

THE MEDICAL TRIBUNAL
OF NEW SOUTH WALES
AT SYDNEY

Thursday 21 April 2005

In Re: Dr Elvin Cheng

And: The Medical Practice Act 1992

DEPUTY CHAIR

Her Honour Judge A AINSLIE-WALLACE

MEMBERS

Dr SAW HOOI TOH

Dr STEPHEN ALLNUTT

Associate Professor PAUL McNEILL

REASONS FOR DETERMINATION

Order:

Pursuant to *Clause 6 of Schedule 2 to the Medical Practice Act 1992* the Tribunal has made a Non Publication Order in respect of the name of the patient referred to in the proceedings.

By a complaint dated 30th August 2004 the Health Care Complaints Commission (HCCC) claimed that the practitioner, Dr Elvin Cheng, has been guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of *section 36* and *section 37* of the *Medical Practice Act 1992*.

The particulars of the complaint are that:

At all relevant times the practitioner worked as a general practitioner at 21 John Street, Lidcombe. Between 13 August 1999 and 30th April 2001 the practitioner treated Patient A on sixty-one occasions.

On 30th April 2001 during a professional consultation the practitioner engaged in inappropriate physical and sexual contact with patient A.

Between 2 September 1999 and 30th April 2001 during professional consultations the practitioner engaged in inappropriate physical and sexual contact with Patient A on about five occasions.

Background Facts

1. At the commencement of the hearing the parties tendered a statement of agreed facts¹. In addition to that statement of agreed facts, many of the facts before the Tribunal were undisputed.
2. The practitioner is a registered medical practitioner. He was first registered in 1985 and has practised continuously in New South Wales since and as a general practitioner since 1987.
3. On 13th August 1999 Patient A consulted the practitioner for the first time, she was then aged thirty-five. After that first consultation she saw the practitioner in his surgery on some sixty-one occasions until the 30th April 2001. There was no dispute that during these visits she presented with medical complaints and/or clinical signs which were treated appropriately by the practitioner.
4. On 2nd September 1999, according to the practitioner² and his clinical notes³, Patient A complained of a history of vaginal discharge. The practitioner conducted a physical and vaginal examination of her. During the vaginal examination the practitioner said that the patient began rocking her pelvis. The practitioner said that he was shocked by her reaction and quickly finished the examination after taking a swab.
5. Patient A returned the following day late in the afternoon again complaining of persisting vaginal symptoms. The practitioner performed another vaginal examination. The patient again began rocking her hips and the practitioner felt her vaginal muscles grip his fingers. He said that she looked excited and moaned in a way which he took to be sexual excitement. When he finished the examination she hugged him and asked him *“Can I have a chat with you?”* He asked her to wait until he had finished seeing his other patients and then they discussed her background, her migration to Australia and her unhappy marriage. She asked the practitioner whether they could have a cup of tea in a coffee shop

¹ Schedule A to the Reasons for Determination

² Statement of Practitioner, Tab 1 Exhibit 1

³ Tab 15 Exhibit A

one day. The practitioner said in a later interview⁴ that she asked him whether they could be friends and he told her that *"I can only see her in the surgery, I cannot do anything outside the surgery and I cannot go beyond any normal doctor/patient relationship"*. The practitioner drove Patient A home.

