that a health practitioner who carries out a theory of healing or medicine is not guilty of professional misconduct simply because of this practice. Thus Ms Kapua would not be guilty of professional misconduct simply because she had adopted the practice of traditional Maori midwifery. However the Tribunal does not interpret the section as diminishing in any way a practitioner's obligations to comply with his or her usual professional standards*".

[128] In *Tizard*[10] the full bench of the High Court discussed the expression "*honestly and in good faith"* (in the predecessor statute). It said:

> "*We accordingly hold that the meaning of 'honestly and in good faith' is simply 'honestly'. That does not mean that it is sufficient in every case to exclude liability for what would otherwise be disgraceful conduct that the practitioner concerned be acting a 'honestly'. That cannot be the case, since the use of the words 'merely because'… make it plain that honest belief in the efficacy of a particular theory is not necessarily a sufficient answer".*

[129] The court further said:

> *"… no decision has recognised the idiosyncratic view of a single practitioner, unsupported by scientific proof or by a significant number of his or her fellow practitioners, as a 'theory of medicine' … Were it otherwise, a practitioner who honestly but mistakenly held an opinion which was seen by the rest of his or her profession as being without foundation and bound, if applied, to cause great harm, could still not be prevented from conducting his practice on that basis".*

[130] The Tribunal has taken these statements of principle into account. In this case historically there had been more emphasis on the value of breast self-examination by women but in general terms, in New Zealand at least, that had rather fallen out of favour with preference for a generalised "*breast awareness*" approach. That is still indicated.

[131] The Tribunal endorses, as noted above, that women should be aware of their breast health and, if there are concerns, then consult appropriately about this. It is part of the more general emphasis on an individual taking responsibility for care of their own health and consulting regarding any concerns of change. What Dr Ben-Dom had done, and this is apparently in many more cases than just those to which the particulars refer because of the references he has produced, was to take the initiative to introduce the topic. The Tribunal cannot comment on the content of consultations with other patients and must focus on those patients to whom the particulars refer. There is no new theory of medicine about this.

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[10] *Op. cit*.

[132] There is no new theory in a doctor advocating a proactive approach to a person's health or indeed to woman in respect of her breast health. It is a question of how and when this is done and that is what the particulars of the Charge refer to. There may also be occasions when the proper approach by Dr Ben-Dom to breast cancer is by clinical breast examination. Again, however, there is no new theory in that and again it is a question of how and when this is done.

[133] Although the articulation of the theory (second version) confuses breast self-examination with breast awareness, the two practices have some differences; although the Tribunal readily acknowledges some overlap. Either way, there may be times when breast awareness is an appropriate method of screening for breast cancer and the Breast Cancer Foundation in the document produced refers to a process for breast awareness which might be said to include elements of breast self-examination. If the topic of breast awareness is to be raised by medical practitioner with his or her patient then it is a question of why, when, how the topic arises, and how the topic is approached. This decision looks only at the individual cases referred to in the particulars. There is no new theory of medicine involved such that section 100(4) can apply and that defence is rejected.

Credibility

[134] In deciding any question where credibility is at stake the tests the Tribunal must take account of the factors enunciated by the High Court in *Rabih v Professional Conduct Committee of Dental Council,*[11] namely the manner and demeanour of the witness when giving evidence; issues of potential bias, that is, to what extent was evidence given from a position of self-interest; internal consistency of the evidence of the witness throughout having regard to previous statements; external consistency between the evidence of the witness and that of other witnesses; and whether non-advantageous concessions were freely tendered.

[135] The Tribunal accepts those tests and, where there is such contest in credibility, has applied them.

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[11] [2015] NZHC 1110 at [40].

Particular 1 - [ ] 2011 – Ms N

[136] The allegation in this particular is that Dr Ben-Dom raised the topic of breast health with this patient in circumstances that did not clinically justify this discussion. There is the second limb that this was done in a manner that was inappropriate in that he raised the topic in front of her son and during an appointment for her son. This is the same patient to whom particular 6 applies but is considered separately.

[137] On [ ] 2011 Ms N brought her [young] son to the Waikanae Health Centre "*because he had an itchy bottom*". Dr Ben-Dom was not her regular general practitioner but she saw him on this occasion. Ms N was aged [ ] years at the time. Dr Ben-Dom diagnosed worms with her son with which Ms N did not agree.

[138] Ms N said that during the consultation Dr Ben-Dom discussed breast screening with her while her son was still in the room. Dr Ben-Dom asked when she had her last breast check and whether she checked herself in the shower. She said he also asked whether her husband checked her breasts for her. She said the conversation made her feel uncomfortable. Five days later, [ ] 2011, she telephoned Waikanae Health Centre to complain about the consultation and a Significant Event Form was completed by the then practice manager, Ms Parker.

[139] Dr Ben-Dom's evidence included that he accepted that the consultation primarily concerned Ms N's son who was suffering from worms. He said that he "*would have simply raised [the issue of breast screening] as a health issue to be explored at the appropriate time*". He said that it "*would not be unusual*" in a consultation concerning a child for the child, once the focus moved from the child, to distract himself with toys available for that purpose; and that it is common for young mothers to attend consultations accompanied by a child. He further said that Ms N's son "*would have been unaware*" of the discussion and, even if he were paying attention, he would not have understood what was discussed.

[140] The Tribunal assesses that, given those expressions used, Dr Ben-Dom could not expressly remember the occasion.

[141] Ms N was cross-examined extensively by counsel for Dr Ben-Dom in relation to this and a later consultation in 2014 to which particular 6 refers. Likewise, Dr Ben-Dom was cross-examined on his version of the relevant events throughout.

[142] Having heard the evidence given by Ms N and that given by Dr Ben-Dom, both under cross-examination, the Tribunal prefers the evidence of Ms N in this incident. Ms N was a credible witness who presented her evidence clearly and dispassionately. Topics were

raised with her, some noted below, to try to discredit the whole of what she said. The cross-examination of her was lengthy but she remained consistent on the essentials.

[143] Dr Ben-Dom's version of events did not carry the same veracity. As noted, the Tribunal suspects Dr Ben-Dom could not specifically remember this occasion. Dr Ben-Dom was preoccupied by his determination to raise the topic of breast health with Ms N because there was some time available for him to do so and it was part of his proactive approach to women's breast health. He was more direct in his manner than may have been appropriate, and his own position is that as an Israeli, that is more the way he behaved. Dr Ben-Dom was not sensitive to the occasion and was not sensitive to any disquiet that Ms N may have been feeling about discussing the topic in front of her son.

[144] Dr Ben-Dom's proactive approach is consistent with what happened for this patient on the later (2014) occasion. It is consistent with what the other witnesses to whom the particulars refer have said. It is indeed consistent with what Dr Ben-Dom himself advocates as the correct approach, to be proactive in initiating breast discussion.

[145] The Tribunal cannot find as a matter of fact that Ms N's son was or was not distracted in the room. The fact is that for this patient at that time she was uncomfortable with the subject having been raised when she had consulted with the general medical practitioner standing in for her usual one about an itchy bottom for her [young] son. There would have been the perfectly straightforward course for Dr Ben-Dom to have adopted if he wished to raise the subject of breast health with Ms N to have asked her politely if he could discuss the issue with her in front of her son and been guided by her response. That did not occur. The bald fact is that that topic was raised which was not clinically justified by the consultation and it was raised in a manner that caused discomfort to the patient, Ms N, such that shortly later she made the complaint to the practice manager.

[146] On the facts this particular of the Charge is found to be made out as malpractice on Dr Ben-Dom's part as that expression is defined by the authorities mentioned above and bringing discredit to his profession. On its own, however, the Tribunal does not consider that this malpractice warrants disciplinary sanction; but cumulatively with the other particulars now to be mentioned, the Tribunal finds that it does.

Particular 2 - [ ] 2012 - Ms E

[147] This particular concerns first the question of raising the topic of breast health and secondly the performing of a breast examination in circumstances where this was not clinically justified; and thirdly the manner in which the examination was conducted with five sub particulars. Ms E was [ ] years of age at the time and her appointment with Dr Ben-Dom was because her usual general practitioner was not available. She went to see about her sore throat.

[148] She said that the discussion with Dr Ben-Dom about her sore throat was only brief and then he asked if she had examined her own breasts. There was further discussion about breast issues and Ms E said that Dr Ben-Dom offered to give her a breast examination then and there. She said she was extremely reluctant to do this because she had not come in for that to which she said Dr Ben-Dom replied "*so you don't enjoy your breasts being touched*?" to which she said "*I didn't say that*". She declined the breast examination but Dr Ben-Dom continued to talk about the importance of this which made her "*really angry*" and Ms E said she said to Dr Ben-Dom that she knew how important it is because her [ ]-year-old [ ] died of breast cancer and left a child; and that this was the only mention she made about her [ ].

[149] There was further discussion about breast issues including frequency of mammograms and then Dr Ben-Dom asked Ms E if she took vitamin D to which she said "*no*". She said there was also discussion about her back muscles which were sore. Dr Ben-Dom discussed the need for a more supportive bra and asked again about breast examinations. This reminded Ms E about her sister-in-law and she described her involvement in the last days of her life.

[150] After Dr Ben-Dom had asked Ms E about breast examinations three or four times she agreed to this. She described the examination in detail with discussion about position for the examination. She said that during the examination she "*was just sitting there and Dr Ben-Dom was against [her] knees and it was if he was milking a cow*". She felt Dr Ben-Dom was too close to her and in her personal space. She said that Dr Ben-Dom did not palpate under her arm but just felt the front of her breasts using his fingers.

[151] Ms E said that while he was examining her breasts Dr Ben-Dom said to her "*Oh, you know that you're very attractive, don't you*?" with which she said "*I'm out of here*" got up, dressed and left. She said she made a complaint orally to the receptionist as she left. She said her comment to reception was "*I've just had the worst experience with that*

doctor" and "*I will never go to him again*". The receptionist, she said, did not ask what she meant.

[152] Ms E further said that when she went to the pharmacy to pick up what she thought was medication for her throat she was given vaginal cream which she said she did not want and so left it behind.

[153] Ms E said that later when she asked for the patient history notes she was furious to read that Dr Ben-Dom had written "*chaperone declined*" because Dr Ben-Dom did not ask her if she wanted a chaperone. She was also furious to read "*breast examination normal*" because she did not think Dr Ben-Dom had given her a proper breast examination. Finally she was concerned about references to anxiety where it was noted "*Discussed life under Anxiety – got to the point where she agrees to try SSRI. To start Cipramil*".

[154] Ms E said she contacted Waikanae Health Centre in October 2017 about the consultation and a note was produced by the Practice Manager referring to this dated [ ] 2017. Some of the content of that note was disputed by Ms E.

[155] For his part Dr Ben-Dom referred to the consultation notes and made extensive comment on the detail of those. There is reference to the sore throat which Dr Ben-Dom said was discussed only briefly. Dr Ben-Dom said that his offer of a breast examination followed the comment by Ms E that she had lost her [ ] due to breast cancer. The Tribunal accepts what Ms E said about the sequence of events, that is that the initiation of the discussion about breast examination came from Dr Ben-Dom, that there was the response from Ms E concerning her deceased [ ], and there was then further suggestion by Dr Ben-Dom for breast examination which Ms E ultimately agreed to.

[156] Dr Ben-Dom said that the twofold purpose of the breast examination was for a standard clinical examination and "*to raise the patient's awareness including teaching her how to check herself*". He said that Ms E did not communicate any reluctance to him about the breast examination and that, if she had, he would not have undertaken such an examination.

[157] As to comments which Ms E said Dr Ben-Dom made about the appearance of her breasts, Dr Ben-Dom completely rejected the assertion made and said he "*would never have made*" such a comment. He challenged Ms E's recall to the point that it is not now reliable.

[158] Dr Ben-Dom said that he was adamant that a chaperone was offered first because that is his "*invariable practice*" and secondly that the clinical note confirms that one was offered.

[159] As to the technique of breast examination Dr Ben-Dom said that the examination started with Ms E lying down but part took place when she sat up. This was done because he wanted to perform an examination of margins and that he "*would have*" explained the reasons for this at the time. He said that he did not palpate under the arm as he usually only does that if something abnormal is found during the breast examination.

[160] There were other aspects of Ms E's evidence challenged by Dr Ben-Dom in his own evidence which, it was said on his behalf, went to credibility but these do not form part of the sub particulars of the Charge.

[161] The Tribunal has weighed up carefully what was said by Ms E and then in turn by Dr Ben-Dom. Much of what Dr Ben-Dom said about the consultation referred to the notes that he made and used the expression "*I would have*" or "*I would not have*". The Tribunal discerns that Dr Ben-Dom is largely relying on his normal practice rather than specific memory of the events.

[162] The Tribunal is satisfied about the credibility of Ms E's evidence. She gave it consistently throughout, particularly so far as the essential events are concerned. There was some challenge to evidence she gave concerning other aspects of the consultation but the Tribunal is satisfied that relevant events were as Ms E described them.

[163] The Tribunal is prepared to give priority to the contemporaneous consultation notes that Dr Ben-Dom made concerning the offer of a chaperone and sub particular a. is therefore not found to be made out on the facts.

[164] The Tribunal finds that the comments about Ms E's physical appearance referred to in sub particular b. were made by Dr Ben-Dom. The fact that the statement was made as Ms E described it is affirmed by her reaction of getting up, dressing, not speaking further with Dr Ben-Dom, leaving the consultation, and in making the remark that she did to the receptionist.

[165] The Tribunal finds that sub particular b. is made out on its facts and that these were inappropriate comments for Dr Ben-Dom to have made about Ms E's physical appearance. This was malpractice on Dr Ben-Dom's part and conduct on his behalf which brought discredit to his profession. It is of sufficient severity separately to warrant disciplinary sanction. Standards in the profession must be maintained and this is a significant lowering of those standards.

[166] The Tribunal is also prepared to accept Ms E's description of how the breast examination occurred rather than the account given by Dr Ben-Dom. Ms E gave her evidence clearly, consistently and convincingly. Any inconsistencies in her evidence of the kind

highlighted by the lengthy cross-examination of her and relied on in submissions for Dr Ben-Dom do not alter the persuasive and consistent description of the examination as given by Ms E.

[167] Sub particular c. of the Charge specifically refers to "*feeling only the front of [Ms E's] breasts and/or by not palpating under her arms*." Dr Ben-Dom's explanation for this was that he only palpates under the arms (in the axilla region) "*if something abnormal is found during the breast examination*".

[168] The evidence from Professor Arroll was that a clinical breast examination

> "*should include light pressing of the breasts and examination of the armpits and above the collar bone [and] examining only the front of the breasts, and not checking the axilla, is inconsistent with accepted best practice*".

[169] The two expert witnesses called for Dr Ben-Dom, Dr Taylor and Dr Reid, did not give evidence on technique at all. Indeed the submissions for Dr Ben-Dom appeared to suggest that Tribunal members could use their own expertise on questions of standards.

[170] The Tribunal concludes that it accepts the evidence given by Professor Arroll and that the breast examination by Dr Ben-Dom of Ms E's breasts was inconsistent with accepted medical practice in relation to the allegation made in sub particular c. which is found to be made out on the facts. Ms E was extremely reluctant to allow Dr Ben-Dom to give her a breast examination but, having done so, expected that it would be done properly and adequately.

[171] In the circumstances the Tribunal does not find, however, that this is professional misconduct on Dr Ben-Dom's behalf separately warranting disciplinary sanction.

[172] Sub particular d. refers to the inaccurate record of the offer of a chaperone and Ms E's decline of this. The Tribunal has found that it accepts the contemporaneous consultation notes made by Dr Ben-Dom and that a chaperone was offered. As the chaperone was offered, if Ms E had indicated she wanted this and Dr Ben-Dom had proceeded with the breast examination in the absence of a chaperone, then there would have been expected to be some complaint or objection from Ms E which apparently did not occur. It might be a reasonable inference for Dr Ben-Dom to have drawn that a chaperone was not wanted.

[173] Accordingly this sub particular d. is not found to be made out on the facts.

