



New South Wales Medical Tribunal

CITATION : HCCC v Dr Piyush JOGIA [2009] NSWMT 7
TRIBUNAL: Medical Tribunal
PARTIES : Health Care Complaints Commission
 Dr Piyush JOGIA
FILE NUMBER(S) : 4022/08 of 2009
CORAM: Murrell, SC DCJ - Grimes, Dr D - Hely, Dr J - Glass, Assoc
 Prof A
CATCHWORDS: Professional Misconduct - Practitioner's name removed from
 Register
LEGISLATION CITED: Medical Practice Act 1992
CASES CITED: Briginshaw v Briginshaw [1938] 60 CLR 336
DATES OF HEARING: 2-9 November 2009
DATE OF JUDGMENT: 4 December 2009
LEGAL REPRESENTATIVES: Mr Strickland SC of Counsel for the Complainant
 Mr Lynch of Counsel for the Respondent

ORDERS:

JUDGMENT:

The Complaint

1 From August to December 2006, Dr Jogia was the patient's general practitioner. The patient alleged that, on 4 December 2006, the practitioner told her that she needed weekly treatment for "vaginal spasms". On 12 December 2006 when she attended for the purpose of undergoing the treatment, the practitioner inappropriately rubbed her genital area using two fingers in a circular motion (T1:53). He said "Don't worry if you find it arousing".

2 The Health Care Complaints Commission (HCCC) complained that the practitioner was guilty of professional misconduct. The practitioner denied the conduct. He agreed that conduct such as that alleged would amount to professional misconduct.

3 The Medical Tribunal exercises its jurisdiction for the paramount purpose of protecting the health and safety of the public: s 2A (3) of the *Medical Practice Act* 1992. Related purposes are to deter misconduct by other practitioners and to uphold the standards of the medical profession. Any finding of professional misconduct is extremely serious. Consequently, the Tribunal will make such a finding only if an allegation is clearly made out and the Tribunal feels comfortably satisfied that it is true: *Briginshaw v Briginshaw* [1938] 60 CLR 336.

The Patient's Background

4 The practitioner placed considerable reliance on the patient's unstable history and psychiatric diagnosis.

5 In late 2006, the patient was 22 years old.

6 The patient had an unhappy childhood. When she was twelve years old, she developed anorexia nervosa (T1:64). In 2003, a guardianship order was made because the patient was resisting treatment. As an adult, from time to time she exhibited symptoms of anorexia nervosa. In 2001, the patient had a "mental breakdown". Since then, she has had chronic depression (T1:64).

7 The patient suffers from borderline personality disorder (or complex post-traumatic stress disorder, T2:136). Persons who suffer from borderline personality disorder "often have highly unstable patterns of social relationships". They may have "intense but stormy attachments" (Exhibit 8). They are inclined to be "needy", emotionally over-sensitive and impulsive, and to exercise poor judgment. They may engage in self-harm (Exhibit 1.1, tab 27). From time to time, the patient overdosed on medication or engaged in other self-harm. On at least two occasions when she overdosed, the patient genuinely intended to commit suicide (T1:68, T2:10). She said that, on other occasions, she overdosed to make herself "numb" or cut herself to "release tension" after an argument (T1:67, T2:61). The patient had a fear of abandonment (T2:137).

8 The patient said that she was raped in March 2005 and suffered an "unwanted sexual experience" in May 2005 (T1:48).

9 In mid-2005, the patient met her future husband. The relationship was volatile.

10 In the period 20 August to 9 September 2005, there were four overdose episodes and at least two other episodes of deliberate self-harm. The patient was admitted to hospital twice. A hospital note of 4 September 2005 refers to the patient becoming upset "re boyfriend leaving her alone". In relation to recent overdoses, a hospital note of 14 September 2005 refers to "a cry for help as she could not cope". On 28 September 2005, a hospital note records "minor overdose yesterday after fight with her partner". On 20 October 2005, there was another hospital admission. On 13 November 2005 a hospital note records "cut herself last night to get (her partner's) attention".

11 In late 2005, the patient fell pregnant. She was identified as a person at risk. In February 2006, Ms Elsey, a registered nurse with experience as a mental health nurse, was allocated to be the patient's perinatal worker until her baby was twelve months old. The patient and Ms Elsey developed a close professional relationship.

