

MEDICAL TRIBUNAL OF NEW SOUTH WALES

DEPUTY CHAIRPERSON: JUDGE J B SINCLAIR QC

**MEMBERS: DR C HAMPSHIRE
DR B WESTMORE
MS R SEXTON**



~~5 JUNE 1998~~

RE: DR JULES VAN LEER AND THE MEDICAL PRACTICE ACT, 1992

REASONS FOR DETERMINATION

This Tribunal is charged with inquiring into a complaint of Professional Misconduct and/or Unsatisfactory Professional Conduct against the Respondent, Dr Jules Van Leer. Particulars of the complaint are as follows -

1. In 1992, the practitioner commenced to treat a female patient, Ms N, and on 22 January 1994, Ms N consulted the practitioner for treatment of a chest infection, during which the practitioner inappropriately:
 - I without wearing gloves, put his hand between Ms N's legs, in the perineal and vaginal area, and started rubbing;
 - II attempted to masturbate Ms N.
2. The practitioner made the following inappropriate comments to Ms N:
 - I asked Ms N 'Do you masturbate?' Or words to this effect.
 - II Stated to Ms N "you are nice and moist'. You are very tense and you're letting off sexual vibes' and 'Would you rather have intercourse', or words to this effect.

The Respondent denies the allegations of improper or unethical conduct made by the complainant. The issue to be determined by the Tribunal principally one as to the credibility of the principal parties concerned namely the patient and the Respondent. A further issue which arose shortly before the hearing is whether there is any real possibility that at the relevant time the Patient was suffering from delirium or delusions in respect of the relevant events.

The Background to this Complaint.

The respondent graduated from Medicine from Queensland University in 1979. Thereafter he worked as a general practitioner in the RAAF for three years and practiced as a GP in Lockhart, a small town near Wagga, came to Tweed Heads in 1989.

The complainant, who was then aged 70 years, resided at Benora Point, Tweed Heads with her husband to whom she had been married, and divorced; and remarried in 1992. She was relatively familiar with me matters having worked as a secretary to several doctors in Sydney for a considerable period and was, to use her words, "from a medical family". The patient first consulted the respondent in March 1993 and continued his surgery for various complaints to attend until 22 January 1994.

Her medical history during that time may be summarised as follows.

On 16 March 1993 in the course of carrying out a complete medical check up the respondent found a lump in the patient's right breast. A mamma confirmed the

lump in the chest and she was referred to Professor McCaffrey, an appropriate specialist, who treated the patient for breast cancer. For the next few months she was under the care of Professor McCaffrey who carried out a right mastectomy. In September 1993 she again consulted the respondent. The patient was coughing up phlegm, she had a temperature, was tired and had lost her appetite for which the respondent gave her a broad spectrum penicillin mixture. The diagnosis was of upper respiratory tract infection. During November she again consulted the respondent on several occasions principally complaining of thoracic spinal pain for which she was referred for x-rays which showed osteoarthritis and osteoporosis. After consultation with Professor McCaffrey the respondent prescribed Primobolin, a steroid, for relief of her condition. At a consultation on 23 November 1993 there was a discussion between the respondent and the patient about her concern about the side effects of Primobolin. The patient was also complaining about coughing for which the respondent carried out a chest examination.

During December the patient consulted the doctor on two occasions because of a productive cough from her lower respiratory tract infection, for which Septrim Forte was prescribed.

On 4 and 13 January 1994 the patient attended the respondent again in respect of her cough and on the latter occasion she collected a further prescription for Primobolin. The patient's final appointment with the doctor was on 21 January 1994 when she complained that her upper respiratory tract symptoms were back again for which the respondent prescribed Vibramycin. There is no suggestion that the medical treatment afforded by the respondent was not appropriate in respect

of her complaints during that period.

There is a conflict of evidence in relation to some aspects of the consultation on 23 November 1993. According to the patient she was suffering symptoms consistent with side effects from Primobolin. The respondent says that to the best of his recollection there were no such symptoms and that the discussion between them was confined to possible symptoms. Further the patient alleges that in the course of the examination the respondent asked her to remove her blouse and then undid her brassiere at the back. She says she made the comment "You're rather adept at undoing bras" to which he replied "My wife doesn't get this treatment". She also asserts that he said to her "Do you masturbate?" to which she replied "No."

The Substance of the Complaint

The patient asserts that she consulted Dr Van Leer again on 22 January 1994 for her chest infection and high temperature. She removed her blouse at his request and he undid her bra, listened to her lungs with a stethoscope and tapped her chest at the back.

The Patient says that the Respondent asked her to get up on the table for examination and he felt her abdomen and listened to her chest. She says that for this procedure no screen was provided and he didn't offer her a gown. He told her her heart was racing, her chest was wheezing and her lungs were rattling. On completion of that examination she put on her blouse and sat down at the desk.