[174] Particular 2 is found to be made out first as to Dr Ben-Dom's having raised the topic of breast health which was not clinically justified and secondly having performed a breast examination also not clinically justified. The breast examination was not expected or

requested initially by Ms E although she later agreed to it. That aspect of particular 2 is found to be malpractice on Dr Ben-Dom's behalf and conduct bringing discredit to his profession separately warranting disciplinary sanction. As to the manner of the performance of the breast examination sub particulars a. and d. are not made out as misconduct. Sub particular c. is found made out on the facts and, while not separately warranting disciplinary sanction, does warrant such sanction cumulatively with other particulars found. Sub paragraph b. is found to be made out on the facts and is found to be malpractice on Dr Ben-Dom's part and conduct bringing discredit to his profession separately warranting disciplinary sanction.

Particular 3 - [ ] 2012 – Ms S

[175] This particular also alleged raising the topic of breast health and performing a breast examination in circumstances that did not clinically justify this and/or when the patient did not expect or request this. Secondly, it refers to the performance of the breast examination with two sub particulars referring to an unreasonable length of time and disproportionate time spent.

[176] Ms S, who had had regular mammograms and never had breast cancer saw Dr Ben-Dom on [ ] 2012 for a sinus infection which Dr Ben-Dom described as acute bronchitis. A female trainee doctor was present for the consultation. Questions were asked by Dr Ben-Dom and antibiotics prescribed. Ms S said that Dr Ben-Dom then asked when was the last time she had had a breast examination and whether he could perform this on her. Because of the presence of a trainee doctor, Ms S said she agreed to the examination "*because [she] thought it would be helpful for the trainee doctor, even though [she] felt unwell*".

[177] Ms S referred to aspects of the consultation including things she said were said to her by Dr Ben-Dom and that she could not recall a curtain round the bed and was not given a sheet to cover her. She said the examination took "*a good 5 minutes*" but then Dr Ben-Dom continued with more of an examination and "*probably spent a good 10 to 15 minutes doing a breast examination and talking about breast education*". They discussed, she said, her sinus symptoms for about 2 minutes.

[178] Dr Ben-Dom acknowledged that the consultation about her bronchitis was very straightforward with a quick diagnosis but he then decided to use the substantial remaining time to explore other issues relating to Ms S's health and he raised other topics

with her. The patient had a family history of breast cancer which led Dr Ben-Dom to raise the topic of the last breast examination.

[179] Dr Ben-Dom described the examination and made comment on the size and density of the patient's breasts which required an examination of the margins, best done with the patient sitting.

[180] Dr Ben-Dom doubted that the discussion would have taken as long as Ms S estimated. In Professor Arroll's evidence he said that large breasts do make an examination a little more difficult and expressed the view that four minutes maximum would be sufficient to complete the examination. Professor Arroll said that 10 - 15 minutes was a long time for the patient to be exposed, that there was no apparent attention to any aspect of demonstration to the trainee doctor and that the breast examination appeared to take an excessive amount of time, with more time on this than the presenting complaint.

[181] Ms S did nothing further about this at the time but after the consultation for her [ ], Ms L, referred to below, in 2015 she sent an email on 26 March 2015 to the Waikanae Health Centre to complain about Ms L's consultation as well as her own in 2012.

[182] The Tribunal has considered this particular of the Charge and its sub particulars. The sub particulars are limited to the time taken for the examination. For the reasons already mentioned the Tribunal finds that during the consultation concerning the upper respiratory tract infection and repeat prescriptions for Ms S it was malpractice bringing discredit to his profession for Dr Ben-Dom to perform a breast examination when this was not clinically justified and was not expected or requested by Ms S.

[183] As to the allegations concerning the performance of the breast examination the Tribunal does not find that either allegation is made out on the facts, that is that the examination was for an "*unreasonable length of time*". The time spent on breast health and breast examination may have been greater than the time occupying the presenting complaint but the Tribunal does not find that that is malpractice on Dr Ben-Dom's part or conduct which brings discredit to his profession.

[184] Particular 3 is found to be made out as malpractice in respect of Dr Ben-Dom's having performed the breast examination when not clinically justified and not expected or requested and that this separately and cumulatively warrants disciplinary sanction; but does not find it made out as to the allegation concerning the manner of breast examination.

Particular 4 - [ ] 2014 – Ms D

[185] This particular of the charge alleges first the raising of the topic of breast self-examination in circumstances that did not clinically justify this discussion nor was expected or requested; and secondly the absence of record of any discussion about breast health in the notes.

[186] Ms D went to the Waikanae Health Centre on [ ] 2014 where she had an appointment with one of the nurses but rang to see if she could see a doctor at the same time because of quite bad eczema on her hands. She was told to raise this with a nurse at the time and did so and was referred to Dr Ben-Dom. She understood Dr Ben-Dom was the emergency doctor and she did not wish to take more time off work and so she saw him.

[187] Ms D spoke of the exchanges that she had with Dr Ben-Dom and the consultation about the eczema; but said that Dr Ben-Dom then asked her to go into his consultation room, which she did. The door was kept open and Dr Ben-Dom asked if she needed any medications that were due and whether he had seen her before.

[188] He then went on, she said, to ask if she knew how to self-examine her breasts to which she replied in the affirmative and that she got a mammogram every two years. Dr Ben-Dom said, Ms D said, that that was not enough and asked her how often she examined her breasts to which she replied "*never*". When asked by Dr Ben-Dom what she was going to do about this she said that she said "*nothing*".

[189] Ms D then left the consultation but said she recalled the same conversation about her breasts having happened when she saw Dr Ben-Dom previously about something else. Ms D said that examining her breasts is a private thing and should not have been discussed unless she had a problem and needed to see a doctor about it; and that it was very strange how Dr Ben-Dom had moved from eczema to breast examinations which she had not asked for.

[190] Ms D wrote to the Waikanae Health Centre on [ ] 2014 complaining about the consultation and received an apology dated [ ] 2014.

[191] For his part Dr Ben-Dom said that his intention was to raise the patient's awareness of breast cancer issues and the importance of mammograms, that no examination took place, and there was no formal examination because of the patient's reluctance to discuss. There having been no discussion, he made no record in the notes.

[192] Dr Ben-Dom referred to the "*reactive ethos at [Waikanae Health Centre] and the wider New Zealand profession*" because of Ms D's reference to her never having been asked about her breasts before.

[193] The first allegation in this particular relates to Dr Ben-Dom's having raised the topic in circumstances that did not clinically justify this and when it was not expected or requested and concerning absence of notes. For the reasons referred to above the Tribunal concludes that it was malpractice on Dr Ben-Dom's part to raise the topic of breast self-examination in circumstances that did not clinically justify this discussion and was not expected or requested. This is conduct which brings discredit to his profession and warrants disciplinary sanction separately and cumulatively with other particulars.

[194] The provisions of the guidelines from the MCNZ are clear as noted above and it was a significant breach of standards for Dr Ben-Dom to apply his own approach to raising this topic contrary to those standards. The standards of the profession must be maintained and it is appropriate that there be disciplinary sanction in respect of this particular.

[195] There is a measure of protection of the public also required because patients must have the confidence when attending a medical practitioner for a consultation that the appropriate guidelines and standards will be observed and they will be dealt with dignity and respect and only in respect of matters for which there is some clinical justification. In the case of breast health, this can only be raised in the context of some apparent concern on the patient's part or some indicator which alerts the medical practitioner to the topic.

[196] As to the absence of any note, the Tribunal's view is that, had any progress in the discussion been made, a note of this should have been made; but that, because the examination was offered and then declined in the context of a brief consultation about eczema, there was no need for a further note of this. It would have been otherwise if there had been some indication at all that a breast examination might have been appropriate for whatever raised reason but that did not occur. The second part of the particular relating to note-keeping is found not to be made out as malpractice or conduct bringing discredit.

Particular 5 (withdrawn)

Particular 6 - [ ] 2014: Ms N

[197] This is the same patient to whom particular 1 refers but on this occasion, some three years later, she consulted with Dr Ben-Dom on her own behalf. Her regular practitioner

at the Waikanae Health Centre was not available and Ms N said she made the appointment "*because [she] was very stressed and tired*". The entry in the notes made by Dr Ben-Dom referred to stress with reasons given. No other subjective matters of concern are noted.

[198] Ms N said that when she entered for the appointment and told Dr Ben-Dom why she was there he said he would look at the file and then said that she had not had a breast check and was due for one. He asked if she would like that done to which she agreed. She said Dr Ben-Dom asked if she wanted to have a nurse or someone else present which she declined.

[199] Ms N said that, as she was lying down on the bed Dr Ben-Dom asked if she was comfortable and if she wanted to take her trousers off which she declined. Ms N said that Dr Ben-Dom asked whether he could undo her bra to which she agreed and as he was examining her breasts he said "*something like 'you have good looking breasts for your age'*" which made her feel uncomfortable. She said that Dr Ben-Dom continued examining her breasts for about 20 – 30 minutes "*doing the same thing over and over again*"; that Dr Ben-Dom asked her to put her arm up and stretch, went "*underneath [her] arms, then went to the computer and came back*"; and did this three or four times. She said that Dr Ben-Dom did not close the curtain around her or give her a blanket or anything to cover herself up with and that during the examination he was very close to her.

[200] Ms N said that Dr Ben-Dom asked her questions "*like "Do you have any breast problems*?" "*Do you have a normal period*" and "*Do you examine your breasts yourself*?"". She said he also asked whether she had sex with her husband and whether her husband examined her breasts to which she replied that that was personal and she refused to answer.

[201] Ms N said that the examination took about 20 - 30 minutes because the appointment was at 2:00 pm, she had been in the waiting room until around 2:20 pm and that it was 3:05 pm by the time she left the practice and was running late to pick up her children from school. She said that during the examination she had asked Dr Ben-Dom three or four times how long the examination would take and whether he had finished as she needed to go.

[202] Ms N complained of the consultation to her husband that evening and said she made a complaint to the practice but this was likely on an online form and could not find any

record of it. The practice manager at the Waikanae Health Centre in her evidence said that she could not find any record of a complaint.

[203] Dr Ben-Dom did not deny that he raised the subject of breast examination with Ms N, raising the importance of breast health issues and breast awareness; and that this would have been a thorough discussion. He completely denied making the reference to Ms N's breasts that she spoke of or asking if she wanted to take her trousers off.

[204] Dr Ben-Dom denied that the consultation took as long as stated by Ms N and said it could not have taken much longer than 15 - 20 minutes and certainly not 45 minutes as suggested. There was extensive cross-examination and discussion about Ms N's movements that afternoon, including time for off-site blood tests which Dr Ben-Dom said would no doubt have taken 15 - 20 minutes.

[205] As to Ms N's statement that Dr Ben-Dom was very close to her during the breast examination, Dr Ben-Dom explained that the examination bed was an old wooden closet with a mattress on top and higher than the usual examination bed and that he was of short stature.

[206] He rejected the evidence that he asked Ms N if she had sex with her husband or whether her husband examined her breasts and said that his usual practice was to ask a patient if she knew how to self-examine and, if she did, how often that occurred.

[207] Dr Ben-Dom denied asking Ms N whether he could undo her bra and then undoing it and said he would never do this. He said that the curtain round the bed was always closed when a patient was getting undressed, examined and dressed again and that this was his invariable practice.

[208] As to any record of the breast examination in the patient notes Dr Ben-Dom accepted this describing it as "*an over-sight*". He referred to the number of issues dealt with in the consultation and that he "*would have been*" running a bit behind schedule and as a result the notes were not as thorough as they should have been.

[209] The Tribunal found Ms N's evidence as to Dr Ben-Dom's having raised the topic of breast health with her during a consultation about stress was convincing as to the emotional response she had to it. She was there for one simple consultation, the topic was raised by Dr Ben-Dom without any request or reason from Ms N, and she then underwent the examination which put time pressure on her. Time pressure is confirmed by Dr Ben-Dom's evidence that he was running a bit behind schedule resulting in notes not being as thorough as they might be.

[210] The onus is on the PCC to prove the individual particulars of the Charge and the Tribunal must be satisfied of this on the balance of probabilities. Sub-particular a. refers to the absence of use of a privacy curtain or modesty blanket. Although Ms N said that Dr Ben-Dom did not close the curtain around her or give her a blanket or other to cover her, Dr Ben-Dom said that the curtain around the bed was always closed when a patient was getting undressed, examined and dressed again; and that evidence is affirmed by Ms Crespin who said that in every sensitive examination Dr Ben-Dom would pull the curtain and let the patient undress in private. A similar statement was made by Ms Goodwin who also referred to the modesty blanket always on the bed. The Tribunal has had to weigh up this conflict in evidence and is not satisfied that it is established on the balance of probabilities that this sub particular is made out on the facts.

[211] The second sub particular refers to an inappropriate comment on the appearance of Ms N's breasts. The Tribunal has had to weigh up the evidence of Ms N on this topic against the denial by Dr Ben-Dom. Ms N was cross-examined extensively by counsel representing Dr Ben-Dom. The accuracy of Ms N's evidence was explored in that cross-examination to ascertain, to use Dr Ben-Dom's counsel's words, if her credibility "*survived*" it. This included such things as reference to statements that Ms N had given to the PCC as it investigated this matter and why Ms N would consult with Dr Ben-Dom several times after the incident if it had been as bad as she described. Specifically in the context of what Ms N said that Dr Ben-Dom said to her Ms N was questioned about the accuracy of what she said to the PCC about the reason for the consultation. The transcript read:

> *"Q. ... if you made a mistake about the reason why you went in for the consultation, you could well also be making mistakes when it comes to remembering things that were said?*
> *A. I totally disagree with that. I really disagree with that, yeah, because I did not make up this breast consultation, I did not make up things he said. I would not go home, why would I do that? Why would I go home to my husband and say he said that if he didn't say it".*

[212] One thing that Ms N did say which impressed the Tribunal was that with many things in her life she deals with them and lets them go and so her memory may not be as accurate; but that with things concerning her feelings, she does remember them more forcibly. This question of what was said to her by Dr Ben-Dom during the breast examination was something she felt strongly about and the Tribunal is prepared to accept that it is more

likely she remembered the detail of what was said on this topic than some of the other matters that she was cross-examined about.

[213] What Ms N said that Dr Ben-Dom said to her and what is alleged in the Charge is consistent with what Ms E has said was said to her and has been accepted by the Tribunal. This gives consistency in the accounts of these two patients. Not the same words were used but the same unnecessary comment and reference was made and the Tribunal accepts that on the balance of probabilities Dr Ben-Dom did comment inappropriately on Ms N's breasts with words to the effect "*you have good looking breasts for your age*". It finds that sub particular b. of particular 6 is made out as malpractice on Dr Ben-Dom's part and as conduct bringing discredit to his profession separately warranting disciplinary sanction.

[214] Sub particular c. refers to the unreasonable length of time taken for the examination of Ms N's breasts. There are conflicts in evidence on this from Ms N and from Dr Ben-Dom. Ms N's estimate was significantly challenged in cross-examination by reference to her movements after the consultation to collect her children from school and to have blood tests, with Dr Ben-Dom's position that the blood tests took place before Ms N collected her children and that she went straight from collecting the children to home; and that therefore the consultation with Dr Ben-Dom could not have taken as long as she said.

[215] The evidence from Dr Ben-Dom was that the entire consultation would not have taken much longer than 15 - 20 minutes and that the breast examination was only part of the consultation. He referred to scheduling requirements. He said that a thorough breast examination, especially if the patient is being taught breast awareness in the process, takes longer than 2 minutes per breast as stated in Professor Arroll's evidence. Questions were directed to Ms N about the detail of the consultation and the submission was made that there was a:

> *"[d]iscussion about the issues causing her stress, her blood pressure was taken, height and weight recorded, discussions about medications and related issues, discussion about issues such as whether she smoked, a raft of blood tests order, presumably followed a discussion about health issues but certainly a discussion about why she was experiencing stress. And all of that covered before there is any move to discuss breast health".*

[216] The Tribunal does not accept that discussion of that nature would have taken a significant amount of the consultation period, and there was no objective evidence that that was so.