6. The practitioner continued to treat Patient A for a variety of illnesses including depression for which he prescribed Zoloft. At a number of her visits, Patient A complained of vaginal irritation or discharge. The practitioner said that on these occasions he performed a vaginal examination and on each occasion the patient rocked her pelvis in apparent sexual excitement.
7. On 20th November 2000 Patient A attended the practitioner and complained of irregular menstruation, abdominal pain and requested a Pap smear. While the practitioner was conducting the vaginal examination, the patient again rocked her hips and attempted to touch the practitioner's penis through his trousers. In his statement⁵ the practitioner said that he was sexually aroused and *"did something inappropriate"*. What he did was to commence a vaginal examination of the patient which progressed to masturbating her and touching her bottom. At the conclusion of the sexual conduct Patient A said to the practitioner that she *"felt comfortable"*.
8. This sexual contact occurred in the course of clinical examinations conducted on the 8th March 2001, 4th April, 18th April and 30th April 2001. On each of these occasions before the sexual contact the patient said that she *"felt comfortable"* which the practitioner clearly interpreted as an invitation for sexual contact.
9. The next contact between the practitioner and Patient A was on the 9th May 2001 when she rang him and asked him what he proposed to give her for her birthday on the following day. The practitioner told the patient that he did not wish this contact to continue because of his wife and family and asked her to go to another doctor. Patient A told the practitioner that she had a video of his conduct with her

⁴ Record of Interview with Police 28th May 2001, Tab 11 Exhibit A, Question 47

⁵ Tab 1, Exhibit 1 paragraph 21

in the surgery and said that she had been advised to go to the HCCC and asked him what he wanted to do about it.

10. What then transpired is that the patient told the practitioner that if he paid her \$300,000 she would give him the video and not expose him. During these negotiations, the patient was assisted by an intermediary who called on the practitioner and showed him glimpses of the video to persuade him of its existence.
11. On the 28th May 2001 the practitioner complained to the police about the attempted extortion by Patient A. An interview was conducted with the police in which the practitioner maintained that his conduct with the patient was entirely lawful and normal as between doctor and patient. Patient A was charged and convicted of attempted extortion of the practitioner. The practitioner was a witness at the trial. Patient A was convicted and ultimately was given a suspended prison sentence. The police, when they charged Patient A were given the video and the investigating officer made the complaint about the practitioner to the HCCC.
12. The video taken by the patient⁶ lasts about ten minutes and shows the practitioner and Patient A in his rooms. The patient removes her trousers and lies on the examination couch. The practitioner appears to examine her abdomen and chest then lifts her bra and appears to examine her breasts. He strokes her abdomen and leg. The practitioner removes her underpants, shines the examination light onto her genital area and appears to examine her vulva. He removes his stethoscope and watch then masturbates the patient, strokes her breast, puts his mouth on her breast while stroking her breast. About four minutes after he had begun masturbating her he turned her onto her side and massaged her buttocks. The patient does not move except to raise her right arm briefly and touch his shoulder. The practitioner remains fully clothed.⁷

⁶ Exhibit E

⁷ Statement of Agreed Facts – Exhibit B

13. In his evidence, the practitioner said that on each of the five occasions on which there was sexual contact between them, he performed the same type of act, that is, masturbating the patient while he remained clothed. He said that he did not believe that each occasion lasted as long as the ten minutes depicted on the video. He believed that the patient reached orgasm on each occasion. Each episode commenced as if it were a clinical vaginal examination and moved to the sexual contact described. It was only on the 20th November 2000 that the patient complained of any symptom which would have indicated the need for a vaginal examination.
14. The practitioner has continued to practise.
15. The practitioner agreed that from the 3rd September 1999 ⁸ he knew that the patient was reacting to his examination in a sexual way. He also acknowledged that he too received a degree of sexual gratification from the examination process,⁹ although he said *“I did have the desire of sexual, you know getting sexual gratification from the contact, and I think that’s why I lost the judgment in realising it.”* The Tribunal finds that although the practitioner said his judgment was clouded, he knew from the 3rd September 1999 that his contact with Patient A was outside the boundaries of proper professional conduct. Whether he appreciated the full gravity of it is another matter.

Personal Background of the Practitioner

16. The practitioner was born in Hong Kong in 1960 and is one of seven children. He migrated to Australia in about 1977 or 1978 and over the next ten years his family also came to live in Australia. He obtained his qualifications in medicine at Sydney University graduating in 1984. In 1988 he commenced practice as a general practitioner. Until these events, the practitioner practised alone but has since 2002 taken on another general practitioner who works three sessions each week in his practice and he hopes to take on another general practitioner shortly.