12 In March 2006, the patient and her husband experienced difficulties in their relationship. The patient perceived that her husband was emotionally abusive. At the same time, she feared that he would leave her. The couple did separate briefly.

13 On 12 June 2006, the patient gave birth to a son. She reported continuing difficulties in her relationship with her husband. In July 2006, a doctor administered an injection of the contraceptive Depo Provera. Thereafter, the patient experienced severe mood swings and abnormal vaginal bleeding (T2:34). On 21 August, the patient was depressed and told the practitioner that her husband was threatening to leave her (Exhibit A, tab 9).

14 In early November 2006, the patient and her husband had a significant argument. The patient cut herself in the hope that her husband would not leave her, that he "would feel bad and he just wouldn't leave" (T2:54, Exhibit A tab 9, the practitioner's note of 20 November).

15 In late November 2006, the practitioner commenced the patient on the antidepressant drug Efexor (Exhibit A, tab 9, the practitioner's note of 20 November) and her mood swings "levelled out a bit" and "stabilised" (T1:35 - 36). On 4 December, the practitioner noted "continuing with Efexor, having

good results”.

Dr Nielssen

16 The practitioner relied upon the opinion of Dr Nielssen, a psychiatrist. The HCCC did not consent to Dr Nielssen examining the patient. On the basis of statements provided in connection with the proceedings and other medical records, Dr Nielssen provided two reports. In the first report, he opined that the patient's psychological condition "could be relevant" to her allegation. He stated (Exhibit 1.1, tab 6, p5):

"A central feature of borderline personality disorder is a fear of abandonment, and deliberate self harm and complaints of victimisation can often be a form of care eliciting behaviour in an attempt to avoid abandonment."

In addition, he considered that the patient's "history of presentations to a large number of general practitioners with gynaecological symptoms that often did not result in a conclusive diagnosis" and her assertion that she had been sexually assaulted twice may be relevant.

17 In his second report, Dr Nielssen referred to the *"well recognized association between borderline personality disorder and false allegations of sexual misconduct and other kinds of false claims"* (Exhibit 1.1, tab 8, p 2).

18 There is no evidence to support an inference that the patient was inclined to make baseless complaints of "gynaecological symptoms". After the birth of her son, the patient complained of persistent bleeding. It was a genuine symptom for which the practitioner treated the patient. The most likely cause was an injection of Depo Provera, a contraceptive, six weeks after the patient's son was born (Dr Bradford's report, Exhibit A, tab 6C).

19 The Tribunal does not infer that the patient's allegations of a sexual assault in March 2005 and an "unwanted sexual encounter" in May 2005 were false. Indeed, they were probably true. There is no evidence of motive to make a false allegation. In particular, there is no evidence that either allegation was made in the context of attention - seeking. It is irrelevant that neither matter was reported to the police. Most sexual assaults (let alone "unwanted sexual encounters") are not reported to the police. The chronology supports the patient's assertion that a sexual assault in March 2005 caused her to move from Sydney to the Central Coast in April/May 2005 (T2:48). The patient attended a Gosford sexual assault clinic (T2:139, T2:144). In February 2006, Ms Eley counselled the patient about coping with the impending anniversary of a March 2005 rape. Dr Nielsen said that people who suffer from borderline personality disorder may present in a way that makes them more vulnerable to sexual assault (T2:199).

20 The Tribunal places limited weight on Dr Nielssen's opinion that there is a *"well recognised association between borderline personality disorder and false allegations of sexual misconduct and other kinds of false claims"*. It is a sweeping generalisation based on the doctor's clinical impression and anecdotal evidence (T2:202 – 203, T2:220). Such generalisations may also be partly informed by subconscious prejudice. The doctor could not identify any research that supported his opinion. Nevertheless, in considering the patient's evidence the Tribunal does take the possible association into account.

21 The Tribunal accepts that a common feature of borderline personality disorder is a fear of abandonment and that people who suffer from borderline personality disorder may engage in deliberate self harm and/or complaints of victimisation as a form of care - eliciting behaviour designed to avoid abandonment. Prior to December 2006, the patient had engaged in such behaviour. In August/ September 2005, the patient took an overdose as a "cry for help as she could not cope" and a second overdose in the context of an argument with her husband. In November 2005 and November 2006, she deliberately cut herself as a form of care-eliciting behaviour directed at her husband.