[217] Professor Arroll's evidence referred to an allegation that the examination took 20 or more minutes and that it seemed there were three of four examinations done at the same visit. He concluded that that time taken, even with multiple examinations, was not justified and that 20 minutes is an inappropriate amount of time for a breast examination in primary care where there did not appear to have been anything complicated about the breasts. Any complications or difficulties would have been explained to the patient and the inference could be drawn that there was nothing of concern because of an absence of referral to secondary services.

[218] The fact that the whole consultation put time pressure on Dr Ben-Dom so far as his saying that this affected his accurate note taking is an indication to the Tribunal that the examination of Ms N's breasts took an unreasonable length of time.

[219] Ms N must have been under some stress about time. She had gone to the consultation with one concern and that had led to the unexpected breast examination. She had responsibility to collect her children from school.

[220] The Tribunal concludes that it is satisfied on the balance of probabilities that this sub particular of the Charge, that Dr Ben-Dom examined Ms N's breasts for an unreasonable length of time, is made out as malpractice and as conduct bringing discredit to the profession. It does not separately warrant disciplinary sanction but does cumulatively with other particulars of the Charge made out.

[221] Sub particular d. refers to inappropriate questions asked during the examination and specifically refers to Dr Ben-Dom's having asked Ms N "*if [she had] sex with [her] husband*". Her reference to this question by Ms N was also in the context of whether her husband examined her breasts.

[222] The evidence from Dr Ben-Dom that he does not ask private and personal questions and limits questions to those necessary for medical purposes is consistent with good medical practice. The PCC has said that there was no suggestion in the Charge that Dr Ben-Dom's behaviour was in any way for self-gratification. Accordingly, the Tribunal is not satisfied on the balance of probabilities that this question was asked by Dr Ben-Dom of Ms N. This sub particular d. is not made out on the facts.

[223] Sub particular e. refers to the absence of record of the breast examination in the patient notes and Dr Ben-Dom accepts that this is factually correct. This is found to be made out as negligence on Dr Ben-Dom's part not separately warranting disciplinary sanction; but cumulatively warranting such sanction with other sub particulars found to be made out.

[224] Particular 6 of the Charge is found to be made out as to malpractice and conduct bringing discredit to the profession by Dr Ben-Dom's having raised the topic of breast health and having performed a breast examination (even although consented to by Ms N) in circumstances that did not clinically justify this. The examination is found to be inappropriate in relation to comments made by Dr Ben-Dom on the appearance of Ms N's breasts and examination for an unreasonable length of time and a failure to record the examination in patient notes. The inappropriate comments separately warrant disciplinary sanction but the unreasonable length of time examination and a failure to record do not separately but do cumulatively warrant such sanction.

Particular 7 (withdrawn)

Particular 8 - [ ] 2015: Ms L

[225] This patient consulted with Dr Ben-Dom about [ ] 2015 about diarrhoea and a urinary tract infection. Dr Ben-Dom is charged with having raised the topic of breast health and offering to perform a breast examination when not clinically justified or expected or requested. It is charged that he did so in an inappropriate manner in raising the topic while the patient felt unwell, asking her to demonstrate breast self-examination in front of him when she had not requested advice on this, and not having recorded any discussion about breast health in her notes.

[226] Ms L is a [ ] and referred to her appointment as an emergency one because she was feeling "*really unwell*" with stomach cramps, diarrhoea and a recurring urinary tract infection. She was [ ] years of age at the time. She said the appointment lasted approximately 20 minutes and she and Dr Ben-Dom discussed the symptoms "*for a little bit*".

[227] Ms L said that Dr Ben-Dom raised the topic of a breast lump she had had removed about [ ] prior, which had been done under specialist care and managed by a separate breast clinic. Ms L said that Dr Ben-Dom spent the majority of the appointment talking about breast examinations which became the focus of the appointment. She said he asked her to show him how she physically examined herself in front of him. Ms L said she did not do that and was quite sick but, even if she had been well, she would have said that was not appropriate.

[228] After further discussion about breast examination, Ms L said that Dr Ben-Dom talked about having a doctor examine her after the lump had been removed. Ms L said that Dr

Ben-Dom examined her stomach but she had to ask him for a urine test. She estimated that over half of the consultation was spent discussing breast examinations.

[229] Ms L said she felt quite confused when she left the room where her [ ] was waiting for her and after an exchange with her, she started crying. She said she told her [ ] that she felt "*very creeped out by what had happened and that most of the appointment was about him talking about breast examinations and breast cancer*." After she spoke to the receptionist one of the nurses came to see her and explained what she needed to do to manage diarrhoea if it did not stop.

[230] That afternoon she and her stepmother (who is Ms S to whom particular 3 refers) wrote to the Waikanae Health Centre referring to both Ms L's and Ms S's appointments with Dr Ben-Dom, with Ms L dictating some of what had happened during her appointment. A letter of apology from the Waikanae Health Centre was received.

[231] Dr Ben-Dom said that after the abdominal examination he thought they should use the time remaining to deal with other health issues and that Ms L was well enough for such a discussion. He said he asked Ms L if they could discuss the issue of breast cancer awareness to which Ms L agreed and that he asked her to demonstrate, whilst clothed, how she carried out self-examination. He thought this was important to her well-being.

[232] Dr Ben-Dom accepted, with hindsight, that he could have discussed the presenting condition at greater length but considered there would be no medical utility in doing so.

[233] The evidence from Professor Arroll discussed the extent to which Ms L felt or was unwell and he said he would not expect a general practitioner to discuss preventive issues with a patient presenting with an acute illness. Professor Arroll referred to the strong family history of breast cancer with the BRCA 1 gene although Ms L said she did not have that gene. He said that, if there were a true concern about a high-risk patient, a discussion on her being referred back to a high-risk clinic where intensive imaging and examination is done may have been appropriate. Dr Ben-Dom's response to that was that Professor Arroll had failed to understand the purpose of his approach which was to increase the patient's awareness of breast health issues, he noting the Royal New Zealand College of General Practitioners' advice that "*doctors should feel more comfortable talking about breast awareness and signs to watch for*". Neither of the expert witnesses for Dr Ben-Dom commented on this patient, as with other patients.

[234] There was no note made in the patient files of any discussion about breast health or breast examination. Professor Arroll said that ideally content of the consultation should be included but conceded that some important topics do get left out. Dr Ben-Dom

acknowledged that the notes were not as comprehensive as they should have been and said that he has since improved the quality of his note recording.

[235] The Tribunal finds that the raising of the topic of breast health and offering to perform a breast examination when this was not clinically justified, expected or requested is, for the more specific reasons given above, malpractice on Dr Ben-Dom's behalf and conduct bringing discredit to his profession. Ms L was there for a specific consultation on an urgent basis. She needed to have that addressed comprehensively; and the evidence concerning having had to take advice from the nurse about how to deal with her diarrhoea indicates that the topic was not adequately canvassed by her consultant general practitioner, Dr Ben-Dom. That is not a specific allegation in the charge, but is indicative of the disproportionate focus that Dr Ben-Dom gave to breast health issues.

[236] Dr Ben-Dom conducted the examination including abdominal examination and noted mild periumbilical tenderness. No issue was presented or was raised by the patient concerning her breast health and there was no call for Dr Ben-Dom to raise the topic with her. If there were aspects in the patient notes concerning the lump removed some two years previously, it may have been appropriate for Dr Ben-Dom to ask if Ms L wished to discuss this issue further with a view perhaps to referral to a specialist but that should have been sensitively raised in the appropriate way and having regard to her presenting condition.

[237] As to the second part of the particular 8 concerning the manner of the consultation the Tribunal finds each of the three sub particulars made out on their facts. Dr Ben-Dom did raise the topic of breast health despite Ms L's feeling unwell. He did ask her to demonstrate breast self-examination in front of him when she had not requested this (although there is a measure of overlap in this part of the allegation with that in the more general topic raised in the first part of particular of the Charge). He acknowledges that he did not record any discussion about this in the patient notes.

[238] This particular of the charge is found made out first that Dr Ben-Dom raised the topic of breast health and offered to perform a breast examination in circumstances that did not clinically justify this discussion and was unexpected or requested, being malpractice and conduct bringing discredit to his profession, separately and cumulatively warranting disciplinary sanction. Each of the sub particulars is made out as malpractice and conduct bringing discredit to the profession and, while none of them separately warrant disciplinary sanction, cumulatively they do warrant such sanction to maintain standards in the profession and to protect the public.

Particular 9 - [ ] 2015: Miss Y ([under 16] years of age)

[239] This particular of the Charge raised different issues from most others. The allegation is that Dr Ben-Dom raised with this [under 16]-year-old female [ ] matters with her not relevant to the consultation or inappropriate with six sub particulars being given. The facts were that Ms Y was feeling run down after working quite long hours at a holiday job and had a really sore throat. She had previously had problems with tonsillitis but she felt something else was wrong. She was going on holiday to [ ] with her family the next day. She was some [under 16] at the time.

[240] She made an appointment with Dr Ben-Dom whom she had not seen before but knew was the general practitioner for her father. This was the first time she had been to the doctors on her own. She described the consultation with Dr Ben-Dom and how he examined her throat and other assessment and questioning. He made some entries into his computer then said to her there was some questions he needed to ask her.

[241] [Suppressed by order of the Tribunal].

[242] Ms Y then said that Dr Ben-Dom raised the fact that he was her father's doctor [Suppressed by order of the Tribunal].

[243] She described a consultation as "*very confronting*" and that night her mother sent an email to the Waikanae Health Centre with Ms Y telling her what to write. The email was produced to the Tribunal. It contains significantly more detail than was given by Ms Y in her direct evidence and she was, of course, available to be cross-examined on its content. Dr Ben-Dom replied to that letter direct to Ms Y apologising for stress and upset. He did not accept a number of matters or points as accurate and said that his conversation "*was driven only and entirely out of a genuine good faith towards doing my best for you*".

[244] Ms Y's mother also gave evidence describing what Ms Y had said to her after the consultation about the questions and exchanges Ms Y had had with Dr Ben-Dom. Ms Y's mother wrote the letter to the Waikanae Health Centre, she having been told by Ms Y what had happened. She referred to a meeting subsequently of other personnel from the Waikanae Health Centre with Dr Ben-Dom and Ms Y where the complaint was discussed but she was disappointed by the outcome.

[245] In his evidence Dr Ben-Dom acknowledged that the presenting consultation was a sore throat but said that in the context of general health that he referred to the dashboard on the computer where there is reference to [Supressed by order of the Tribunal]

[246] His evidence to the Tribunal was that he then said to Ms Y[ ] This seemed, he said, to be a proper question for a general practitioner to ask a patient who was only [under 16]. [ ]

[247] Dr Ben-Dom then gave evidence of the discussion he had with the patient concerning this topic. He denied asking Ms Y [ ].

[248] He further said that he assured Ms Y he would not disclose to her father what she had told him. The Tribunal does note that one of the letters produced by Dr Ben-Dom referred to later in the context of penalty was in fact written by Ms Y's father. It is unsigned but does contain the subscript "*(Mr Y is the father of the [under 16] year old girl)*". There is otherwise no reference in the text to the consultation that Ms Y had with Dr Ben-Dom.

[249] In his evidence Professor Arroll said that it is a reasonable question to ask a woman of [under 16] years of age active[ ] irrespective of what she presented with. This is accepted by the Tribunal. Professor Arroll said, however, that it should be approached with the appropriate words [ ].

[250] Reassurance about the confidentiality of the discussion would be best practice and doctors need to be very careful about disclosing information about family members to either party, he said. He described the issues concerning [ ] and absence of reassurance of confidentiality as serious breaches of good practice.

[251] It is not part of the Charge as brought and the Tribunal can do no more than comment on this; but there are concerns raised in respect of this patient that are troubling. Dr Ben-Dom was the general practitioner who had consulted with both Ms Y and her father. Ms Y's evidence was that another doctor is her family general practitioner. The letter that Ms Y's mother wrote to the Waikanae Health Centre contains quite significant detail (not in the direct evidence) of discussion that Ms Y had with Dr Ben-Dom concerning family matters. Ms Y was sensitive about [ ] being discussed with Dr Ben-Dom. She was concerned that what she would have said, or might say, might be passed on to her father in much the same way as the letter records discussion about other family members. The evidence from Ms Y underlined the importance of reassurance that should have been given of complete confidentiality. No explanation was given to the Tribunal about the subscript to Mr Y's letter later produced as mentioned above; but the question must be asked as to who entered that subscript and whether it was done with Mr Y's knowledge; in which case it is an indicator to him that his daughter had seen Dr Ben-Dom.

[252] The first allegation in particular 9 is that Dr Ben-Dom raised [ ] with Ms Y when this was not relevant to the consultation. This all occurred in the context that the presenting issue was a throat infection and the patient was planning to travel overseas. As noted above, the Tribunal accepts that it is appropriate for a general practitioner to raise the subject of [ ] with a female of this age irrespective of what she presented with [ ].

[253] Sub-particular a. refers to asking Ms Y if she [ ]. Professor Arroll gave an example of how the topic might be sensitively raised. That contrasts so strongly with the way in which Dr Ben-Dom raised it which he described in this way:

> *"So, I asked her permission to talk about - to raise this issue?*
> ***CHAIR:*** *Asked her permission?*
> *A. Permission, yes, and I received it. And that was, and that's the only question I asked her, [ ]"* **.**

[254] [Suppressed by order of the Tribunal].

[255] The Tribunal finds this sub particular made out as malpractice on Dr Ben-Dom's part bringing discredit to his profession and separately warranting disciplinary sanction for maintenance of standards in the profession.

[256] Sub particulars b., c., and d., refer to the discussion concerning [ ].

[257] Ms Y, who was aged [ ] years by the time she gave evidence, was a convincing witness who described the circumstances of the consultation clearly and her evidence is to be preferred to that of Dr Ben-Dom. The evidence is consistent in itself despite the cross-examination of her; and it is consistent with the evidence of the other patients to whom particulars refer in the context of Dr Ben-Dom's raising matters of personal sensitivity such as breast health and examination. Her truthfulness is to be assessed from her reaction after the consultation in making the complaint and from the wording of that complaint.

[258] Those three sub particulars are found made out on the facts and are malpractice on Dr Ben-Dom's part bringing discredit to his profession cumulatively together but separately from other particulars and charges, all warranting disciplinary sanction for maintenance of standards in the profession.

[259] The Tribunal finds there is significant doubt in relation to sub particular e. concerning questions being made for general health screening purposes such that it is not satisfied that this particular is made out on its facts. The only reference was to entries having

being made by Dr Ben-Dom on the computer and an assumption that Ms Y made that this related to some completion of a medical record for her.

[260] Sub particular f. concerning absence of record of the discussion is found to be made out as negligence on Dr Ben-Dom's part and bringing discredit to his profession and, as with other sub particulars concerning note-taking, not separately to warrant disciplinary sanction but cumulatively with those other such sub particulars to warrant such sanction to maintain standards in the profession and to protect the public.

Particular 10 – [ ] 2016 – Ms A

[261] The two aspects of this sub particular relate to the raising of the topic of breast health when not clinically justified or not expected or requested and secondly the manner of those activities.

[262] Ms A said that she needed an emergency appointment because her asthma was playing up as was that of her daughter, [ ], who was [ ] at the time. She had not seen Dr Ben-Dom before. The notes made by Dr Ben-Dom in the Patient Medical History include "*Severe Astma/COPD … Prolonged expirium, wheezing*".

[263] Ms A said that Dr Ben-Dom examined her and checked her chest and after a brief examination started talking about women getting breast examinations, asking if she had ever had her breasts checked. There was further discussion about that and Dr Ben-Dom asked if she wanted a breast examination or for him to show her how to do it properly.

[264] When Ms A declined this Dr Ben-Dom, she said, just would not take "*no*" for an answer and asked a couple of times if she wanted a breast examination which she declined. She said she felt upset and shaky in giving that response.

[265] She then said that Dr Ben-Dom asked her daughter to leave the room which made her feel anxious but after that had happened Dr Ben-Dom asked her again about breast examination which she again refused. Her daughter re-entered the room but Dr Ben-Dom sent her straight outside again despite Ms A agreeing to her remaining. Her daughter did return to the room shortly later and Dr Ben-Dom referred to Ms A's making an appointment if she needed to talk to someone about breast examination.