⁸ Transcript page 26 line 8-10

⁹ Transcript page 26 line 48-50

17. In his statement the practitioner said that he had a traditional Chinese upbringing in which sex was a forbidden topic. He said he was shy and had little contact with girls. He believes that his decision to become a Christian made him more reticent about sexual matters. He was, however, not a complete ingénue, the practitioner was at all relevant times a married man and he has three teenage children. In 1984 the practitioner married a woman he had met through the church. She was his first girlfriend. It seems from the practitioner's statement that their sexual life was unfulfilling and that his wife did not appear to enjoy sex with him.
18. There were other strains in their relationship. The practitioner was working hard at having his practice accredited which required a number of hours to be spent each week doing necessary paper work whereas his wife devoted a great deal of energy to the children's education and pursuits. Being a sole practitioner, the practitioner said that he worked about sixty-five hours each week in consultation with patients.
19. The Tribunal accepts that at the time these events occurred, the practitioner was under considerable personal and professional stress.
20. Patient A approached the practitioner on 9th May 2001 and on a number of occasions after that before the practitioner complained to the police on 28th May 2001. Before he went to the police, he told his wife of his sexual misconduct and sought counselling from the Pastor of his Church.
21. The Pastor, Reverend Charles Cheung, wrote ¹⁰ that the practitioner, after confessing his misconduct to him, resigned from his post as Sunday School teacher and all other positions which he held at the church ¹¹. Since then Reverend Cheung has offered counselling to both the practitioner and his wife and, in his opinion, there has been a marked improvement in their relationship. The practitioner enjoys the continuing support of the Pastor and the Church community to whom he also revealed his misconduct.

¹⁰ Exhibit 1 tab 2

¹¹ Reference of Gabriel Chan, Exhibit 1, tab 3

22. The practitioner first consulted a psychiatrist, Dr Keith Chee on 15th June 2001 and has seen Dr Chee for monthly counselling and therapy. Dr Chee's reports ¹² indicate that he also saw the practitioner's wife on a number of occasions. Over the course of their consultations, Dr Chee has encouraged the practitioner to address the matters which were causing him personal and professional stress, for example, by reducing the hours of work and allowing more time for his wife and family. Dr Chee worked with the practitioner on developing an understanding of professional boundaries and circumstances in which he may become vulnerable to overstepping those boundaries. Dr Chee reported that in his opinion, "*the practitioner has a genuine and continuing interest in learning about boundary issues in doctor-patient relationships and identifying the appropriate standards in professional boundaries*" ¹³.
23. The practitioner also consulted Dr Murray Wright, a psychiatrist, who prepared reports for the Tribunal hearing. Dr Wright also gave evidence to the Tribunal. He first saw the practitioner in March 2004 and has seen him on a number of occasions since. In his report of 23 March 2004, Dr Wright said that:
- "...he did understand the sexualised nature of his patient's behaviour and his own sexual response, and that, at least in part, his failure to deal appropriately with the situation was related to a degree of sexual gratification which he experienced through this behaviour..."*
- I believe that Dr Cheng's involvement in what became a sexualised interaction between himself and his patient was opportunistic, and I accept that he probably did not initiate the sexualised interaction. However, he failed to deal appropriately with his patient's sexualised behaviour, and I believe this was because he experienced a degree of sexual gratification himself and so colluded in an interaction which became more sexualised as time went on."*
24. Dr Wright believed that the practitioner's failure to terminate the relationship with Patient A was caused by a number of factors including his lack of sophistication and experience, personal isolation and professional demands. This was exacerbated by the practitioner's "*very poor understanding*" of professional boundaries and how to deal with transgressions.