The Tribunal's Assessment of the Patient

22 The patient presented as a credible witness who was not shaken in cross-examination. Her evidence was internally consistent. The patient made appropriate concessions against interest. For example, she conceded that, in connection with marital arguments, she had overdosed and engaged in other deliberate self-harm. She conceded that, when admitted to hospital, she had often minimised the seriousness of her behaviour in order to obtain early discharge (T2:10).

23 Following the consultation on 12 December, the patient conducted herself in the manner that one would expect of a person who had been sexually assaulted. The patient made an immediate complaint to her husband. The Tribunal accepts that the patient's husband was a truthful witness. He said that, when the patient returned home after the consultation of 12 December, she appeared to be upset. Her eyes were red and it looked as though she had been crying. She went to the bedroom. She was crying. He encouraged her to disclose the source of her unhappiness. Far from insisting that the practitioner had done something wrong, the patient said that she "wasn't sure if she was over-reacting". In evidence, the patient said that she was shocked by the practitioner's conduct and wasn't sure whether it was right or wrong. Initially, she assumed that he was treating "vaginal spasm" (T2:74 – 75). According to the patient's husband, in the days and weeks following the disclosure, the patient was not generally depressed or upset, although she would become angry when she "thought about it" (T2:120). On 15 December, the patient made a complaint to Ms Elsey in similar terms to the complaint that she had made to her husband. When she complained to Ms Elsey, the patient appeared to be genuinely sad (T2:133.37). On 20 December, the patient and her husband saw Dr Badami and his wife, RN Badami, in relation to the patient's chronic bleeding problem. The patient declined a vaginal examination. Dr Badami usually referred his patients to a male gynaecologist, but the patient requested a referral to a female gynaecologist. At the end of the consultation, she became teary and distressed. She enquired whether it was normal for a doctor to say "You may be aroused during the course of this procedure".

24 On 20 November, the patient demonstrated confidence in the practitioner when she disclosed that she had been sexually assaulted and had been the subject of an "inappropriate sexual advance". No motive has been suggested for the patient to select her trusted general practitioner as the target of a false allegation.

25 The practitioner relied on inconsistent statements by the patient. For example, the patient gave evidence that, after the incident on 12 December, she made an appointment with Ms Elsey for 15 December, but it is apparent from Ms Elsey's notes that the 15 December appointment was made before 12 December. In her statement, the patient said that she did not think that the practitioner was wearing gloves, but in evidence she conceded that she was unsure one way or the other (T2:27, T2:33). According to the patient's statement, after the assault she dressed and left immediately. In evidence, the patient conceded that, if she told Ms Elsey that she had sat down and had a conversation before leaving, then it probably did occur (T1:71, T2:21).

26 These are the type of inconsistencies that one would expect in the case of any witness. Generally, there was a high level of consistency between the patient's evidence, statements that the patient made at earlier times, contemporaneous medical records and the evidence of other witnesses.

27 The patient said that, in January 2009 after a change in her medication regime, she accidentally overdosed (T1:69). The practitioner placed considerable reliance on the conflicting accounts that the patient reportedly gave to health-care professionals to whom she spoke in connection with the associated hospital admission (T1:80 – 81). Apart from being internally inconsistent, those accounts also differed from the account given in evidence. In assessing the patient's reliability as a witness, the Tribunal accords little weight to this matter. Regrettably, histories taken by hospital staff are often incomplete or even inaccurate. If the patient did give different and conflicting accounts, it may have been because she was confused under the influence of medication.

28 The only possible motive that was suggested for the patient to fabricate the allegation was that the patient engaged in care-eliciting behaviour because she was worried about abandonment by her husband and/or Ms Elsey. Consequently, the Tribunal has given careful consideration to the patient's diagnosis of borderline personality disorder and to her history of overdose and other deliberate self-harm as a form of care-eliciting behaviour.

29 There is no history of making false sexual allegations against third parties as a form of care-eliciting behaviour or otherwise. If the allegation against the practitioner was a form of care-eliciting behaviour, then it was a new form of such behaviour.