[266] Ms A estimated that Dr Ben-Dom asked her about breast examinations three or four times after she had first declined including when her daughter was out of the room. She said she was "*extremely upset*" when he asked her daughter to leave the room and he raised the topic again. Ms A said that her perception was that Dr Ben-Dom was not

concerned about her asthma which they did not discuss for long and he seemed more focused on breast health and breast examinations which left her "*pretty upset*".

[267] Dr Ben-Dom acknowledged that, after having discussed the asthma concerns he asked Ms A if they could discuss breast cancer awareness to which she agreed. The reason he asked her daughter to leave the room was to "*save both from possible embarrassment*". He acknowledged that this had an unexpected effect on the patient "*who acted unfavourably*", but he did not explain why he asked her daughter to leave the second time. Dr Ben-Dom accepted that he failed to pick up on the patient's reluctance to discuss the issue and has learned that he has to be more receptive to the signals of a patient's comfort.

[268] He said he overlooked the notes because the consultation went beyond 15 minutes and there was time pressure. There had been no detailed discussion, he said, of the issue of breast health. Again the Tribunal notes that time pressure could have been of his own making in having raised the subject in the first place.

[269] Professor Arroll referred in his evidence to a pattern of not attending to the acute presenting problem and focusing on prevention. He also said that a prudent doctor would normally write something about the distress induced in a patient as part of a consultation as a means of protecting themselves against subsequent complaints.

[270] As to the first part of the particular the Tribunal finds that Dr Ben-Dom did raise the topic of breast health which was not clinically justified nor expected nor requested by the patient. Ms A was presenting with a serious respiratory complaint and this should have been the primary focus. This was malpractice on his part and bringing discredit to his profession separately warranting disciplinary sanction and cumulatively with other like charges.

[271] The three sub particulars are found to be made out on the facts. Ms A was a convincing witness and her evidence was consistent with that type of activity referred to in the evidence of other patients as accepted by the Tribunal.

[272] Sub-particular a. refers to the repeated offer to perform a breast examination after this had been initially declined and that is found to be made out as conduct bringing discredit to Dr Ben-Dom's profession separately warranting disciplinary sanction and cumulatively with other such particulars.

[273] Sub particular b. refers to the request for Ms A's daughter, then [ ] years of age, to leave the room with a repeat offer for a breast examination in her absence. This is found to be

made out as conduct bringing discredit to his profession and separately and cumulatively warranting disciplinary sanction.

[274] Sub particular c. refers to note-taking and this is found to be made out as negligence not separately, but cumulatively with other like particulars, warranting disciplinary sanction.

Particulars 11 and 12 - 24 May 2017 – Ms Alison Kenny

[275] Particular 11 of the Charge also refers to the raising of the topic of breast health and performing a breast examination when not clinically justified; and to the manner in which this was done, with four sub particulars. Particular 12 refers to the same patient and the same consultation and the offer to perform a cervical smear test in inappropriate circumstances with two sub particulars being given.

[276] This consultation was for Ms Kenny who had gone to the Waikanae Health Centre for a Venlafaxine repeat. She normally sees another doctor at the Waikanae Health Centre but she had seen Dr Ben-Dom once before when she thought he was very thorough which she admired.

[277] Ms Kenny said that she arrived at 6:30 p.m. when it was dark and there seemed to be only the receptionist and Dr Ben-Dom present. Dr Ben-Dom wrote a prescription for the Venlafaxine but asked other questions about her health. He told her she was due for another cervical smear, that there was a backlog and he could do it then if she wanted, which she declined.

[278] Dr Ben-Dom then asked a question about breast examination and her last mammogram and then asked about self-examination of her breasts, which she said she did. That topic was then discussed and Dr Ben-Dom then, she said, suggested that he examine her breasts. Because of a family history she agreed to this. She prepared for the examination and, while this was occurring, Dr Ben-Dom said to her, she said, that she should mention to the receptionist that she wanted to be his patient.

[279] Ms Kenny said that while Dr Ben-Dom was examining her breasts he said something "*along the lines of 'for your age, they're quite full'*" which she did not think was right. She said that at no time did Dr Ben-Dom offer for someone else to be present in the room while he did the breast examination.

[280] When she left the room it was dark and she had some concerns about lighting in the practice and outside. She said the appointment lasted about 45 minutes and, as she began to discuss the matter later with her husband, she "*began to feel uncomfortable*". Ms Kenny said that three days later she emailed Waikanae Health Centre with some general

questions and received a response; with another response about a week later. The general questions she had raised referred to the presence of someone else in the clinic other than her and the doctor and about lighting issues. There was reference to a chaperone and a later passage in the letter included "*at no point was I offered someone else present in the room*".

[281] This consultation occurred after the exchanges that Dr Ben-Dom had had with the Waikanae Health Centre including his written undertaking of 1 June 2016 referred to above. Sub particulars a. and b. both refer to breaches of that undertaking. In his evidence Dr Ben-Dom referred to the undertaking he had given and the context of that. He said there was a justification in Ms Kenny's case for raising the subject of breast cancer prevention because the records indicated a gap between mammograms. Mammograms are performed biannually and it is Dr Ben-Dom's view that they should be more regular than this or that there should be some other examination in the intervening years.

[282] Ms Kenny said that Dr Ben-Dom said that things can develop between mammograms. Dr Ben-Dom's evidence referred to the family history of breast cancer that Ms Kenny had with details given. He did not deny having made reference to Ms Kenny's breasts and the words she said he said "(*for your age, they're quite full*"), but explained that he was making a reference to dense tissue and fullness which equates with an increased risk of breast cancer. Dr Ben-Dom said he was confident that he had offered a chaperone but that Ms Kenny had overlooked this; and that it has been his practice to offer a chaperone for 28 years. He said that he raised the issue of a smear test as a reminder and generally does not do them himself anyway.

[283] As to the absence of notes, Dr Ben-Dom said that Ms Kenny was the last patient he saw, that his wife, who had arrived from her work in Wellington by train and was not feeling well, was waiting for him outside, that he turned off the computer and rushed to take his wife home, and forgot in the hurry to write about the breast examination. Evidence was given by Mrs Ben-Dom to confirm this last item, but attention was drawn to Minutes of a meeting on 7 June 2017 at which Dr Ben-Dom was present in which it is recorded that he "*indicated he had no defence*" to the lack of documentation concerning this consultation and made no reference to urgency to pick up his wife.

[284] The expert evidence from Professor Arroll included that raising the subject of breast health contrary to the undertaking[12] to "*utterly avoid*" doing this unless brought up by the patient was a very concerning breach of undertaking and to Dr Ben-Dom's having "*clandestinely ... not [recording] what he had done in the notes*". Professor Arroll opined that there was a breach of the undertaking in not having offered a chaperone and that this was inconsistent with general advice and professional standards. The comments about Ms Kenny's breasts were "*extremely inappropriate to make*" he said. Professor Arroll finally referred to a letter from Dr O'Connor to the MCNZ dated 14 June 2017. That letter notified the MCNZ of concerns about the work practices of Dr Ben-Dom and led to the inquiry which led to the laying of this charge. Dr O'Connor referred to the written undertaking which had been given by Dr Ben-Dom and the complaint from Ms Kenny and said that: "*when presented with the complaint Dr Ben-Dom's initial response was to be angry with [Ms Kenny], describing her as 'stabbing him in the back'*". Professor Arroll said that this showed "*no component of self-doubt or reflection; just a blaming of the patient [which was] a very doctor centred comment and not considered appropriate for a modern GP*".

[285] The Tribunal has considered this particular. This event occurred after Dr Ben-Dom had given the undertaking to the Waikanae Health Centre referred to. The particular of the Charge is worded to include reference to that undertaking. The undertaking had been given and the consultation was in the context of a Sensitive Examinations Protocol which the Waikanae Health Centre had established in April 2015 following other complaints concerning Dr Ben-Dom which included that a chaperone would always be present if available and not just offered: and that an invasive or sensitive examination would only be performed if the clinical presentation warranted it or at the specific request of a patient or as part of a recognised New Zealand screening programme.

[286] As with many other particulars, the first allegation concerns raising the topic of breast health and performing the breast examination when this was not clinically justified. On its own, for the reasons already mentioned this was malpractice on Dr Ben-Dom's part and brought discredit to his profession. He had no occasion to raise the topic at all with this patient who was in for a repeat prescription.

[287] Although defensive about the timing and personnel still at the practice, Dr Ben-Dom should have been particularly conscious of the lateness of the hour and the likely absence

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[12] Refer paragraph 60 above

of other personnel. He should have been aware of the extra time that that examination would take particularly because his excuse was urgency to get to his wife to provide transport. This aspect of the conduct alone warrants disciplinary sanction to maintain standards in the profession and for protection of the public in similar circumstance. That is independently of the four sub paragraph allegations.

[288] Sub paragraph a. deals with the same topic of raising the subject of breast cancer but in the context of his written undertaking to "*utterly avoided*" raising breast cancer prevention unless this was brought up by the patient. These were words taken from Dr Ben-Dom's own offered undertaking given 1 June 2016. This is the only additional factor to the more general allegation mentioned above. It may have some relevance to employment issues for Dr Ben-Dom with his employer but that is not for the Tribunal.

[289] The allegation is made out as malpractice on Dr Ben-Dom's part in bringing discredit to his profession warranting disciplinary sanction; but not to any extent to which amounts to duplication of the finding concerning the general allegation.

[290] Sub particular b. refers to failure to offer a chaperone and the breach of the direct wording of the undertaking. The Tribunal prefers the evidence of Ms Kenny in this matter. A failure on Dr Ben-Dom's part to offer a chaperone is consistent with his single-minded cavalier approach to making breast health issues a priority over the presenting issue. The Tribunal cannot accept his general statement about always offering a chaperone. It is mindful of the evidence of the nurses who referred to this having been done in their experience; but is not satisfied on the balance of probabilities that this occurred on this occasion. Dr Ben-Dom could not have offered a chaperone without taking account of the lateness of the hour and the possibility there was not one present.

[291] Dr Ben-Dom referred to the words used by Ms Kenny in her email to the Waikanae Health Centre some days later when she said

> "*I am making an inquiry with regards to what the protocol is for when a patient visits a doctor or on these matters… Should there be a female nurse, chaperone in the room when a breast examination is taking place…*"

He argued that this should be interpreted as indicating that Ms Kenny declined a chaperone but later wondered whether, as a matter of practice policy, a chaperone had to be present. He opined that the issue only came to mind as a result of the feeling of unease on discovering that the area outside of the consulting room was in darkness when she left the room and the receptionist had left the premises.

[292] The Tribunal does not accept that interpretation of those words or Dr Ben-Dom's surmise about how Ms Kenny felt. This is especially when the email also included:

> "*At no point was I offered someone else present in the room*."

The wording of the undertaking referred to a chaperone nurse being offered to be present "*during the discussion and always present during the physical examination*". The Tribunal does not accept that Ms Kenny may have been offered a chaperone and declined this but nevertheless wrote the email that she did three days later on 27 May 2017.

[293] This sub particular of the Charge is found to be made out as malpractice on Dr Ben-Dom's part and conduct bringing discredit to his profession and separately to warrant disciplinary sanction.

[294] Sub particular c. refers to inappropriate comments during the breast examination about Ms Kenny's breasts and the Tribunal finds as a fact this to be made out having occurred. It is effectively acknowledged by Dr Ben-Dom although with his interpretation of what he was referring to. This is malpractice on Dr Ben-Dom's part bringing discredit to his profession. It does not separately warrant disciplinary sanction but, cumulatively with other particulars concerning inappropriate comments, does warrant such sanction for maintenance of standards in the profession and protection of the public.

[295] Sub paragraph d. refers to the absence of record of the breast examination. That is established on the facts and admitted to by Dr Ben-Dom. The Tribunal has suspicion about his offered excuse concerning haste to transport his wife. That is inconsistent with the fact that he offered the examination and then conducted it seemingly under no time pressure. A breast examination must be recorded in notes for future reference by any medical practitioner dealing with the patient, particularly in the context of breast health. Dr Ben-Dom's failure to record the examination in his notes is negligence and conduct bringing discredit to his profession warranting disciplinary sanction separately and cumulatively with other similar particulars.

[296] Particular 12 refers to the offer to perform a cervical smear test where no chaperone was offered and no record was made of the offer. There seems no dispute as to the facts that the offer was made. The offer may not in itself have included reference to a chaperone. It was declined by Ms Kenny and that was the end of the matter. Perhaps if she had agreed there may have been some offer of a chaperone, although that is doubtful given the matters pertaining to the breast examination referred to above. The offer should have

been recorded in the notes for future reference, although, the offer having been declined, there were no significant consequences of the failure to record.

[297] The Tribunal is not satisfied on the balance of probabilities that there was negligence or malpractice on Dr Ben-Dom's part or conduct bringing discredit to his profession and that particular is not made out.

The Charge: summary of conclusions

[298] Dr Ben-Dom is, and was at the time, a registered medical practitioner practising in New Zealand. There are standards that apply to his profession that applied at the time. Those are clearly spelled out in the various editions of Good Medical Practice and other Guides published by the MCNZ.

[299] Dr Ben-Dom came from Israel when he said there was a different ethical approach to the practice of medicine, but the only evidence on that was his own evidence and that of his wife (not a medical practitioner). That ethical approach was, in summary, that a medical practitioner should take a proactive approach to medicine dealing with the whole health of the patient and making full use of available time for consultation. He contrasted that with what he said he thought the approach in New Zealand was. Because of his perception of that contrast Dr Ben-Dom continued to press a case for his own philosophical approach of proactivity to health and, in the context of matters raised by the Charge, specifically in relation to breast health.

[300] Over several years he has taken that proactive approach. Over the period covered by the Charge from June 2011 to May 2017 Dr Ben-Dom's saw the respective female patients referred to in the Charge and in respect of several of them raised with them issues of breast health, techniques for breast self-examination, and for them to have a breast examination by him. In each case this was in the context of a significantly different presenting complaint, in many cases a complaint which was urgent or was readily and quickly able to be otherwise dealt with. Dr Ben-Dom chose to raise the topic with these patients and to take the time to discuss that with them; in some cases despite the time pressure that that created for them; and apparently for his own accurate and adequate note-taking.

[301] There were complaints made by some of these patients and Dr Ben-Dom became aware of those complaints. Matters came to a head when he was confronted by his employer about this and he gave a categorical and written undertaking to refrain from that practice.

Despite this, in respect of the last patient, he raised the subject again and carried out a breast examination in breach of his written undertaking to his employer.

[302] He has been charged by the PCC in respect of those matters. He has strenuously defended the Charge, producing extensive material to justify his approach. He called two expert witnesses on the subject. To support his position Dr Ben-Dom produced statements from various present or past patients of his endorsing his proactive approach. That only serves to confirm to the Tribunal that this is the approach that Dr Ben-Dom considered the right one. A significant part of his defence on this topic concerned the value and techniques of breast self-examination. Evidence and submission on that topic occupied a significant part of the hearing. Dr Ben-Dom appears to the Tribunal to be still fully convinced that his approach is the right one. This is emphasised again in the submission on costs received from counsel on his behalf mentioned below.

[303] That focus does not distract the Tribunal from the principal question of whether in respect of each of the individual female patients concerned this proactive approach advocated by Dr Ben-Dom was clinically justified. That takes into account the medical questions concerning the presenting complaint and the ethical standards applicable in New Zealand.

[304] The Tribunal has found that in each case raising the topic and carrying out the examinations that he did was not clinically justified. This was a significant breach of standards and amounted to malpractice on Dr Ben-Dom's part bringing discredit to his profession and warranting disciplinary sanction.

[305] The second broad aspect of the Charge related to features of the examination or discussion that took place including, in respect of one patient where breast issues were not raised, discussions with her (a [under 16]-year-old female) about sexual matters. Although there may have been a justification in raising these topics with this adolescent at the time, despite the presenting complaint, there should also have been sensitivity about the circumstances surrounding the consultation and particularly about the language used to approach the subject sensitively. This just simply did not occur.