She says he asked her questions about the side effects she was experiencing with the steroids. She says she told him she was not happy with the steroids, that she was experiencing skin upsets, sore breasts, notable weight gain, voice change and an enlarged clitoris which was making her very uncomfortable.

Thereafter she says the respondent said to her "Do you masturbate?" to which she said "No" and he replied "I can help you, please take off your pants." She thought he was going to examine her and got up on the examining couch again but he put his hand between her legs and started rubbing her vagina and clitoris. He had no gloves on and he said "you are nice and moist". She said "What are you doing?" and he replied "Masturbating you" whereupon she said "I don't need that. If that is therapy I can do it myself" and got up off the couch.

The Respondent then said to her "you are very tense and letting off sexual vibes" and as she was putting her pants back on he said to her "would you prefer to have intercourse Patricia?". The Patient said she pretended not to hear him, but he repeated the question. She didn't answer and he then said "when did you last have an orgasm?" The Patient was angry and said the first thing that came into her head which was "a month ago".

Shortly after she left the examining room in the company of the doctor, signed the Medicare form and the doctors last words were to leave off the steroids for a month and said "that was the only medication I could give you at the time".

The Patient did not consult the Respondent again.

On 27 January 1994 the Patient attended the Twin City surgery of Dr Richard Chambers. According to Dr Chambers she presented with a history of a cough and a wheeze for 10 days on a background of previous breast cancer, diagnosed in March 1993, and subsequent recurrent viral infections treated with multiple course of antibiotics.

By letter of 7 April 1994 to the Department of Health in Brisbane, in the course of making complaints against the Respondent and Dr Chambers the patient asserted that she consulted him, had pathology tests done which proved negative and then asked for a referral on his suggestion to see a specialist regarding medication for the osteoporosis as she could not take oestrogen. She complained that after 4 telephone calls and one visit to the surgery asking only for a referral to a specialist she heard nothing further from Dr Chambers. She came to the conclusion that he had probably spoken to the Respondent and been told not to touch this woman or something of that nature and thereafter refused further treatment for her in relation to her request for a reference to a specialist.

The respondent firmly denies any improper or unethical conduct on his part. He has produced to the Tribunal his clinical records in respect of the patient. His clinical cards contain the following entry for 22 January 1994 –

"22/1/94

Upper respiratory tract infection is now back for 4 days. She feels tired, has a temperature and a cough with a little bit of phlegm.

On examination

Her ears, nose and throat are normal. She has rattles in the right posterior lower lobe.

Plan

Vibramycin 100mg tab 1 twice a day 21SP Review in 10 days

Consider a repeat chest x-ray and bronchoscopy.”

His file on the patient includes comprehensive notes on his first examination of her and a 4 page questionnaire completed at the time. It also includes reports on radiological examinations on 17 March, 19 March, 5 November, 10 November and 23 November 1993 and short reports from Professor John McCaffrey dated 23 April and 13 May 1993.

The respondent denies he carried out any examination of the plaintiffs abdomen on 22 January 1994. He says that if there was any reason to examine her abdomen on that day he would have written down the reason for it and the outcome of the examination. He has no recollection of her complaining to him about side effects from the medication prescribed - had she made any complaints he would have noted them in the patient's history card. He denies that on 22 January 1994 she complained of experiencing skin upsets, sore breasts, noticeable weight gain, voice change and an enlarged clitoris. He concedes that it was his practice to ask the patient to remove her blouse and bra for the purpose of a chest examination. He does have a recollection of an examination on 23 November at which time the patient was concerned about possible side effects from taking Primobolin and her ongoing cough. He did carry out a chest examination and he says that, to the best of his recollection, the patient was rather anxious about the possibility of side effects from taking Primobolin as distinct from

complaining of side effects as she asserts.

He doesn't deny that he may have undone her brassiere on a number of occasions in the course of examinations but he says the removal of the bra and the blouse is usually left up to the patient. "If I am going to listen to their back or their back and sides only I leave the blouse on and I usually leave the bra on." He said "I just ask the patient to undo the bra or I undo the bra depending on the circumstances. He recalls her proffering to him at one time a slip of paper dealing with the possible side effects of the ingestion of Primobolin. He says that in the course of performing an abdominal examination on a patient he does not use a screen but does offer the patient a gown. He does not believe that the patient discussed the side effects of Primobolin during any consultation other than 23 November 1993. He specifically denies the patient's allegation that in the course of the consultation on 22 January that he had any conversation about whether or not she masturbated, that he put his hands between her legs and rubbed her vagina and any of the conversation between them as alleged by the patient.