30 Dr Nielssen agreed that, if at the time that the allegation was made the patient's relationship with her husband was good, then there was less chance that the allegation was care-eliciting behaviour (T2:203). On 20 November, the patient told the practitioner that, following significant differences in early November, her husband was "supportive" and the relationship was "okay now" (Exhibit A, tab 9). The patient's husband had a poor memory for dates, but he confirmed that, in the period prior to 12 December, the marital relationship was happy (T2:98 – 99, T2:107).

31 Ms Elsey was an impressive witness. She made thorough notes of her meetings with the patient and often recorded the patient's feelings about her husband. Ms Elsey's contemporaneous notes support the patient's evidence that, in the period immediately before and after 12 December 2006, the patient enjoyed a relatively happy and stable relationship with her husband. Between 31 August 2006 and 22 December 2006, the patient made no complaint to Ms Elsey concerning the relationship. On 23 November 2006, the patient reported to Ms Elsey that the relationship had "improved" and that her husband was "being supportive". On 15 December, the patient reported feeling "well supported" by her husband. It was not until 16 January 2007 that the patient reported a "return of troubled relationship" and that she "no longer (felt) supported by (her husband)". (Exhibit 1.2, pp 453 – 456).

32 Further, Ms Elsey's notes (Exhibit 1.2, pp 453 – 457) indicate that, immediately before 12 December 2006, the patient's general psychological health was good. On 20 November 2006, she appeared to be depressed, but she felt better on 21 November. She looked well on 23 November. On 4 December, the practitioner noted that the patient was "having good results" on Efexor, which he had recently prescribed for depression. When Ms Elsey saw the patient on 15 December 2006, the patient reported that she was "very well" although she was concerned about the practitioner's conduct.

33 There is no basis upon which it could be inferred that the patient may have fabricated her story in an attempt to avoid abandonment by Ms Elsey. From the outset, the patient knew that she would receive Ms Elsey's support for a period of 12 months after the birth of her son, i.e. until mid-2007. In late 2006, there was no reason for the patient to fear imminent abandonment by Ms Elsey. Ms Elsey's notes do not reflect such a concern. In evidence, Ms Elsey rejected the hypothesis (T2:151 – 152).

Assessment of Dr Jogia's Account

34 For several months prior to 12 December, the patient consulted the practitioner in relation to persistent bleeding (among other complaints). On 4 December, the consultation immediately preceding that of 12 December, the patient complained of pain and bleeding. The practitioner undertook speculum and digital vaginal examinations, and a rectal examination (to exclude the possibility of rectal bleeding). In part, he noted:

"Speculum and digital exams carried out, appears to have minor vaginal tear and vaginismus.

Rectal exam carried out, patient has constipation ++

Advised faecal softener, advice given r/v next week."

By "vaginismus" the practitioner meant a spasm of the muscle around the vagina caused by the minor vaginal tear. By "r/v next week", he meant "review next week".

35 The complete notes made by the practitioner on 12 December were:

"Patient returned with vaginal irritation and discomfort. Vaginal examination carried out with consent (chaperone offered and patient declined), appears to have vaginal thrush, advised (Canesten) cream."

36 In evidence, the practitioner said that, on 4 December, he told the patient to return if she had any problem with constipation. On 12 December, she returned unexpectedly, complaining of "pain and itching down below". The practitioner said that the patient reported that she still had the symptoms from the previous week (T2:226). He also said that the patient didn't complain that she was still bleeding and he didn't see any blood (T2:283). He decided to perform a vaginal examination because he wanted to see whether the minor vaginal tear observed at the previous consultation had resolved and whether there was any pelvic infection (T2:227). He intended to undertake a digital examination and then a speculum examination, and to take swabs (T2:278). He would normally undertake a speculum examination before a digital examination. However, he was aware that the patient's pre-existing vaginal tear may not have healed and may have cause pain on examination. He believed that it would be "kinder" to commence with a digital examination. The patient agreed to a vaginal examination. He asked whether she wanted someone present. She declined the offer. He prepared gloves, a speculum, swabs and KY jelly. He used his left hand to part the labia. He used two fingers of his right hand to apply the cream at the vaginal entrance. The practitioner demonstrated the two-finger circular motion with which he applied the jelly. Before he put his finger into her vagina, the patient said: "Please stop, it's hurting, please stop". He stopped immediately. He noticed a white material on his fingers, consistent with a thrush infection. He asked the patient whether she was all right. She replied in the affirmative. He told the patient that he thought that she had thrush. He advised her to purchase Canesten cream to treat the thrush.