[306] The Tribunal's decision has gone through the individual aspects of the manner of the consultations for each patient and the findings are set out above. The witnesses who gave evidence for the PCC were consistent in that what they said about essential matters, they spoke credibly about what had occurred in the consultations for them, and the description of essentials relating to the Charge was credible. They were all cross-examined by counsel for Dr Ben-Dom (even to the extent where at one stage objection

was raised by counsel for the PCC that could have given rise to rulings under section 85 of the Evidence Act 2006).

[307] Two essential general facts were undisputed, namely the general nature of the presenting complaint and the discussions concerning breast health, and/or breast self-examination and/or conducting of clinical breast examination in respect of all patients other than the [under 16]-year-old.

[308] There are several aspects that separately require disciplinary sanction, several that cumulatively require that sanction, and several that have been found not to be made out. Each particular is dealt with in detail above.

[309] Dr Ben-Dom had not adopted and was not practising any theory of medicine or healing such that he may avail himself of section 100(4) of the HPCA Act.

[310] This decision having been announced to the hearing submissions were made on penalty.

Penalty

Penalty - the PCC position

[311] The PCC pressed for an order for suspension for at least one year, censure, and conditions; and an order for contribution to costs.

[312] Having referred to the principles and previous cases the submissions for the PCC mentioned the following relevant features, namely the vulnerability and breach of trust for the individual patients, particularly with the [under 16]-year-old alone with the doctor for the first time; and nature and duration of the conduct, the harm to patients, and the breach of undertaking and associated failure to heed multiple warnings. Reference was made to Dr Ben-Dom's lack of insight and recognition of remorse.

[313] It was emphasised that the public need protection to ensure that Dr Ben-Dom's medical practice meets professional standards; and that professional standards must be maintained by denouncing the conduct and deterring others from engaging in similar conduct. Reference was made to the differences between the conditions now sought by the PCC and those that had been imposed by the MCNZ on an interim basis while the matter was investigated.

Penalty - Dr Ben-Dom's position

[314] For Dr Ben-Dom it was first submitted that the only order required was one of censure and that this would most appropriately protect the public and deter others. It was said that Dr Ben-Dom had a genuine belief that what he was doing was appropriate and

justified although the Tribunal has now found differently. Other cases were distinguished in submissions on their facts. A censure would indicate to the profession that the Tribunal clearly denounces Dr Ben-Dom's approach in New Zealand. Some education is required, it was said. Dr Ben-Dom is not conducting these examinations now and has not done so for some 1.5 years and indeed, it was said, with the exception of Ms Kenny, since 2016.

[315] While Dr Ben-Dom thought at the time that the New Zealand approach was wrong, he has since learned that that approach is the one that he must follow. He knows that he must be diligent in not following his old approach now. The Tribunal has difficulty accepting that submission. During the whole of the hearing, evidence given and submissions made the impression received was that Dr Ben-Dom still considers that his approach is the right one. Even the submissions later made in writing on costs appeared to advocate that.

[316] Reference was made to the stress pressure and consequences already faced by Dr Ben-Dom and his wife and family as a consequence of the complaints made, the investigation and the laying and hearing of this Charge. He does not need time for further reflection because he has effectively done this in the last 2.5 years.

[317] Standards in New Zealand are set, it was said, by an order for censure and any order for suspension would significantly interfere with Dr Ben-Dom's rehabilitation.

[318] The Tribunal was guided carefully through the different letters written by patients or former patients; and a selection of comments from letters and statements quoted by Dr Ben-Dom in his evidence. It has noted those carefully; although it also notes the PCC objection that in many cases there is no evidence that the authors knew the detail of the Charge brought against Dr Ben-Dom and many of them were undated. The Tribunal also notes that some of the passages relied on go to the propriety of the conduct and, of course, the Tribunal has now made findings on that. Attention was drawn to responses from the then practice manager concerning Dr Ben-Dom's abilities as a medical practitioner.

[319] A statement from a registered clinical psychologist, Ms Annemette Sorensen, dated 29 June 2017 (presumably obtained for purposes other than the Tribunal hearing) was produced which referred to the six occasions she had seen Dr Ben-Dom between June and July 2016 and his reaction to the then complaint concerning his practice but she referred to the discussion they had had about his "*desire to take a very proactive approach in cancer prevention, assessment and education*" and how this could have the

"*unintended effect of intimidating some patients*". She said that Dr Ben-Dom had reflected on this a lot and was actively working on understanding the needs of individual patients better. She spoke about her perception of Dr Ben-Dom and his values which the Tribunal has taken into account.

[320] Again, however, despite that apparent understanding in 2016, Dr Ben-Dom still spoke of his belief in the proactive approach in his evidence to the Tribunal and the whole of his presentation appeared to the Tribunal to advocate that his proactive approach is the right one and did not in any way indicate understanding to the contrary.

[321] The Tribunal does not accept the submission made that that letter demonstrated "*very high level of insight*" or of a changed approach or insight, as was submitted. Dr Ben-Dom's whole defence to the Charge against him, the material produced by him and on his behalf, the extensive questioning of former patients to try to undermine their credibility on all topics, and the submissions made on his behalf all serve to emphasise to the Tribunal that there are significant concerns about Dr Ben-Dom's insight and about his ability to moderate his behaviour and accept the New Zealand standards of conduct as established by the MCNZ.

[322] The mitigating factors pressed for Dr Ben-Dom were that it was said:

a) That the offending was at the "*low range of seriousness*";

b) That there was no physical or financial harm to the patients from the conduct (although no reference was made to emotional harm except that, when pressed, counsel referred to a "*sense of disquiet*" and ultimately a sense of distress, unease and concern);

c) That findings of misconduct in themselves are a significant penalty to Dr Ben-Dom and could potentially limit his ability to find employment;

d) The steps that Dr Ben-Dom has taken to review his practice;

e) His unblemished medical career;

f) His loss of income for a period of 13 months during which interim conditions imposed by the MCNZ were in place, causing a loss, it was said, of some $180,000 - $190,000.00;

g) That Dr Ben-Dom has effectively suffered a 13 month period of suspension with a further 17 months working under the constraints of interim conditions; and

h) That Dr Ben-Dom has learned a significant lesson.

[323] There was available, it was said, the facility of mentor from a local general practitioner and details of what was proposed was given.

Penalty - discussion

[324] The available penalties for the Tribunal are:[13]

a) That registration be cancelled.

b) That registration be suspended for a period not exceeding 3 years.

c) That the health practitioner be required, after commencing practice following the date of the order, for a period not exceeding 3 years, to practise his or her profession only in accordance with any conditions as to employment, supervision, or otherwise specified.

d) Censure.

e) A fine of up to $30,000.00 (but not if he or she has been convicted of a relevant offence or damages have been awarded against him or her – not the case here).

f) Costs.

[325] The principles behind penalty orders of the Tribunal as clearly set out on the basis of authorities[14] are:

a) What penalty most appropriately protects the public.

b) The important role of setting professional standards.

c) A punitive function (although this is not the principal purpose behind in the order but may be a secondary consequence).

d) Rehabilitation of the health professional.

e) That any penalty imposed is comparable to other penalties imposed upon health professionals in similar circumstances.

f) Assessing the health practitioner's behaviour against the spectrum of sentencing options that are available and trying to ensure that the maximum penalties are reserved for the worst offenders.

g) An endeavour to impose a penalty that is the least restrictive that can reasonably be imposed in the circumstances.

h) Whether the penalty proposed is fair, reasonable and proportionate in the circumstances presented.

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13 Section 101 of the HPCA Act

14 *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 3354; *Katamat v PCC* [2012] NZHC 1633 at paragraph 49 and *Joseph v PCC;* [2013] NZHC 1131 at [65] – [66]; *Singh v Director of Proceedings*, [2014] NZHC 2848 (esp. paragraphs [56] – [60] and [66])

[326] In *A v* Professional *Conduct Committee*[15] the High Court said that four points could be expressly and a fifth by implication from the authorities namely:

> *"First, the primary purpose of cancelling or suspending registration is to protect the public, but that 'inevitably imports some punitive element'. Secondly, to cancel is more punitive than to suspend and the choice between the two turns on what is proportionate. Thirdly, to suspend implies the conclusion that cancellation would have been disproportionate. Fourthly, suspension is most apt where there is 'some condition affecting the practitioner's fitness to practise which may or may not be amenable to cure'. Fifthly, and perhaps only implicitly, suspension ought not to be imposed simply to punish."*

[327] The Court went on:[16]

> *"Finally, the Tribunal cannot ignore the rehabilitation of the practitioner: B v B (HC Auckland, HC 4/92, 6 April 1993) Blanchard J. Moreover, as was said in Giele v The General Medical Council [2005] EWHC 2143, though ' ... the maintenance of public confidence ... must outweigh the interests of the individual doctor', that is not absolute – 'the existence of the public interest in not ending the career of a competent doctor will play a part."*

[328] The Tribunal is also mindful of the remarks of Randerson J in *Patel v Dentists Disciplinary Tribunal*[17]. That case involved an appeal by a dentist whose name had been removed from the register by the Dentists Disciplinary Tribunal in relation to charges arising from his treatment of an elderly couple for whom he carried out crown and bridge work, accepted by the Court as being "*grossly incompetent and completely unacceptable*"[18].

[329] In discussing the purpose of disciplinary proceedings the Court said:

> *"[28] The Dentist Act does not provide any guidance on this subject but I am satisfied that the following statement of principle by Eichelbaum CJ in Dentice v Valuers Registration Board [1992] 1 NZLR 720, 724-725 is apposite in this case:*
>
> > *Although, in respect of different professions, the nature of the unprofessional or incompetent conduct which will attract disciplinary charges is variously described, there is a common thread of scope and purpose. Such provisions exist to enforce a high standard of propriety and professional conduct; to ensure that no*

[15] *A v Professional Conduct Committee* [2008] NZHC 1387 at [81]
[16] At [82]
[17] Auckland HC; AP77/02; 8/10/02;
[18] Paragraph 32

> *person unfitted because of his or her conduct should be allowed to practise the profession in question; to protect both the public and the profession itself against persons unfit to practise; and to enable the professional calling, as a body, to ensure that the conduct of members conforms to the standards generally expected of them; see, generally, Re A Medical Practitioner [1959] NZLR 784 at pp 800, 802, 805 and 814. In New Zealand, such provisions exist in respect of medical practitioners, barristers and solicitors, dentists, architects, pharmacists, real estate agents and a number of other professionals and callings, as well as valuers; …*

[330] There are serious concerns that the Tribunal has that Dr Ben-Dom continues to hold the views on the ethics that he had which are contrary to those promoted in New Zealand by the MCNZ. Although these events occurred between 2011 and 2017, Dr Ben-Dom still attended the hearing himself advocating the proactive philosophy that he espoused and says he had learned from his experience before coming to New Zealand. He produced a range of documents espousing that philosophy and tried to justify his behaviour on the basis of these. He produced through counsel the report from the registered clinical psychologist mentioned concerning consultations in 2016 and relied on what was said there about his reflections and lessons learned. Despite this and despite the undertaking he had given to his employer he then offended again in 2017 in respect of Ms Kenny. Final submissions on costs appear to be advocating his position on this.

[331] Although most of the references from former patients produced by him appear to be undated, they do refer to Dr Ben-Dom's departure from the Waikanae Health Centre practice which the Tribunal is prepared to take as evidence that they have been more recently written. They do not give any indication as to when they were treated by Dr Ben-Dom in this more proactive way.

[332] Opening remarks by counsel on Dr Ben-Dom's behalf included: "*this approach by Dr Ben-Dom can now see might not have been to everyone's taste…*" "*if we're going to live in a global community with people coming to live and work here from other countries then perhaps we need to have a wider understanding of these issues*" referring to Dr Ben-Dom's evidence setting out his approach to breast health which reflected both his proactive approach to health as well as prevention of disease and early diagnosis.

[333] The Tribunal's assessment of how Dr Ben-Dom's case was presented and the evidence he gave is that he may now be aware of New Zealand standards and relevant guidance principles but that he does not still personally agree with them.

[334] While early decisions of the Tribunal are helpful, each case must be considered on its own facts and principles but there must also be an endeavour to reach consistency, as noted in the *Roberts* decision above. The cases referred to the Tribunal by the PCC were*:*

Dr Ravi Tamma[19]. This general practitioner faced an allegation that he had conducted an unnecessary physical and/or intimate examination (including a sexually transmitted infection check) without offering a chaperone and obtaining informed consent and in a manner that did not allow the patient adequate covering or privacy to undress. The doctor admitted the charge and it was found that there was no justification for him to have performed a full body physical examination while the patient was naked. His sexually transmitted infection check was wholly unjustified in the absence of any relevant symptoms or any inquiry about sexual history or activity. The doctor was censured and suspended for 18 months with conditions imposed following resumption of practice. It was submitted for Dr Ben-Dom that that case can be distinguished on the basis that there was there no issue about whether the conduct was appropriate.

McNair[20] This medical radiation technologist was found to have opened and closed a patient's gown around her hip area exposing her underwear; that there was insufficient evidence that this was for sexual gratification purposes and was rather a failure appropriately to communicate. He was censured and fined $2,000.00 with conditions placed on his practice. It was noted that he lacked insight and appeared to have been are unable to improve his conduct despite cautions.

Samiyullah[21] This physiotherapist had placed his hand inside a patient's bra during a physiotherapy treatment and examination of the upper torso area. There was no clinical justification for examining the upper torso and there was found a reasonable inference that the touching was for sexual gratification. Because he was no longer registered in New Zealand he could not be suspended or have his registration cancelled but conditions should he return were indicated. He was censured and fined $2,000.00.

[19] 577/Med13/247D
[20] 680/MRT/14/289P
[21] 169/Phys08/90D

Derry[22]. This physiotherapist exposed the patient's breasts without clinical justification while acting as a physiotherapist, but it was found there was no evidence of sexual gratification or stimulation. There were other inadequacies in the physiotherapist's understanding of boundaries and professional standards. The Tribunal noted he narrowly avoided suspension but he was censured, fined $5,000.00 and had conditions placed on his practice for 12 months including presence of a chaperone and undertaking a mentoring programme. The submission was made by counsel for Dr Ben-Dom that that case too did not involve support for what the practitioner was doing as had been promoted in this case by Dr Ben-Dom.

Chebbi[23]. This medical practitioner did not offer a chaperone for an abdominal or breast examination in breach of a condition earlier imposed by the MCNZ that he have a chaperone and in breach of a voluntary undertaking concerning that. He was censured and fined $1,000.00 with conditions on his practice. Those conditions included a requirement for a chaperone but also for a notice in the doctor's waiting room of the requirement for a chaperone. There was particular concern about recurrence of this behaviour.

[335] The Tribunal has considered those cases with their distinctions from the present case and their similarities. In the present case the doctor has strenuously defended his actions and sought to justify them; he appears to continue to think that the approach he had was the right one and was justified; he raised the subject of breast health and allied topics when this was not clinically justified and proceeded in some cases to a physical examination; although that was consented to. He raised the subject of her []with Ms Y in a way that caused her distress and was inappropriate.

[336] The PCC is not alleging that there was any element of sexual motivation about what Dr Ben-Dom did in respect of these patients. That is important to emphasise because the Tribunal has approached the case on that basis, that is that there is no suggestion made of prurience or sexual gratification, but rather that Dr Ben-Dom approached the subject and undertook his examinations given his own views about the importance of promotion of breast health rather than the New Zealand standards that applied at the time and continue to apply.

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[22] 143/Phys07/79D

[23] 541/Med12/223D

[337] An aggravating feature is that this continued despite complaints having been made by several of the patients and with Dr Ben-Dom being made aware of that. Particularly in respect of Ms Kenny he had by then faced the issue and had given clear and written undertakings which he then breached.