¹² Exhibit 1, tab 10

¹³ Report 11th March 2005

25. Throughout the course of the consultations between Dr Wright and the practitioner, Dr Wright formed the opinion that there was a very low prospect of any recurrence of sexual misconduct because the practitioner was addressing the factors which led to the misconduct by cutting down his professional hours and continuing counselling with Dr Chee. Through his consultations with the practitioner, Dr Wright said that the practitioner had developed a better understanding of boundary issues and how to cope with any transgressions, such that it was “*sufficient*” to enable him to practice without risk to his patients.
26. Dr Wright’s evidence to the Tribunal was that he remained of the view that the practitioner had a low risk of re-offending. He rejected the proposition put to him by counsel for the complainant that the practitioner was predatory of his patient but said that he was opportunistic, his reaction being “*a response to the opportunities that arise without due reflection or regard*” ¹⁴.
27. Early in the consultations between Dr Wright and the practitioner, Dr Wright thought that the practitioner was apportioning blame for the conduct to both himself and the patient. Later in their discussions, Dr Wright said that it became apparent that the practitioner understood the complexity of the patient’s condition and that she herself may have had needs which translated into inappropriate sexual behaviour when he could not manage the boundary transgression. This position was well articulated by the practitioner in his evidence and the Tribunal accepts that he clearly understands his role in failing to stop the relationship with Patient A at an early stage.
28. There was abundant evidence before the Tribunal from the practitioner and others to whom he had spoken within his social and professional circle that he has been deeply shamed and humiliated by his conduct.
29. Although the practitioner clearly and widely admitted his wrongdoing to his wife, the Pastor and church groups, he was not as forthcoming with the police. On the

¹⁴ Transcript, page 56 line 18-20

28th May 2001 when he made the complaint to the police, he participated in a recorded interview in which he maintained that his contact with Patient A was not improper and that he had treated her no differently from how he treated his other patients. Clearly that was not correct and the practitioner acknowledged it as such to the Tribunal. He explained it by saying that he was trying to minimise his role in the sexual conduct, that he was afraid that the police would charge him and that he may face disciplinary action. Although the Tribunal regards this course as regrettable, in the light of all of the evidence which points to the practitioner's rehabilitation, the Tribunal is of the view that this does not cause it to disregard or to have doubts about the genuineness of the rehabilitation.

30. A submission was made on behalf of the complainant that the practitioner failed to concede the misconduct to the HCCC before January 2004 when he had known of the complaint since July 2002. The practitioner had sought and was receiving legal advice throughout this period, and the Tribunal is of the view that it would not be appropriate to draw any conclusion adverse to the practitioner for not making admissions in these circumstances.
31. It was suggested to Dr Wright in cross-examination that the practitioner was merely repeating to him the content of his counselling sessions with Dr Chee without having really understood the principles underlying the counselling. Dr Wright said that his discussions with the practitioner about this revealed a sophisticated understanding of the issues that did not imply rote learning or insincere responses.¹⁵ The Tribunal accepts that the practitioner has understood and learned about the ethical issues surrounding his misconduct from various sources but principally from his sessions with Dr Chee.
32. The HCCC engaged Dr Ian Chung to perform a peer review of the practitioner. That review included viewing the videotaped encounter between the practitioner and Patient A on 30th April 2001. Dr Chung regarded the practitioner's actions as inappropriate and unprofessional and warranting the extreme disapproval of Dr Chung and his peers.¹⁶

¹⁵ Transcript page 65 line 25 ff

¹⁶ Exhibit A, tab 14

Discussion

33. This matter concerns *sections 36 and 37 of the Medical Practice Act 1992 (the Act)*.

34. Those sections are in the following form:

S 36(1) “For the purposes of this Act, unsatisfactory professional conduct of a registered medical practitioner includes each of the following:..

(a) Any conduct that demonstrates a lack of adequate knowledge, skill, judgement or care, but the practitioner in the practice of medicine.....