37 The Tribunal does not accept that the practitioner's notes of 12 December reflect what occurred on that day. Further, the account that the practitioner gave in evidence is implausible.

38 First, the patient's return on 12 December could not have been "unexpected" because, on 4 December, the practitioner entered "review next week". The notes of 4 December are consistent with the patient's evidence that, on 4 December, the practitioner advised her to return for treatment of "vaginal spasms".

39 Second, there was no legitimate reason to undertake a digital examination prior to a speculum examination. It is usual practice for a swab to be taken in the course of a speculum examination and prior to any digital examination, so as to minimise the risk of contamination. In evidence, the practitioner said that he usually performed a speculum examination before a digital examination, and that appears to be the order in which he conducted the examinations on 4 December. On his account, on 12 December the practitioner believed that the patient could have had pelvic inflammatory disease, which would be investigated by taking a swab. The practitioner said that he had prepared swabs. It is improbable that he would have compromised the integrity of a swab by undertaking a digital examination before the speculum examination/ swab.

40 Third, the notes of the consultation on 12 December do not refer to important clinical matters about which the practitioner gave evidence. If the patient's pain was so severe that the practitioner had to abandon the examination before it commenced, then that should have been noted and the note "vaginal examination carried out with consent" is misleading. It is also significant that the practitioner failed to note the possible diagnoses of vaginal tear and pelvic inflammatory disease, and failed to note that the symptoms reported on 4 December had not resolved.

41 Fourth, if the practitioner did not know the cause of the patient's severe pain and he considered that there was possible pelvic inflammatory disease, he should have discussed his concern with the patient. He should have arranged follow-up treatment. For example, he should have arranged another consultation for the purpose of examining the area or expedited a specialist consultation.

42 Fifth, the practitioner had undertaken previous vaginal examinations of the patient on 30 August and 4 December (Exhibit A, tab 9). He said that, in accordance with his usual practice, prior to any such examination he would have asked the patient whether she wanted someone present. Yet it was only on 12 December that he noted such an offer. The patient denies that that he made the offer on 12 December or at any other time (T2:12).

43 Sixth, on 20 December the patient complained to Dr Badami and RN Badami that she was experiencing ongoing bleeding and dyspareunia (painful sex). Although thrush can be associated with bleeding, on 20 December there was no discussion of thrush. The patient had previously suffered from thrush and was familiar with the symptoms. The patient was adamant that, on 12 December, thrush and Canesten (the treatment for thrush) were not mentioned (T2:78, T2:81).

44 The Tribunal formed the view that the practitioner was prepared to fabricate answers as he perceived the need to arise. For example, he said that on 4 December he was able to see the vaginal tear through the speculum as he inserted it because the speculum was transparent. The medical members of the Tribunal were unable to accept that assertion because a speculum is always inserted with the blades closed. In evidence before the Tribunal, the practitioner said that he normally performed a speculum examination first, but he told the s 66 inquiry that he normally undertook a digital examination first (Exhibit B, p13).

45 The Tribunal accepts the patient's evidence that, on 4 December, the practitioner suggested that she leave her baby at home when she next attended (T1:61). The patient's husband confirmed that the patient discussed the request and arranged to leave the baby with him on 12 December (T2:103). The Tribunal does not infer that the practitioner made the request because he had already formulated a plan to engage in inappropriate conduct. When the request was made on 4 December, the patient considered that it was a reasonable request. The practitioner may well have made the request because the baby was a distraction. However, the fact that the practitioner denied making such a request is a matter to be taken into account when assessing the practitioner's credibility.

46 The patient was a credible witness. The practitioner was not. The Tribunal is comfortably satisfied that the practitioner inappropriately rubbed the patient's genital area.

47 The Tribunal finds that the complaint is established. The practitioner is guilty of unprofessional conduct that is sufficiently serious that it justifies removal of the practitioner's name from the Register and amounts to professional misconduct.

48 The Tribunal orders that the practitioner's name be removed from the Register and that there be no application for review of this order for three years.

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