He also denies the assertion made by the patient in her statutory declaration of 6 May 1997 that on one occasion between May and November 1993 he asked the patient to remove her blouse, undid her bra at the back and when she said "You're rather adept at doing that", he replied "even my wife doesn't get this treatment.

He denies that on 30 November 1993, or at any time, he asked her "Do you masturbate?" to which she replied "No".

In support of the patient's assertions evidence was given by the patient's husband,

Mr [SN]. He says when the patient arrived home from the surgery on 22 January 1994 she was in a state of shock from which he assumed she had been given a bad report relating to her breast cancer. He says she assured him that was not the case but that she had just had a very distressing experience with Dr Van Leer. She said he had sexually molested her, had attempted to masturbate her and had suggested that she was uptight.

In the course of his oral evidence Mr [SN] conceded that his statement had been typed by his wife. He says that she had been in indifferent health throughout 1993 and was not able to carry out her normal duties in the house as she used to do. He doesn't recall her coughing a lot at night, complaining of high temperature or being a little confused at times, or being disoriented or irrational.

A short letter was also tendered from the plaintiff's daughter to the effect that her mother had contacted her soon after the event, though she does not remember the exact date. Her mother was very upset on the phone and told her that she had been sexually molested by her doctor.

There was also tendered a letter from Dr Richard Chambers who confirmed that the patient consulted him on 27 January and reported being dissatisfied with her previous GP. At that time she presented with a history of coughing and wheezing for 10 days and a background of previous breast cancer

diagnosed in March 1993 and subsequent recurrent viral infections treated with multiple courses of antibiotics. Investigations he arranged to exclude other causes

of persistent cough and low immunity disclosed no abnormality. He confirmed the results of the tests to the patient when she rang his surgery on 10 February. Her symptoms were then settling and he did not advise any further treatment. At her request he obtained a copy of the bone density test carried out by South Coast Radiology, arranged earlier by the respondent. Thereafter he does not recall any further conversations with the patient.

The patient asserts that she came to Dr Chambers' surgery on 4 occasions to obtain a referral for further investigations. Dr Chambers has no recollection of seeing her on such occasions.

A report was also tendered from Professor John McCaffrey who saw her on 13 March 1994 for review of her medical condition. He says that at the end of the consultation, as she was about to leave, she became somewhat distressed and then told him of an incident which occurred with Dr Van Leer which was of a sexual nature and had both offended her and caused her great concern and obvious distress. He advised her the appropriate action for her to take would be to lodge a complaint and suggested some names of women doctors since it was obvious to him she would not be returning to her original family doctor and he thought she would feel happier and more secure with a woman doctor.

There is an entry in a diary kept by the patient for 22 January 1994 which reads-

"Washing - home all day - "Jules" AM - !!!

Bad cough - (leave off steroids)"

For the respondent the principal material which tends to support his evidence is the contemporaneous entries made in his clinical records. Written reference have been tendered from Mr A D Mitchell, solicitor of Tweed Heads, w has known the respondent for a period of 10 years as his family doctor; Mr K B Butler, chartered accountant of Coolangatta; Dr Paul Davies of Tweed Fads and Dr D Allan, who attended university with the respondent and who has worked as his associate in the same surgery for the past 9 years.

The substance of those character references is that the respondent is a happily married man who lives with his wife and three teenage children. They say the allegations of misconduct are absolutely inconsistent with the character and reputation of the respondent who is known to these people as hardworking, successful, trustworthy and an honourable man who conducts his affair with the highest personal and ethical standards and who exhibits genuine concern for his patients.

Evidence was also adduced from Dr David Quinn, clinical pharmacologist to the effect at it is quite possible that Mrs Neil's perception of the events has been altered by -

- The excessive effects of the prescribed methenolone acetate
- Delirium related to chest infection - pneumonia and high fever.

For the complainant opinions to the contrary were given by Dr Julian Lee, Thoracic Physician and by Dr D J Handelsman, Director of Andrology Unit at Royal Prince

Alfred Hospital, University of Sydney. The respondent in evidence, said that he did not believe that the patient was suffering from delirium at the time of the consultation on 22 January 1994.

The Tribunal is satisfied that the evidence does not support a finding that the patient was suffering from delirium or any other condition affecting her perception of events on 22 January 1994.

Opinion evidence was received from Dr I M Chung, who was retained by the Health Care Complaints Commission. In his opinion -

1. Dr J Van Leer's standard of record keeping, drug use and examination of [The patient] are acceptable.
2. The actions and statements attributed to Dr Van Leer, by the patient, are totally unacceptable in any clinical situation and attract his strongest and extreme disapproval and in his opinion the strongest and extreme disapproval of peers of good repute and competence.