(m) Any other improper or unethical conduct relating to the practice or purported practice of medicine.”

S 37 “For the purposes of this Act, professional misconduct of a registered medical practitioner means unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner’s name from the Register.”

35. The practitioner admitted the acts alleged and conceded that they constituted professional misconduct. The Tribunal is satisfied to the relevant standard ¹⁷ that the practitioner is guilty of professional misconduct.

36. The issues at the hearing concerned the appropriate orders which should flow from this finding.

37. The jurisdiction of the Tribunal is a protective not punitive one. The purpose of disciplinary proceedings is to maintain proper ethical and professional standards in protection of the community and also to protect the good standing and reputation of the profession. When an order for suspension or removal from practice is made, its purpose is *“from the public point of view, for the protection of those who require protection, and from the professional point of view, in order that abuse of privilege may not lead to loss of privilege.”* ¹⁸

¹⁷ *Briginshaw v Briginshaw* (1938) 60 CLR 336. That is that the Tribunal must be comfortably satisfied on the balance of probabilities but that having regard to the serious nature of the charge and the consequences, the satisfaction cannot be produced by “inexact proofs, indefinite testimony or indirect references”.

¹⁸ *Clyne v NSW Bar Association* (1960) 104 CLR 186 at 201-202

38. At the outset, the complainant conceded that removal of the practitioner's name from the register was not an appropriate order but that the Tribunal should order that the practitioner be suspended from practising for a period. That was refined in submissions during which the complainant submitted that a period of twelve months suspension would be appropriate.
39. For the practitioner it was argued that suspension was not a necessary result of the finding of professional misconduct.
40. In determining an appropriate order which meets the objects of the act, the Tribunal has taken into account the steps which the practitioner has taken towards his rehabilitation since the sexual misconduct. The Tribunal accepts that the practitioner has taken positive and appropriate steps to address the factors which contributed to his misconduct and that he will continue to seek professional help.
41. The evidence of Dr Wright, in particular, persuades the Tribunal that although the practitioner may not have a perfect understanding of the nature of professional boundaries, he has progressed in his understanding of the complexities of the issue to the stage where he may practise safely and pose no risk to the public. The Tribunal also accepts the opinion of Dr Wright that the sense of shame and humiliation to the practitioner both professionally and privately which this conduct has brought is also a factor in the determination that the practitioner poses a low risk to the public if he were to continue to practise.
42. The Tribunal has come to the view that there is no protective function which is to be served by an order suspending the practitioner from medical practice.
43. Nonetheless, the conduct of the practitioner was a grave breach of the trust and power which is a consequence of his right to practise. Even though the Tribunal accepts that his judgment of the gravity of the conduct may have been clouded by the sexual gratification he obtained from the contact with Patient A, he knew that the relationship with the patient was not a proper one, yet he allowed it to continue.

44. The conduct deserves to be denounced in protection of the standing and reputation of the profession. In the view of the Tribunal this can be achieved if the practitioner is severely reprimanded and fined.
45. The parties agreed that the Tribunal should impose conditions on the practitioner's registration.¹⁹ Two sets of conditions were proposed depending on whether the Tribunal imposed a period of suspension of the practitioner's right to practice. The Tribunal will impose the relevant agreed conditions.

Orders:

1. That Dr Cheng is severely reprimanded
2. That Dr Cheng be fined the sum of \$10,000.
3. That the following conditions be placed on Dr Cheng's registration;
 - a. Dr Cheng is to attend upon a psychiatrist of his choice at a frequency to be determined by his psychiatrist. Dr Cheng is to authorise the psychiatrist to report to the Medical Board on treatment and to inform the Board of failure to attend for treatment, termination of treatment or if there is a significant change in health status including a significant temporary change. Dr Cheng is to attend upon the psychiatrist for a period of two years.
 - b. Dr Cheng is to continue his education in relation to maintenance of proper professional boundaries and medical ethics for a period of two years from the date of this order. Dr Cheng is to report to the Medical Board every six months on his continuing education.
 - c. Dr Cheng is to continue to employ a general practitioner or work with at least one other medical practitioner for a period of two years from the date of this order. Dr Cheng is to report to the Medical Board every three months on his employment of a general practitioner including the name of the practitioner and the hours worked.
 - d. Dr Cheng is not to work as a medical practitioner for more than 50 hours per week for a period of two years from the date of this order. Dr Cheng is to report to the Medical Board every three months on the hours worked.

