NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	**1105/Med 19/448P**
UNDER	The Health Practitioners Competence Assurance Act 2003 ("the 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 OF NEW ZEALAND** **Applicant**
AND	**DR H** registered medical practitioner of X **Practitioner**

HEARING held at [ ] on 15 – 19 June 2020

TRIBUNAL: Mr D M Carden (Chair)
Dr B Howcroft, Assoc Prof J McKenzie, Dr I Stewart and Mr C Nichol (Members)
Miss D Gainey (Executive Officer)

APPEARANCES: Mr D La Hood and Mr D Moore for the Professional Conduct Committee
Mr M McClelland QC and Ms R Daley for the Practitioner

DECISION OF THE TRIBUNAL

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Introduction

[1] This case concerns communications by, and availability of, a medical specialist. A Charge has been laid by a Professional Conduct Committee (PCC) of the Medical Council of New Zealand (MCNZ) against Dr H (hereafter referred to as the Practitioner) under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act).

The Charge and hearing

[2] The full text of the Charge (as was amended without significant opposition from time to time) is set out in the Schedule to this decision. It has seven particulars but deals with allegations in two categories, namely "*unprofessional behaviour towards colleagues*" and "*availability when rostered as on-call doctor*".

[3] The allegations relate to separate incidents, the first on [ ] 2014 concerning an alleged failure to come to the hospital within a reasonable timeframe (particular 3). The second event was on [ ] 2016 alleging rudeness and verbal abuse towards a colleague (particular 1) and failure to come to the hospital within a reasonable timeframe (particular 4) and then on [ ] 2016 being unable to be contacted on his cellphone despite contrary advices (particular 5). The third event was on [ ] 2017 alleging initial refusal to see a patient in a timely manner. The fourth event was on [ ] 2017 with allegations of having been "*brusque*" towards a colleague (particular 2) and refusal to provide treatment advice during a telephone call to that colleague (particular 7).

[4] There was produced to the hearing an agreed bundle of documents which had been prepared and was submitted on the basis canvassed at an earlier telephone conference, namely that each document in the bundle:

(i) is what it purports to be on its face;

(ii) was signed by any purported signatory shown on its face;

(iii) was sent by any purported author to, and was received by, any purported addressee on its face;

(iv) was produced from the custody of the party indicated in the index;

(v) is admissible evidence; and

(vi) is received into evidence as soon as referred to by a witness in evidence, or by counsel in submissions, but not otherwise

[5] The PCC called evidence from the witnesses involved in the respective events or incidents and the Practitioner gave evidence himself and produced a bundle of references. Following the hearing the Tribunal advised its decision on whether the Charge and any of its particulars were made out and this was followed by written submissions from the parties (who did not request any further oral hearing) as to penalty. An interim order for suppression of the name of the Practitioner had been made and the Tribunal's decision on his application for permanent suppression is contained in this decision.

The Charge: general

[6] The submissions for the PCC emphasised the test for establishing professional misconduct and that the primary purpose of disciplinary powers was the protection of the public by maintenance of professional standards. It referred to applicable professional guidelines and Tribunal comments in *Emmerson*[1] that guidelines promulgated exist for good and proper reasons, with a responsibility for every doctor to know precisely what the current rules are or, if they do not, to find out (in the context of the need for ongoing learning). Extracts from the MCNZ publications *Good Medical Practice* and *Unprofessional Behaviour and the Health Care Team* were emphasised.

[7] It was submitted for the PCC that the because there was one single charge with seven particulars there could be no objection to the use of all evidence in respect of each particular, citing *Morahan v Wellington Standards Committee 2*[2]*.* The extract from that decision made it clear, however, that in considering the charge against the law practitioner in that case findings in relation to events prior to that time "*were merely contextual*".

[8] The Tribunal was encouraged to disregard cross-examination and evidence on peripheral issues of no or marginal relevance, such as the absence of evidence from

[1] 887/Med16/358P

[2] [2019] NZCA 221

some doctors, how a complaint was made, and the process of drafting briefs of evidence. The submissions went through the individual particulars and concluded that separately or cumulatively the Practitioner's conduct amounted to a departure from acceptable standards and warranted disciplinary sanction.