[338] This case calls for a suspension. Dr Ben-Dom needs to undertake more education and self-analysis in the matter. There needs to be a deterrence factor about the orders that the Tribunal makes because it is in this way that standards can be set and the profession and the public protected from medical procedures that are not clinically justified. The conditions ordered by the Tribunal are referred to below but these will help to achieve that objective. In addition, however, the Tribunal is aware that there has been a significant period of time during which Dr Ben-Dom has effectively been unable to practice because of interim conditions imposed by the MCNZ. There was apparently a period of 13 months when he could not practice until those conditions were varied by order of the District Court. Following that time there has been the further period during which Dr Ben-Dom's ability to practise has been limited by those conditions. Although it seems to the Tribunal that Dr Ben-Dom has not in fact used that time for further reflection, the Tribunal has taken those periods of time into account as justifying a reduction in the suspension period that it would otherwise have ordered.

[339] Accordingly, the Tribunal does not order any further period of suspension. It is appropriate for deterrence purposes that there be however, a fine ordered as monetary penalty for Dr Ben-Dom and that is fixed at $5,000.00 and is ordered below.

[340] There must be conditions imposed on Dr Ben-Dom's future practice for a period of three years from when this decision takes effect. These are effectively as sought by the PCC and articulated below but in summary:

a) He needs to complete an education programme within 18 months.

b) There is required to be a female chaperone present who is a registered health professional when Dr Ben-Dom sees any patient for a breast examination at no additional cost to the practice he is working in or for. Dr Ben-Dom resisted this condition first because he had already had 17 months with his current employer where a chaperone was required to be provided which proved disruptive to the practice and costly; and that there should be no further need for a chaperone. Secondly, he resisted any chaperone for any female patient under 14 years of age but the Tribunal is not prepared to restrict the condition in that way. The condition expressly refers to "*any breast examination*" and most, if not all,

female patients under 14 years of age that he sees would not be having that examination.

c) There needs to be a notification to current or prospective employers of this decision and conditions. (The conditions proposed in this context by the PCC made reference to the undertaking of "*any intimate examination of a female patient*", but the Tribunal does not see the necessity to extend the chaperone requirement to that category of consultation).

d) Dr Ben-Dom must have in place at all times notices in both the waiting room and his consultation room in appropriate languages to inform patients of the chaperone requirement.

e) At the discretion of the MCNZ a random audit can be undertaken including checking appropriate chaperone notices and a review of patient notes.

f) There was also sought a condition concerning name suppression for Dr Ben-Dom, if ordered. Name suppression is not ordered by a decision of the majority of the Tribunal as noted below but, had there been name suppression, there would need to have been permission to the MCNZ to publish any conditions on the register and relevant entries on the MCNZ website to comply with its statutory obligations for notification. Similar orders have been made in other such cases where there has been a name suppression order.

Non-publication of names

[341] There has already been made certain orders for non-publication of names and these are affirmed below. Particularly the names and all identifying details and particulars of the affairs of the individual patients, except Ms Kenny who did not seek this, is ordered.

[342] The name of the practice, Waikanae Health Centre, the two witnesses who were or had been nurses there, Ms Crespin and Ms Goodwin, and the two general practitioners who had had dealings with Dr Ben-Dom and had been practising at the Waikanae Health Centre, Dr O'Connor and Dr Edwards, had been ordered on an interim basis but that was primarily to protect the identity of Dr Ben-Dom. No order for non-publication of Dr Ben-Dom's name is made by the Tribunal on a permanent basis and there is therefore no need for continuation of any order for non-publication of the names of those parties for that purpose. They had not otherwise sought name suppression and there is no established basis for this.

[343] The former practice nurse at the Waikanae Health Centre, Ms Parker, had an interim order for non-publication made by the Tribunal and the PCC sought to have this made into a permanent order on the basis that there was no need to identify her. Ms Parker effectively acknowledged at the time that there was no real basis for non-publication of her name. The only possible basis could be identification of Dr Ben-Dom if there had been an order for non-publication of his name; which there is not.

[344] The interim orders in respect of all those parties will lapse after 20 working days of the date this this decision takes effect. That will allow a time for consideration by individuals of their options. If an order for non-publication of Dr Ben-Dom's name had been made, then different considerations would have applied. Likewise, the interim order for non-publication of Ms Kenny's name will continue for that period because the lifting of the order in respect of her name may have the effect of identifying Dr Ben-Dom.

[345] An interim order for suppression of the name and identifying details of Mrs Ben-Dom had been made by the Tribunal. There was no formal application by her for permanent order for non-publication of her name or identifying details although she is referred to by Dr Ben-Dom in his affidavit in support of his application and is considered in that context. The interim order will lapse after 20 working days of the date that this decision takes effect.

[346] In the particular personal circumstances for Ms Y, there should be a permanent order also suppressing the detail of the exchanges she had with Dr Ben-Dom. These were personal matters of a highly sensitive nature; she did not want her personal details made known to her father who is a patient of Dr Ben-Dom and, although her name is ordered suppressed, the Tribunal considers the further protection should be given of suppressing that detail which is ordered below.

[347] Dr Ben-Dom applied for non-publication of his name and identifying details and particulars of his affairs. An affidavit in support affirmed 7 November 2019 referred to his daughter's then completing her fourth year at medical school in Auckland who he said was "*very concerned at the implications for her of publication of [his] name in connection with this case*" and referred to this as being the source of great concern and anxiety for her.

[348] The affidavit referred to Dr Ben-Dom's son who is an electrical engineer also studying in Auckland where Dr Ben-Dom speculated that publication of Dr Ben-Dom's surname "*may cause difficulties for him when working with medical academics*".

[349] The affidavit referred to Dr Ben-Dom's wife, Mrs Ben-Dom, working for a very reputable company in Wellington with many stakeholders when no one (with one exception) knows about this matter and no clients had been informed. Dr Ben-Dom again opined that there "*is a real risk to her reputation if our family name is published*".

[350] The affidavit spoke of Dr Ben-Dom's own work situation as a medical practitioner, he saying he has worked hard to build his reputation and his efforts to re-establish his career could be futile without suppression of his name which would result in his having difficulty financially supporting his daughter during her studies.

[351] It was submitted for Dr Ben-Dom in support of the application that his offending was at the low range of seriousness, that the offending did not warrant humiliation of Dr Ben-Dom and his family by publication, that the public would be adequately protected by the condition requiring notification to any future employer, and that the emphasis should be on rehabilitation in the absence of any order for suspension. Reference was made to certain cases, including the following extract:

> *"In the normal course where a professional person appearing before a Disciplinary Tribunal is found guilty of an offence, that person should expect that an order preventing publication of his or her name will not be made. This will be especially so where the offence found to be proved or omitted is sufficiently serious to justify striking off or suspension.*
> *Where the orders made by a Disciplinary Tribunal in relation to the future practice of a defendant are directed towards that person's rehabilitation and there is no striking off or suspension but rather as here, a decision that the practice may continue, there is much to be said for the view that publication of the defendant's name is contrary to the spirit of their decision and counter-productive".*

[352] The application was opposed by the PCC. No ground had been made out sufficient to justify any order, it was submitted. Reference was made to the case of *ANG v A Professional Conduct Committee*[24] where it was said that there were significant health and personal factors raised. Reliance was placed on *Davey v Professional Conduct Committee of the Nursing Council*[25] which included:

> "*A person's identity has been regarded as an essential part of the transparency of a process. I consider this to be so plainly correct that it is not necessary to dwell on it. Suspicions about who it is, and why their identity is being guarded, will inevitably lessen the standing of a system such as that envisaged by the appellant's submission*[26].

[24] [2016] NZHC 2949
[25] [2012] NZHC 765
[26] At [11]

and:
"

Whilst protection of the public is a component, the public interest is also advanced by confidence in the regulatory process. Openness is an integral component of that"[27]

[353] Reference was also made to *Tonga v Director of Proceedings*[28] where reliance was placed on the effect that publication would have on family members but name suppression, which had been ordered in the Tribunal, was not continued by the High Court.

[354] It was submitted that no significant factors, as normally required, had been demonstrated for non-publication in this case.

Non-publication of name - majority decision - Chairperson, Dr Krause, Dr Wilson, Mr Nichol

[355] Section 95 of the HPCA Act includes:

"***95 Hearings to be public unless Tribunal otherwise orders***
(1) Every hearing of the Tribunal must be held in public unless the Tribunal orders otherwise under this section or unless section 97 applies.

(2) If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on application by any of the parties or on its own initiative) make any 1 or more of the following orders:
...
(b) an order prohibiting the publication of any report or account of any part of a hearing, whether held in public or in private
...

(d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person."

[356] The presumption in section 95(1) of the Act that the Tribunal's hearings shall be in public is the primary principle and endorses the principle of open justice; but section 95(2) does give the Tribunal discretion to grant name suppression.

[357] The test is whether it is "*desirable*" to prohibit the publication of the name or any particulars of the affairs of the person in question and the Tribunal must consider both:

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[27] At [9]
[28] Christchurch High Court; CIV 2005-409-2244; Panckhurst J; 21 February 2006

a) The interest of any person and

b) The public interest.

[358] There have been many public interest factors identified by other Tribunal decisions. These include:

a) Openness and transparency of disciplinary proceedings.

b) Accountability of the disciplinary process.

c) Public interest in knowing the identity of a health practitioner charged with a disciplinary offence.

d) Unfairly impugning other practitioners.

[359] The decision on the application for non-publication of name in respect of Dr Ben-Dom (and, to the extent relevant, his wife) is a decision of majority of members of the Tribunal. They have considered the various factors raised by Dr Ben-Dom and taken into account previous decisions on the issue. Dr Ben-Dom has not effectively advanced significantly any matters concerning himself other than the impact this may have on his professional life, particularly in the context of rehabilitation referred to below. Unlike many other applications there is an absence of any suggestion of medical consequences or effect for him. He has relied on the effects that publication of his name will have, or could have, on family members.

[360] The majority has taken into account those opinions expressed by him. They are not substantiated in any way by evidence. The majority has had to use its own discretion on possible consequences of family members.

[361] There is some guidance from the *Tonga* case referred to where there was not any order for non-publication made despite the assessed consequences for the doctor's family member (upheld on appeal). Consequences for family members is raised often in the context of an application for non-publication of name. There are few, if any, cases where that has been a persuasive factor on its own and none has been brought to the attention of the Tribunal.

[362] The effect of publication of any health practitioner's name is always expected to have an impact on their reputation and ability to practise their profession. The impact may vary with individual cases, but it is certainly an accepted consequence.

[363] It is important for the Tribunal to make orders where a charge is found to be made out which protect the public and maintain standards in the profession. There should be no element of punishment in any decision on an application for non-publication of name.

[364] The majority has weighed carefully the possible impact that declining Dr Ben-Dom's application for non-publication will have on his rehabilitation into practice and ongoing practice. Dr Ben-Dom has continued to practise (albeit perhaps with some limitations arising from the conditions imposed on a temporary basis by the MCNZ) since the matter came to a head and the process leading to the Charge was commenced. Any publication of the matter including Dr Ben-Dom's name must refer to the Charge and its components, including the PCC position that there was no suggestion of sexual motivation in Dr Ben-Dom's behaviour and including his reasons, and the principles and authorities he relied on, for acting in the way that he did. The public can make its own assessment of the position in the light of that information.

[365] The evidence provided to the Tribunal suggests that Dr Ben-Dom enjoyed a significantly good reputation as a medical practitioner (apart from the matters to which the Charge refers). That should continue and any publication of his name in the limited context of the Charge should not have undue adverse consequences for him or his professional life.

[366] Also to be weighed is the right for patients, or potential patients, to be fully informed on matters relevant to the professional practice of a medical practitioner they are seeing or intending to see. Women are entitled to know about the approach that Dr Ben-Dom has had to breast health in the past and the total context of the matters to which this decision refers and are entitled to make their own decision on whether or not to consult with him or continue consulting with him in the circumstances.

[367] Another significant factor is that other practitioners should not be impugned by non-publication of Dr Ben-Dom's name. That can to a large extent be controlled by suppression of other identifying details but nevertheless is still a factor.

[368] The majority has weighed up these issues and concludes that it is not satisfied on the balance of probabilities that a case has been made out for an order for non-publication of Dr Ben-Dom's name.

[369] As to Mrs Ben-Dom's name, there was really no application by her in her own right for an order for non-publication. The interim order in respect of her name was made primarily so that it would not identify Dr Ben-Dom. The majority having decided not to make a permanent order for non-publication of Dr Ben-Dom's name, it follows from that that there should be no continuation of the interim order for Mrs Ben-Dom.

[370] Those interim orders will lapse 20 working days after this decision takes effect.

Non-publication of name - minority decision - Dr Bond

[371] It is the view of Dr Bond that there should be an order for non-publication of Dr Ben-Dom's name and identifying details and all particulars of his affairs which would in turn mean permanent orders for non-publication of his wife's name, the practice name, and the various personnel identified with the practice; and perhaps the name and identifying details of Ms Kenny. The reason for that would be that their names could identify Dr Ben-Dom.

[372] Dr Bond was persuaded by the effect that Dr Ben-Dom said publication of his name would have on his daughter and her career, his son and his career and on his wife's position. Those are persuasive matters for Dr Bond and outweigh the other considerations referred to by the majority.

[373] Dr Bond would have made an order for non-publication accordingly.

Costs

[374] The PCC sought an order for costs under section 101(1)(f) of the HPCA Act. It referred to case authority. Schedules of its various costs was produced totalling $219,585.26. A Schedule of the estimated costs for the Tribunal was produced totalling some $142,538.43. That gave a total as at the time of hearing of some $362,123.00. Since then, as submissions for the PCC had emphasised, there have been further costs incurred by the PCC in respect of the lengthy submissions from counsel for Dr Ben-Dom on the subject of costs needing reply. The PCC sought an order for 50% contribution to those costs from Dr Ben-Dom which is some $181,000.00.

[375] The oral submissions for Dr Ben-Dom addressed the percentage contribution issue. It was then sought that there be written submissions on issues pertaining to costs and these were provided in due course and replied to by the PCC.

The statutory provision

[376] Section 101(1) includes

> "(1) In any case to which section 100 applies, the Tribunal may—
> …
> (f) order that the health practitioner pay part or all of the costs and expenses of and incidental to any or all of the following:

(i) any investigation made by the Health and Disability Commissioner under the Health and Disability Commissioner Act 1994 in relation to the subject matter of the charge:
(ii)any inquiry made by a professional conduct committee in relation to the subject matter of the charge:
(iii)the prosecution of the charge by the Director of Proceedings or a professional conduct committee, as the case may be:
(iv)the hearing by the Tribunal".

Jurisdiction questions

[377] The submissions for Dr Ben-Dom addressed various jurisdictional questions. It was said that the costs and expenses to which section 101(1)(f) of the HPCA Act applies do not include the fees payable to Tribunal members, the cost of providing premises, the costs of the Executive Officer, or secretarial support. It was said there was a clear distinction in the provisions in section 101(1)(f) and it is only the "*actual and reasonable expenses*" incurred by the Tribunal in respect of the proceeding which qualify for the purposes of section 101(1)(f)(iv). The provision of suitable premises, the supply of the Executive Officer and secretarial support is to be, it was submitted, under section 104(1) at the responsible authority's expense (in this case the MCNZ). Provision of secretarial support would include the cost of a stenographer. Reference was made to section 103A of the HPCA Act recently enacted and to the remarks made at the time of enactment by the Minister of Health. Accordingly it was submitted that the following could not form part of any costs order against Dr Ben-Dom in favour of the PCC:

i. The fees payable to the Chair.
ii. The fees payable to Tribunal members.
iii. The fees payable to the executive officer.
iv. The cost of the stenographer.
v. The cost of the venue, including the PCC witness room.
vi. The cost of the White Board.

[378] The Tribunal rejects those submissions. The Tribunal is established under section 84 of the HPCA Act. Section 104 has statutory provision for resourcing of the Tribunal including that the responsible authority must at its expense make available suitable premises, the Executive Officer nominated and secretarial support. Under clause 4, Schedule 1, of the HPCA Act the chairperson of the Tribunal must be paid fees at a rate for the time being fixed by a majority of chairpersons of all responsible authorities and they are to agree on the principles that are to govern the determination of fees payable to any member of the Tribunal who is not the chairperson. Under the recently enacted

section 103A of the HPCA Act registration authorities are charged with resourcing the Tribunal's administration costs.