¹⁹ A document to that effect was prepared and delivered to chambers after the conclusion of the case and will now be marked as Ex F.

- e. Dr Cheng is to attend for review by Dr Wright or such other Board nominated psychiatrist as the Medical Board may nominate every six months for a period of two years from the date of this order. Dr Cheng is to authorise the psychiatrist to report to the Board.
- f. These conditions may be varied or eased by the Medical Board at any time.

A. Ainslie- Wallace J

Deputy Chair

I certify that these 45 paragraphs are a copy of the Tribunal's Reasons for Determination.

Associate to Her Honour Judge Ainslie-Wallace

11 January, 2007

Dr Stephen Allnut

Member

Dr Saw Hooi Toh

Member

Associate Professor Paul McNeill

Member

Ainslie-Wallace J

Deputy Chair

I certify that these 45 paragraphs are a copy of the Tribunal's Reasons for Determination.

Associate to Her Honour Judge Ainslie-Wallace
11 January, 2007

IN RE: Dr Elvin Cheng

AND: The Medical Practice Act (1992)

DEPUTY CHAIRMAN

JUDGE A M AINSLIE-WALLACE

JUDGMENT

On the practitioner's application for suppression of his name.

Background

46. In the course of disciplinary proceedings between the practitioner and the Health Care Complaints Commission (the HCCC), an order was sought suppressing the name of the practitioner from publication.
47. The facts and circumstances of the case are referred to in detail in the determination of the Tribunal, however for the purposes of this judgement, it is sufficient to relate that the practitioner engaged in sexual misconduct with a patient (Patient A) over a period of months. On the last of these occasions, 30th April 2001, Patient A took video film of the sexual conduct. When the practitioner brought the relationship between them to an end, the patient used the video in an attempt to extort \$300,000 from him.
48. The practitioner took the matter to the police and Patient A was charged and later convicted by a jury. The practitioner was a witness in those proceedings which necessarily involved the playing of the video to the jury.
49. In both the District Court and in the Court of Criminal Appeal, an order was made suppressing the name of the practitioner as complainant in the trial of Patient A. Clearly the reason for that order was to protect the identity of the practitioner as a victim of attempted blackmail so as to encourage others who may find themselves in a similar position to come forward.

50. It was argued before the Tribunal that to allow the practitioner's name to be published in association with the disciplinary proceedings would have the effect of completing the threat made to the practitioner by Patient A, that is, it would expose his sexual misconduct with her to the wider community and damage his reputation and standing in the community.
51. The normal rule and the principle of courts is that justice is administered in courts which are open to the public. Circumstances sometimes require exceptions to this rule, the circumstance of attempted extortion is one where the identity of the victim is suppressed.
52. Proceedings before a Medical Tribunal brought under the *Medical Practice Act* are not punitive but are for the protection of the community and of the reputation and standing of the medical profession. It is inherent in the requirement to protect the public that information about a practitioner be readily available to enable a potential patient, should he/she so wish, to enquire if the practitioner had been the subject of an order under the Act or to make a complaint about the practitioner.
53. In this case it would be inconsistent with the purpose of the Act to make an order which suppressed the name of the practitioner. For those reasons, I declined to suppress the name of the practitioner.

I certify that these 8 paragraphs are a copy of her Honour's judgment.

.....
Associate to Her Honour Judge Ainslie-Wallace
21st April 2005