[9] The general submissions for the Practitioner gave an overview, describing the issues as "*in reality … employment issues … which were treated by [the Practitioner's employer] as such*". The Tribunal was encouraged to disregard rumours and unsubstantiated allegations and any vague and prejudicial perceptions created by hearsay evidence. The background to the genesis of the complaint which led to the investigation and the Charge having been brought were addressed. Emphasis was placed on the need for any charge to cross the threshold of requiring disciplinary sanction with reference to extracts from the judgment in *Williams v A Professional Conduct Committee*[3].

[10] The submissions addressed the absence of expert evidence, particularly as to allegations in particulars 3, 4 and 6 of conduct falling seriously short of acceptable clinical standards, with express reference to the allegations of "*a reasonable timeframe*" and "*a timely manner*". Such assessments should, it was said, only be made by the Tribunal after receiving and considering evidence from an independent objective expert witness with proper recognised expertise in the relevant area. The only witness for the PCC to express any observation as to the appropriateness or otherwise of the Practitioner's conduct was in fact the complainant and her evidence related to the specific allegations.

[11] Emphasis was placed on the components for a disciplinary finding including the factual allegations, that each separate instance fell short of required standards and that the overall conduct must meet the threshold for discipline. The submissions addressed the onus of proof and the standard of proof. Emphasis was placed on High Court decision extracts concerning the threshold for discipline particularly from *Cole*

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[3] [2018] NZHC 2472

v Professional Conduct Committee[4], *Collie v Nursing Council of New Zealand*[5], *Williams*[6], and *O v Professional Conduct Committee*[7].

[12] As to guiding statements and professional standards documents, it was submitted these are "*not black letter law*" and have not been subject to the same degree of scrutiny as statute. Care must be taken when relying on them and they are not determinative, it was said, either in terms of setting standards or for establishing professional misconduct with reference to *O*[8] and *Staite v Psychologists Board*[9].

[13] Guidance as to the proper manner for assessing the credibility of witnesses was discussed with reference to *Rabih v Professional Conduct Committee of the Dental Council*[10] which refers to the manner and demeanour of a witness, issues of potential bias to the extent evidence may have been given from a position of self-interest, internal consistency of the evidence of the witness throughout, external consistency of the evidence of the witness with that given by other witnesses, and whether non-advantageous concessions were freely tendered (and the Tribunal accepts those as useful criteria when addressing credibility).

[14] The Tribunal was encouraged to disregard hearsay evidence in this case with submissions addressed to Clause 6(1), First Schedule, of HPCA Act and *W v Health Practitioners Disciplinary Tribunal*[11]. The Tribunal notes that *W* is under appeal but takes note of what the High Court ruled in that case.

[15] As to propensity evidence, the submissions for the Practitioner challenged the PCC position that in assessing each particular, facts from all particulars can be taken into account; with the Tribunal being urged to consider the evidence in respect of each separate standalone allegation separately. Reliance was placed on a decision of the Medical Practitioners Disciplinary Tribunal[12] which accepted advice from a barrister appointed by it to assist the Tribunal that the Charge must be established on its own merit and cannot use "*mere propensity reasoning as a 'make weight'*".

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4 [2017] NZHC 1178
5 [2001] NZAR 74
6 Op cit
7 Auckland HC: CIV2010-404-8237; 5 August 2011; Allan J
8 Op cit
9 Christchurch HC: AP 52/98; 18 December 1998; Young J
10 [2015] NZHC 1110
11 [2019] 3 NZLR 779
12 *Re Ford:*201/00/61C/84C

[16] In his evidence to the Tribunal the Practitioner gave background first concerning his qualifications in [ ] and subsequently, terminating in a Fellowship at [ ] in [ ] and subsequent Fellowship in [ ]. He referred to his employment with the same employer, between [ ] until his resignation took effect on [ ] with his having practised at the same hospital during those years. He spoke of his particular areas of interest as including [ ].