Having shortly reviewed the evidence tendered in the course of this inquiry it is apparent that the primary task of the Tribunal is to make appropriate findings in relation to the credibility of the principal witnesses namely the patient and the respondent. The onus of proof of the complaint lies on the complainant. The standard of proof is the test described by the High Court in *Briginshaw v. Briginshaw* 60CLR336 which is further explained in *Rejfeld v. McElroy* 112CLR517 and confirmed more recently by the Court of Appeal in *Bannister v. Walton* 1993 30NSWLR695. Such standard of proof is frequently referred to by the shorthand

phrase of being "comfortably satisfied on the balance of probabilities".

The Tribunal has come to the conclusion that we are not satisfied that the evidence of the patient is to be preferred to that of the respondent. Our reasons, shortly stated, for coming to this conclusion are as follows -

1. There is no truly independent evidence to support the position put by either party. Both parties presented well in the course of their evidence and little assistance is to be gained from their demeanour during the course of the hearing. The evidence does not disclose nor suggest any reason why the patient would make false accusations against the respondent.
2. In assessing the weight of the patient's evidence there are several matters which cause the Tribunal some concern, namely-
 - a) She says that the doctor's question to her on 13 November 1993, "Do you masturbate?" shocked and offended her at the time. This allegation first arose in her additional statutory declaration made on 16 May 1997. It is not mentioned in her original statutory declaration of 25 February 1995 nor in her report to the Queensland Medical Board dated 7 April 1994 nor in her long letter to the complaints Unit of the New South Wales Department of Health of 22 January 1994. She said in evidence she didn't recall the incident until 1997 which is a little difficult to understand bearing in mind her background and what she expected of members of the profession. On the other hand she said she regarding it as unethical and uncalled for not to provide a screen or gown for examinations and for the doctor to undo her bra

for examinations. It is therefore difficult to accept that such a question about masturbation from Dr Van Leer would not have been foremost in her mind when she first complained about his conduct especially as part of the complaint concerned the question of masturbation.

- b) The patient's diary was originally tendered as some confirmation of the events of 22 January particularly in respect of the conversation about leaving off steroids. That part of the diary entry is of some significance in that it appears to be written in at a different time to the balance of the entry. Furthermore the three exclamations marks after "Jules" AM appear to be of little significance in that such exclamation marks is not an isolated entry in the diary, she used exclamation marks when referring to a new bank book and at other times in her diary. It is also noted that she repeatedly refers to "Jules" in the diary although she said it was her custom to call doctors "Doctor" and that she was shocked when the respondent called her Patricia. It is also noticeable that in her diary she doesn't mention the side effects of the steroids although she does note symptoms such as "cough worse", "feeling sick".

- c) We also note that in her letter of 7 April 1994 the patient complained to the Brisbane Medical Board of "highly unethical behaviour by two local doctors" namely the respondent and Dr Chambers although the substance of the complaints against both doctors was quite different.

- d) Furthermore we note that when examined by Dr Chambers only 5 days after her last consultation with Dr Van Leer there is no suggestion that she mentioned to him suffering from the side effects of Primobolin.
 - e) There is also some minor inconsistency in the chronology of events as she recounts them in writing on different occasions. Incidental matters such as these raise in the minds of the Tribunal some reservation about the reliability of the patient's evidence.
3. The weight to be attributed to the evidence of the patient's husband is diminished to some extent by the fact that the patient appears to have typed his statement in consultation with her husband.
 4. On the other hand the respondent's credibility was enhanced by his consistency, he did not contradict anything that he had noted. He conceded some things may have occurred that he did not make a note of nor remember it. He kept adequate clinical notes and in our opinion the proposed management plan for the patient's chest infection was appropriate. The respondent's clinical notes support his assertion that to the best of his recollection no abdominal or vaginal examination occurred on 22 January 1994.
 5. The Tribunal must take into account too, the evidence as to the character and reputation of the respondent. It is relevant to his credibility and to the

unlikelihood that a man of that character and reputation would be guilty of the misconduct alleged.

Accordingly the order of the Tribunal is the complaint be dismissed with costs.

Costs

The appropriate rationale for making an order for costs is that it is just and reasonable that the successful party should be reimbursed for costs incurred in the absence of grounds connected with the complaint or the conduct of the proceedings which make it unjust or unreasonable that there should be such reimbursement.

The complaint being dismissed it is appropriate that the costs follow the event subject to the following qualifications.

The issue of delirium was raised only 2 full working days before the hearing of the complaint commenced. The complainant was required to obtain expert medical evidence at very short notice and conduct further conferences with the patient and her husband. The issue was resolved firmly in favour of the complainant. The complainant is entitled to its costs in relation to that issue.

Accordingly the costs orders are -

1. The complainant to pay the respondent's costs of the inquiry.