[379] Under section 101(1)(f) the Tribunal may order the health practitioner in question, in this case Dr Ben-Dom, to pay part or all of the costs and expenses of the four items listed which include (sub paragraph (ii)) any inquiry made by a professional conduct committee, (sub paragraph (iii)) the prosecution of the charge by a professional conduct committee and (sub paragraph (iv)) the hearing by the Tribunal. That anticipates that there will be taken into account by the Tribunal in considering whether to make any order under that provision all of the costs of inquiry and prosecution by the professional conduct committee and all of the costs incurred by the registration authority in resourcing the Tribunal for the hearing.

[380] Sub paragraph (f)(iv) of section 101(1) makes no reference to costs incurred by a professional conduct committee in respect of the hearing by the Tribunal but more generally refers to costs and expenses of and incidental to the hearing and this would include the costs for the responsible authority (in this case the MCNZ) in resourcing the Tribunal under section 104; and this includes suitable premises, the Executive Officer and secretarial support.

[381] The Tribunal accepts the submissions for the PCC in reply that section 103A deals expressly with administration costs for the Tribunal; and that the express provisions of subsection (6) which reads:

> (6) In this section, **general administration costs** means all expenses payable by or on behalf of the Tribunal in connection with the administration of the Tribunal that are not payable in respect of any proceeding under section 104(1)(a) or (b) (including, without limitation, insurance costs and member training costs)

encapsulates that all administration costs for the Tribunal not met by resourcing under section 104 are to be met by the resourcing provisions of section 103A.

[382] Payment of fees to the chairperson and Tribunal members will have been incurred by the Tribunal at the rates which have been fixed under clause 4, Schedule 1; and the rates taken into account in this case were the rates that had been so fixed.

[383] The Tribunal has jurisdiction to order costs in respect of the provision of an Executive Officer and costs in respect of the provision of secretarial support (subject to questions of quantification mentioned below). The cost of providing a venue, and a White Board are costs for the Tribunal to be resourced by the MCNZ and are eligible for an order for

costs against Dr Ben-Dom. The cost of the PCC witness room is more a cost incurred by the professional conduct committee in prosecution of the charge and can be taken into account in any order for costs against Dr Ben-Dom (subject to quantification argument).

[384] There was the further submission that in ordering a contribution towards costs against a practitioner the Tribunal is a judge in its own cause and therefore there is no jurisdiction. That is not accepted because it is for the responsible authority to resource the Tribunal under section 104 and to pay fees to the members under clause 4, Schedule 1. Those are costs and expenses directed by the legislation to be considered by the Tribunal under section 101(1)(f) as being "*costs and expenses of and incidental to … the hearing by the Tribunal*".

[385] Accordingly the Tribunal rejects the jurisdiction arguments raised by Dr Ben-Dom.

Quantification of costs

[386] Dr Ben-Dom next challenged the estimate of time spent by the chairperson and Tribunal members, which was estimated at 80 hours, he saying that the transcript showed 54 hours 10 minutes. Conceding short adjournments, it was submitted that the hearing for the chairperson and Tribunal members was less than 80 hours. That argument anticipates that under the agreement reached by the majority of responsible authorities under clause 4, Schedule 1, a chairperson and members will only be paid for sitting time and not other time and that is not the case. The cost estimate for the Tribunal was an estimate only.

[387] The Tribunal will take the submission into account in the totality of reasonableness; just as it will need to take into account the post-hearing and drafting time for this lengthy decision. The Tribunal does not accept that the jurisdiction to order a contribution to costs against a practitioner in respect of time spent by the chairperson or Tribunal members is limited to actual sitting time.

[388] There was then a challenge to the amounts estimated for the Executive Officer costs. There were two different rates, one up to 30 June 2019 and one from then on. It was submitted that a claim for 115 hours was for hearing time and was inaccurate. There is no such claim for that number of hours. The total time claimed is 187 hours 15 minutes and the reference to 115 is a rate per hour that applied for the earlier period. The Tribunal does not accept that its jurisdiction to order a contribution toward costs from a health practitioner in respect of the cost of provision of an Executive Officer is limited in any way to the hearing hours for the Tribunal. As noted above the responsible authority must make available the Executive Officer under its resourcing obligations and the cost of

doing so is a cost of the hearing by the Tribunal. It was said that no information was supplied as to what the nature of the work that the Executive Officer did outside the hearing; but the Tribunal is prepared to accept, in the absence of evidence to the contrary, that the work by the Executive Officer was reasonably put into preparation for this hearing and the conduct of it and is a cost reasonably incurred by the responsible authority, the MCNZ, in its resourcing obligations. There were all attendances for processing the charge, arrangements for telephone conferences and directions and drafting of orders, and exchanges concerning an appropriate hearing date and available Tribunal members. There were several applications before the hearing which needed to be processed by the Executive Officer and ruled on by the Tribunal or chairperson; there was the location of, and arrangements for, the appropriate hearing facility with allied accommodation; there were arrangements with Tribunal members for travel and accommodation requirements; and there were the other necessary liaisons that the Executive Officer had to have. That all takes time and the Tribunal has no information before it to question the time claimed. The general scheme of the HPCA Act is that all those costs can reasonably be taken into account in an order for costs against a practitioner.

[389] There then followed challenges by Dr Ben-Dom to the effectiveness of the cost of the stenographer claimed; the venue in Wellington; whether a negotiated rate for the venue was sought; why two members of the Tribunal were required to stay at the venue; and the practitioner's expectation that he would be consulted about these costs before they were incurred.

[390] There were then submissions about inquiries that had been made about alternative and cheaper venues which, it was said, could have been used. No evidence was tendered as to what was submitted or any opportunity for the Tribunal to assess the reasonableness of the alternative venues mentioned.

[391] The Tribunal hearings must be at a venue which is available, which must have the appropriate hearing and breakout rooms, must have suitable accommodation for Tribunal members, and must be reasonably located for travel and convenience. That is not always an easy exercise. The Tribunal is satisfied that none of the criticisms made by Dr Ben-Dom relating to these matters can be taken into account in an order for costs. The resource of a stenographer is a significantly important and valuable contribution to a hearing for the Tribunal, especially a lengthy hearing such as in this case where there

was extensive cross-examination and matters of record to be assessed by the Tribunal members.

[392] There was then a challenge to the provision by the PCC of the PCC witness room. It was said that no such facility was offered to Dr Ben-Dom for himself or his witnesses. A lack of even-handedness was submitted. Again alternative venues at a cheaper rate were mentioned. The Tribunal accepts the cost incurred by the PCC in providing a witness room. That is part of the costs of prosecution of the Charge by the PCC. It is available for consideration under an order for costs against the practitioner. The Tribunal accepts in this case that the patients who gave evidence required significant support and guidance throughout the process. Some were quite traumatised by the cross-examination conducted to "*destroy*" their credibility.

[393] There was then a challenge to the accommodation provided and the cost of this. That accommodation included two Tribunal members and the Executive Officer who needed to travel to Wellington for the purpose. The entry "*Flights (Akl – Wlg rtn x 2; Akl – Wlg rtn*)" referred to two return flights from Auckland to Wellington for one Tribunal member and one return flight for another who remained in Wellington.

[394] There was a challenge to the provision of meals for the seven people who remained at the hotel over the period. In fact the Schedule includes only lunches for seven people with morning and afternoon tea provided for Tribunal members, the parties, counsel and other persons present. The Tribunal does not accept that this is not a reasonable expense incurred as provision of a suitable premises to be the sourced by the MCNZ and available for a costs order against Dr Ben-Dom.

[395] The comments concerning travel and taxi fares are noted and taken into account in exercise of the Tribunal's discretion.

[396] There were then challenges made by Dr Ben-Dom as to PCC costs and expenses. First it was said that there was insufficient information provided as to the time spent by the respective PCC members. Secondly, it was submitted that the fees payable to PCC members are not costs and expenses of and incidental to the inquiry. In reply the PCC said that members of the PC Committee are paid for time spent and must abide by a strict policy of reimbursement. It was said for the PCC that this case involved a significant amount of time interviewing witnesses and assessing information gathered. That Dr Ben-Dom disputed each of the allegations added to the time spent.

[397] The Tribunal accepts the position taken by the PCC. Section 101(1)(f) includes reference to any inquiry made by a professional conduct committee in relation to the

subject matter as well as the prosecution of the Charge by the professional conduct committee. The submissions for Dr Ben-Dom spoke of voluntary work being done for nothing by the PCC members but did not address any legal basis for that suggestion. The Tribunal does not accept the submission that, fees having been paid to the PCC members, the MCNZ should bear the cost of that and it should not be available for consideration in an order for costs. There is no reason for the Tribunal to consider that in this case, which occupied 10 days of hearing and is encapsulated in this decision, should not have taken the time for inquiry and investigation and prosecution by the PCC that is claimed and the Tribunal is satisfied on the balance of probabilities that the claim is appropriate.

[398] There was then a challenge to the legal fees and expenses claimed by the PCC. First, it was said that the legal fees, claimed at $189,577.94, were high and challenges made to the lack of detail provided. The payment for 80 hours for legal adviser costs (in fact second counsel for the PCC) were challenged on the basis that the hearing did not occupy that period of time; and there was reference to payments made to another firm of lawyers. The PCC accepts that those latter costs, totalling $2,543.08 should be removed from the Schedule.

[399] A challenge was made to an entry for $900.00 for 4.5 hours of travel by one of the legal advisers. Relying on provisions in a document which refers to Crown Solicitors' costs, it was submitted that a reduced hourly rate should apply for travel. In reply it was submitted that Crown Solicitors operate on a different fee structure, with the criminal justice system following a different model. Unlike that model, there is no government contribution to the costs incurred by the responsible authority and its committees. In any event the rate, $200.00 per hour in the case of Ms Kennedy, a senior legal adviser, was said to be significantly lower than would be charged out if the legal adviser were employed by a law firm.

[400] As to legal costs incurred, it was submitted that it was inappropriate that there should be sought to be recovered costs for employees of the MCNZ and that it was open to question whether these were costs incurred by the PCC. In reply it was said that the MCNZ employs legal advisers to save incurring external legal costs and each legal adviser's costs based on time is charged out. To suggest, it was submitted, that an in-house

lawyer's time cannot be accounted for in a cost award is "*illogical and inconsistent with recent case law [cited]*[29]".

[401] The Tribunal accepts that the cost of legal advice to the PCC is a cost and expense of and incidental to an inquiry made by it and the prosecution of a charge by it. It further accepts that, to the extent that work is done by an employee or employees of the MCNZ, the cost of that work is appropriately recoverable by the PCC.

[402] It was submitted for Dr Ben-Dom that

> *" ... as a matter of fundamental principle legal fees incurred in prosecuting a practitioner should not be recoverable from that practitioner. To require a practitioner to pay part of the cost of a lawyer in prosecuting him – and in this case two lawyers – breaches fundamental notions of fair-play*".

The erosion of public confidence undermines "*the nobility of the legal system*", it was submitted. Nothing could be expected to erode public confidence in the legal system more than a requirement that a person contribute to the fees of the lawyers engaged to prosecute him or her, it was submitted. That principle was rejected for the PCC and is not accepted by the Tribunal. The provisions of section 101 are clear as noted above and the Tribunal is bound to apply the statutory law when that is sought by the PCC.

[403] Another challenge raised by Dr Ben-Dom was that the PCC employed junior counsel. The Tribunal notes what is said by him as to economies that his client made. It is noted that there was throughout an assistant, described as a paralegal, with senior counsel for Dr Ben-Dom. The PCC submitted that the need for junior counsel was obvious in this case. The hearing involved a total of 20 witnesses, including 3 experts. It was a lengthy hearing and involved a significant amount of preparation particularly with so many "*lay*" witnesses. The Tribunal does not accept that challenge by Dr Ben-Dom and does accept that this was an appropriate case for junior counsel to assist for the whole of the hearing. This decision, although lengthy, has tried to encapsulate the essence of many issues that are raised by Dr Ben-Dom, including his lengthy submissions on costs and the Tribunal has been helped by the presentation of the case by counsel.

Costs percentage to be ordered

[404] As noted above the PCC sought a contribution of 50% towards the cost involved.

[405] Submissions for Dr Ben-Dom included:

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[29] *Royal Forest and Bird Protection Society of New Zealand Inc v Northland Regional Council* [2019] NZHC 449; *McGuire v Secretary for Justice* [2018] NZSC 116 at [88]

a) That he had been successful in respect of many of the sub particulars of the Charge.

b) That he could not be faulted for having defended the Charge.

c) That it was not unreasonable to defend those parts of the Charge found against him, particularly on the general topic of breast health and a proactive approach to advice on that topic.

d) That he had incurred costs in defending those parts successfully defended.

e) That his approach to the general breast health question could not be described as idiosyncratic. His submissions again referred to that subject and sought to justify his stand on it with the submission that there was a substantial public interest in the topic and the medical profession needed guidance on it, such that it should bear a significant part of the costs of this hearing.

f) That there had been "*insufficient assistance afforded to Dr Ben-Dom in bridging the cultural gap between New Zealand and Israel and in adapting to the different approaches to medical practice in the two countries*".

g) That doctors who are contemplating moving to New Zealand to practise medicine should not be deterred from doing so "*by the knowledge that inadequate orientation will be provided, and draconian consequences visited upon the practitioner as a result of any failing flowing from the inadequate orientation*".

[406] Reference was then made to the relevance of means to pay with analogy being drawn to the ability to pay a fine in the criminal jurisdiction (*Director of Proceedings v Parry*[30]). Detail was given of Dr Ben-Dom's means and there has subsequently been an affidavit filed with the Tribunal (although this did not contain a clear and succinct tabulation of assets and liabilities, income and outgoings). The detail of that has been taken into account.

[407] It refers to a home (value not given) owned by a Family Trust for the Ben-Dom family subject to an outstanding commitment. Dr Ben-Dom has mentioned his income currently from employment and the fact that this is slightly reduced from earlier income because of costs of providing a chaperone by his employer. He refers to a modest vehicle, a significant cash deposit in his lawyer's trust account to meet his own legal fees, and a pension fund, which he wants to retain intact for his retirement, of a substantial amount.

[30] [2002] 2 NZLR 249

[408] He does not refer to debts other than legal costs which he says may be in excess of the sum in the savings account. Previous savings have been exhausted in legal fees. Dr Ben-Dom is supporting his daughter through her university academic career which includes accommodation costs (which he describes as a cultural expectation) and which he says will be a substantial outlay over the years of her qualification.

[409] He concludes that his ability to meet an order for costs is limited.

[410] The submissions for Dr Ben-Dom concluded that there should be no order for costs at all.

[411] The PCC does not dispute that means are relevant and that has been encapsulated in many of the decisions of the Tribunal and the courts on appeal.

[412] Other reply submissions for the PCC included:

a) That Dr Ben-Dom did not need to defend every detail of every aspect of the Charge.

b) That of the 42 sub particulars alleged only 10 were not proven.

c) That characterisation by Dr Ben-Dom of issues in the Charge as "*points of principle*" indicated a disturbing approach by him and complete disregard for the way his behaviour made the patients feel.

d) That it was only in respect of particular 12 that the Tribunal found against the PCC with all other particulars been established.

e) That, while Dr Ben-Dom was entitled to defend the Charge, matters were unreasonably defended in light of the convincing evidence to the contrary.

f) Rejecting suggestions that Dr Ben-Dom had insufficient assistance from the practice he worked for but, even so, that is a factor which goes to penalty rather than costs.

Costs – discussion

[413] Section 101 of the HPCA Act provides in this context:

> *"... the Tribunal may—*
>
> *....*
>
> *(f) order that the health practitioner pay part or all of the costs and expenses of and incidental to any or all of the following:*
>
> *(i) ...*
>
> *(ii) any inquiry made by a professional conduct committee in relation to the subject matter of the charge:*
>
> *(iii) the prosecution of the charge by ... a professional conduct committee, ...:*

(iv) the hearing by the Tribunal".

[414] There are two statements of principle relevant from decisions in the High Court. The first of these is *Cooray v Preliminary Proceedings Committee*[31]:

> "*It would appear from the cases before the Court that the Council [the MCNZ that then had jurisdiction in the matter] in other decisions made by it has in a general way taken 50% of total reasonable costs as a guide to a reasonable order for costs and has in individual cases where it has considered it is justified gone beyond that figure. In other cases where it has considered that such an order is not justified because of the circumstances of the case, and counsel has referred me to at least two cases where the practitioner pleaded guilty and lesser orders were made, the Council has made a downwards adjustment*".

[415] The second case mentioned is *Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council*[32]. There it was said[33]:

> "S*o far as costs orders were concerned, the Tribunal correctly addressed a number of authorities and principles. These included that professional groups should not be expected to bear all the costs of a disciplinary regime and that members of the profession who appeared on disciplinary charges should make a proper contribution towards the costs of the inquiry and a hearing; that costs are not punitive; that the practitioner's means, if known, are to be considered; that a practitioner has a right to defend himself and should not be deterred by the risk of a costs order; and that in a general way 50% of reasonable costs is a guide to an appropriate costs order subject to a discretion to adjust upwards or downwards…"*

[416] The starting point is 50% but there are other factors which may be taken into account to reduce or mitigate that proportion. Those factors include that the hearing was able to proceed on an agreed statement of facts, any co-operation from, or attendance at the hearing by, the practitioner, and consistency with the level of costs in previous decisions. The balance of costs of the prosecution after the orders for costs must be met by the profession itself.

[417] It is for the PCC, which is a committee appointed by the MCNZ, to choose whether to bring a charge and what that charge should address. The scheme of the HPCA Act is that all resources for the Tribunal are to be met from the responsible authorities. This is either for provision of administration costs under section 103A or for resourcing of Tribunal cost requirements under section 104. This means that the profession in question

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[31] HPCA Act HC: AP 23/94; 14/9/95; Doogue J;
[32] [2012] NZHC 1138
[33] Paragraph 34

as a whole will meet the whole of the costs incurred by a professional conduct committee of a responsible authority in any inquiry by it in relation to the subject matter of the charge and any prosecution of the charge by it; and will meet the resourcing of the Tribunal fees, expenses, suitable premises, Executive Officer and secretarial support.

[418] After the Tribunal has made a finding under section 100, it may order the health practitioner in question to pay part or all of the costs and expenses listed in sub paragraph (f).

[419] The PCC has provided information about the costs and expenses it has incurred in its inquiries and in prosecution of the Charge. The Tribunal accepts, apart from the items withdrawn totalling $2,543.08, that the cost estimates as provided to the hearing are reasonable costs and expenses incurred by the PCC in that inquiry and the prosecution of the Charge. There would additionally have been costs incurred in responding to the lengthy submission on costs from the practitioner and that needs to be taken into account in exercise of the Tribunal's discretion.

[420] As to costs and expenses of and incidental to the hearing by the Tribunal the Tribunal rejects the various challenges made to the amounts of those and finds that those costs and expenses were reasonably incurred as resource for the Tribunal (and that it has jurisdiction to make that finding). The estimate provided to the hearing did estimate some items then unknown, such as the time taken subsequently to write this decision and for consultation and decision on the costs question which had been reserved, and it may contain some items not entirely accurate.

[421] In deciding whether to make any order under such section 101(1) of the HPCA Act the Tribunal must take into account a number of factors and these include the means of the practitioner to meet any such order. In this case there were several interlocutory applications to be dealt with before the hearing commenced being applications by both parties. Then the hearing itself lasted effectively 10 days and that required meeting reasonable travel and accommodation expenses.

[422] The reason it took so long was that on the one hand Dr Ben-Dom sought to justify his philosophical approach to the practice of medicine in the context of the particulars and on the other hand he sought to discredit each of the patients in question by extensive cross-examination. The principal issue before the Tribunal was whether, in the individual particulars of each patient, steps were taken which were not clinically justified (and this referred to raising the topic of breast health, breast self-examination, and clinical breast examination) and then various detail about the manner of the consultation.

The Tribunal listened carefully to all the evidence and submissions on Dr Ben-Dom's behalf on the proactive approach thesis of his but had to do so specifically in the context of the presenting complaints of each patient and what was clinically justified for them. The hearing lasted as long as it did significantly because Dr Ben-Dom defended all allegations. There cannot be said to have been any co-operation on his behalf in reducing hearing time or cost.

[423] If he genuinely had realised by the time of the hearing that his philosophical approach was not acceptable in New Zealand,that was not apparent from his evidence, submissions on his behalf, questioning of witnesses, or total approach. Dr Ben-Dom has chosen to advocate his philosophy in any event and that has taken time and cost. In respect of some of the sub-particulars found not to be made out or separately not to warrant disciplinary sanction, such as adequacy of note-taking, Dr Ben-Dom effectively acknowledged that and that acknowledgement reduced the time that needed to be spent and should be taken into account for Dr Ben-Dom. Contrast with that, however, was the purported justification for not having made any notes concerning the consultation with Ms Kenny which has been discounted by the Tribunal.

[424] The Tribunal does not accept that there is any evidence of significant learning benefit to the medical profession in New Zealand from the way Dr Ben-Dom conducted his case or the authorities he mentioned. The material provided by him was not proven, had some limited reliability, and in some cases was self-conflicting. The medical profession in New Zealand sets its own standards and other practitioners should be aware of these. Particularly is this the case in respect of patient autonomy which has been a significant pillar in the provision of health services in New Zealand, at least since the Cartwright Inquiry. Dr Ben-Dom's proactive approach smacks of the attitude taken by certain medical practitioners before that Inquiry, one of "*I know what is best for you*".

[425] Considering the factors that can be taken into account in the context of costs, the Tribunal does not consider that any credit should be given to Dr Ben-Dom for any of these matters. The normal starting point is 50% for the reasons referred to in the cases mentioned above. There is no reason to depart from that in this case. The next question is the means of the practitioner. The Tribunal has taken account of the detail in Dr Ben-Dom's affidavit. The fact that Dr Ben-Dom has incurred significant cost and will need to use some, if not all, of the savings for further legal costs in defence of this matter was a choice that he made. He chose to espouse the defence that his philosophy was the right one despite the evidence to the contrary and he chose to have his defence conducted with

the cross-examination and argument that there has been. If that has incurred significant cost for him, that was his choice. It has also put the PCC to the expenses it has and the cost of resourcing the Tribunal.

[426] The Tribunal has had to weigh up all competing factors and concludes that the amount to order Dr Ben-Dom to pay pursuant to section 101(1)(f) is the sum of $160,000.00. This is approximately 50% of the sum of $320,000.00, an amount which the Tribunal has reduced from the claims that total of $362,123.00[34] having regard to all relevant factors.

Result and orders

[427] The Charge is found to be made out to the extent referred to above.

[428] Dr Ben-Dom is ordered censured.

[429] Dr Ben-Dom would have been suspended for a period but, in view of the factors mentioned, no order for suspension is made.

[430] Dr Ben-Dom is fined the sum of $5,000.00.

[431] Dr Ben-Dom may only practice his profession after commencement of practice following the date this decision takes effect for a period of 3 years in accordance with the following conditions:

a) Dr Ben-Dom is to complete an education programme designed to address medical ethics, sexual and professional boundaries, cultural competence, and clinical records. This is to be completed to the satisfaction of the MCNZ within 18 months of the date this decision takes effect. The education programme will be supervised by a vocationally registered peer approved by the MCNZ's Registrar on advice from its medical advisors. All this to be at Dr Ben-Dom's expense.

b) Dr Ben-Dom is to have a female chaperone present when seeing female patients for any breast examination and that chaperone must be a registered health professional and must be provided at any cost by Dr Ben-Dom with no additional cost to the practice for which Dr Ben-Dom is then working.

c) Dr Ben-Dom is to notify his current and any prospective employer of this decision and of these conditions, including especially condition b) concerning a female chaperone.

[34] See paragraph 373

d) Dr Ben-Dom must have in place at all times notices in both the waiting room and his consultation room (in the languages primarily spoken in his practice) to inform patients of the requirement that a female chaperone be present for any breast examination.

e) Dr Ben-Dom must meet the reasonable costs of any random audit undertaken at the discretion of the MCNZ to ensure compliance with these conditions and a review of the notes of female patients who have undergone breast examinations.

[432] Dr Ben-Dom is ordered to pay the sum of $102,400.00 towards the costs of inquiry made, and prosecution of this charge, by the PCC; and the sum of $57,600.00 towards the costs and expenses of and incidental to the hearing by the Tribunal being approximately the same proportions as costs incurred, namely an approximate division of 64%/36%.

[433] A permanent order is confirmed for non-publications of the names or particulars of the affairs or which may identify any of the patients referred to in this decision except for Ms Kenny; and the interim order for Ms Kenny will lapse 20 working days after this decision is notified to the parties.

[434] A permanent order is made for non-publication of the whole of the information relating to the consultation Dr Ben-Dom had with Ms Y.

[435] By majority decision, Dr Ben-Dom's application for an order for non-publication of his name or identifying details or any particulars of his affairs is declined but the interim order made by the Tribunal will continue for 20 working days after this decision is notified to the parties and then lapse.

[436] The interim orders for non-publication of the names and identifying details of Waikanae Health Centre, Dr Edwards, Dr O'Connor, Ms Crespin, and Ms Goodwin will all lapse 20 working days after this decision is notified to the parties.

[437] Pursuant to section 157 of the HPCA Act the Tribunal directs the Executive Officer:

a) To publish this decision, and a summary, on the Tribunal's website;

b) To request the MCNZ to publish either a summary of, or a reference to, the Tribunal's decision in its next available publication to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Auckland this 17th day of April 2020

David M Carden
Chairperson
Health Practitioners Disciplinary Tribunal

SCHEDULE

Pursuant to sections 81(2) and 91 of the Act, the Committee lays a charge that Dr Ran Ben-Dom acted in breach of his ethical obligations and accepted standards of practice, including but not limited to the Medical Council's Statement *Good Medical Practice* (June 2008, April 2013, June 2016); the Medical Council's Statement on *Sexual Boundaries in the Doctor-Patient Relationship – A resource for doctors* (October 2009); and the Medical Council's Statement on *The maintenance and retention of patient records* (August 2008), in the following manner:

1. On or about [ ] 2011, during a consultation with –**[Ms N**'s] [ ] year old son, Dr Ben-Dom raised the topic of breast health with [Ms N], in circumstances that did not clinically justify this discussion and in a manner that was inappropriate in that he raised the topic in front of her son and during an appointment for her son; and/or

2. On or about [ ] 2012, during a consultation with **[Ms E]** about a throat complaint, Dr Ben-Dom raised the topic of breast health and performed a breast examination in circumstances that did not clinically justify this examination and/or when [Ms E] did not expect or request this examination, and/or performed a breast examination in a manner that was inappropriate, in that he:

   (a) did not offer a chaperone; and/or

   (b) made inappropriate comments about [Ms E]'s physical appearance by stating "you know that you're very attractive, don't you?" or words to that effect; and/or

   (c) examined [Ms E]'s breasts in a manner that was inconsistent with accepted medical practice, namely by feeling only the front of her breasts and/or by not palpating under her arms; and/or

   (d) inaccurately recorded in [Ms E]'s patient notes that he had offered –[Ms E] the opportunity to have a chaperone present for the examination and that she had declined a chaperone; and/or

3. On or about [ ] 2012, during a consultation with **[Ms S]** about an upper respiratory tract infection and repeat prescriptions, Dr Ben-Dom raised the topic of breast health and performed a breast examination in circumstances that did not clinically justify this examination and/or when [Ms S] did not expect or request this examination, and/or performed a breast examination in a manner that was inappropriate, in that he:

   (a) examined [Ms S]'s breasts for an unreasonable length of time; and/or

   (b) spent more time on the topic of breast health and breast examination than on [Ms S]'s presenting complaint; and/or

4. On or about [ ] 2014, during a consultation with **[Ms D]** about blistered eczema on her hand, Dr Ben-Dom raised the topic of breast self-examination in circumstances that did not clinically justify this discussion and/or when [Ms D] did not expect or request advice on breast health and/or Dr Ben-Dom did not record of any discussion about breast health in [Ms D]'s patient notes; and/or

5. [Deleted at hearing]

6. On or about 15 August 2014, during a consultation with **[Ms N]** about stress**,** Dr Ben-Dom raised the topic of breast health and performed a breast examination in circumstances that did not clinically justify this examination and in a manner that was inappropriate, in that he:

   (a) did not use a privacy curtain or modesty blanket during the examination; and/or

   (b) commented inappropriately on the appearance of [Ms N]'s breasts by stating "you have good looking breasts for your age" or words to that effect; and/or

   (c) examined [Ms N]'s breasts for an unreasonable length of time; and/or

   (d) asked an inappropriate question during the examination, by asking Ms N if she had sex with her husband; and/or

   (e) did not record the breast examination in [Ms N]'s patient notes; and/or

7. [Deleted at hearing]

8. On or about [ ] 2015, during a consultation with **[Ms L]** about diarrhoea and a urinary tract infection, Dr Ben-Dom raised the topic of breast health and offered to perform a breast examination in circumstances that did not clinically justify this discussion and/or when [Ms L] did not expect or request advice on breast health and/or in a manner that was inappropriate, in that he:

   (a) raised the topic of breast health despite [Ms L] feeling unwell; and/or

   (b) asked [Ms L] to demonstrate breast self-examination in front of him when she had not requested advice on breast self-examination; and/or

   (c) did not record any discussion about breast health in [Ms L]'s patient notes; and/or

9. On or about [ ] 2015, during a consultation with [ ] year old **[Ms Y]** about a throat infection, Dr Ben-Dom raised [ ] matters with her when this was not relevant to the consultation and/or was inappropriate, in that he

   (a) asked her whether she [ ]; and/or

   (b) asked her if [ ]; and/or

   (c) told her that [ ] or words to that effect; and/or

   (d) told her to consider [ ] and/or

   (e) indicated to her that the questions about [ ] were required for general health screening purposes; and/or

   (f) did not make any record of this discussion in [Ms Y]'s patient notes; and/or

10. On or about [ ] 2016, during a consultation with **[Ms A]** about asthma, Dr Ben-Dom raised the topic of breast health in circumstances that did not clinically justify this discussion and/or when [Ms A] did not expect or request advice on breast health and/or in a manner that was inappropriate, in that he:

   (a) repeatedly offered to perform a breast examination and/or to demonstrate breast self-examination after [Ms A] had declined his initial offer of a breast examination; and/or

(b) asked [Ms A]'s [ ] year old daughter, who was present during the consultation, to leave the room and then reiterated his offer to perform a breast examination; and/or

(c) did not make any record of any discussion about breast health in [Ms A]'s patient notes; and/or

11. On or about 24 May 2017, during a consultation with **Alison Kenny** about a repeat prescription for venlafaxine, Dr Ben-Dom raised the topic of breast health and performed a breast examination in circumstances that did not clinically justify this discussion or examination and/or in a manner that was inappropriate, in that:

    (a) raising the subject of breast health was in breach of Dr Ben-Dom's written undertaking to Waikanae Health Centre (dated 1 June 2016) that he would "utterly avoid" raising breast cancer prevention unless it was brought up by the patient; and/or

    (b) no chaperone was offered for the discussion of breast health or during the breast examination, in breach of Dr Ben-Dom's written undertaking to Waikanae Health Centre (dated 1 June 2016) that a "chaperone nurse would be offered to be present during the discussion and always present during the physical examination"; and/or

    (c) he made inappropriate comments about Alison Kenny's breasts during the breast examination, by stating "for your age, they're quite full" or words to that effect; and/or

    (d) no record was made of the breast examination in Alison Kenny's patient records; and/or

12. In addition, also on or about 24 May 2017, during his consultation with **Alison Kenny**, Dr Ben-Dom offered to perform a cervical smear test on Alison Kenny in circumstances where it was inappropriate, in that:

    (a) no chaperone was offered; and/or

    (b) no record was made of the offer of a smear test.

The conduct alleged above amounts to professional misconduct in that, either separately or cumulatively, it amounts to malpractice or negligence in relation to his scope of practice pursuant to section 100(1)(a) of the Act; and/or has brought or is likely to bring discredit to the profession, pursuant to section 100(1)(b) of the Act.