[17] The Practitioner gave further information about his on-call hours which he described as commencing at 1:1 (which the Tribunal interprets to mean every weekend) during the week from 8:00 am on Monday to 5:00 pm on Friday and 1:2 (again interpreted to mean every second weekend) on-call services over the remaining weekend hours. His employment agreement included that the normal immediacy of reply to calls was between 15 and 30 minutes, with no time frame for seeing patients as this "*depended on clinical need and varied based on patients' presenting symptoms*". It is the Tribunal's view that, although those contractual provisions may have determined his employment obligations, the Practitioner had overriding obligations owed to his profession.

[18] The Practitioner referred to other professional commitments and time pressures and said that he found his "*on-call obligations to be extremely onerous [as he] was constantly on-call for 12 days consecutively with only 2 days off in-between*". Then there were changes to his on-call obligations at another more distant hospital and in 2007 his weekend on-call obligations reduced to 1:4 that is, on-call one weekend every four. Hours then shortened for him but he said he was still on call sometimes 12 days consecutively. He said that he worked under "*an on-call roster of this kind for 23 years*".

[19] The Practitioner also gave evidence about his interactions with the Emergency Department at the hospital he was working at. In earlier days his referrals came from a general practitioner or from an [ ] well placed to determine urgency. He opined that Emergency Department doctors varied greatly in the amount of training or experience they had with [ ] and that they had a "*very low threshold*" for contacting the [ ] rostered on-call for patients presenting with [ ] complaints. This created issues for him which he described as "*fragmented medical care*" and patients with relatively benign or low-level complaints presenting at the Emergency Department. He

described that as the background to his interactions with others to which the particulars of the Charge referred. The increasingly low threshold for contacting him exacerbated, he said, his already onerous on-call obligations and he felt that his "*preference for preserving continuity of care was misperceived*".

[20] Following his interaction with the specialist to whom particular 1 refers and an investigation into this by his employer he decided to attend a communication course favoured by his employer's managers and recommended to him by a colleague. The first part of this course he attended in [ ] 2017 and the second part in [ ] 2019. He said that that course gave him "*a lot of good insights into the way different personality types interact*" and was something that he was "*mindful of in [his] practice*". That background was alluded to also by submissions on the Practitioner's behalf.

Discussion

[21] The Charge is 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 a 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 that practitioner practised at the time of the conduct.

[22] 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[13]. Although malpractice is often equated with negligence it is perhaps better considered as a broader concept, capable of encompassing neglect, but also of extending to trespassory conduct in the process of caring for patients in relation to consent, breaches of patient confidence and fiduciary obligations, and certain other forms of conduct[14].

[23] 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

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13 *Collie v Nursing Council of New Zealand;* [2001] NZAR 74 at [21]
14 *Tovaranonte:* 870/Med16/344P at [50]

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.[15]

[24] In considering any charge of misconduct under the HPCA Act the Tribunal must, having found that the acts or omissions in question were misconduct or likely to bring discredit to the relevant profession, 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[16].

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

[26] The Tribunal has considered all seven particulars of the Charge separately and cumulatively, as the Charge alleges.

[27] The first event in time was the events on [ ] 2014, followed some two years later by the events of [ ] and [ ] 2016, the events on [ ] 2017 and events on [ ] 2017. There are significant lapses of time between those successive events. There cannot be said to be any evidence of propensity towards the types of behaviour alleged in the Charge before the first event, [ ] 2014, and it is considered on its own merits. Nothing that occurred on that occasion can in any way be said to be propensity evidence towards what is alleged on the next occasion on [ ] and [ ] 2016. Those events and the particulars which refer to them, 1, 4 and 5, are considered on their own merits. Likewise with the remaining events on [ ] and [ ] 2017 (particulars 6, 2 and 7) these are considered on their own merits because the Tribunal does not regard there as having been any evidence of propensity towards behaviour from earlier events arising, and in any event particulars 4 and 5 are found not to be made out and the findings in respect of particular 1 are that any misconduct does not separately warrant disciplinary sanction.

[28] The Tribunal has taken into account the background pressures to which the Practitioner referred in respect of his on-call responsibilities but has considered the individual particulars of the Charge on their merits, addressing those other matters more in the context of penalty.

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[15] *Collie v Nursing Council of New Zealand* at [28].

[16] *PCC v Nuttall;* 8/Med04/03P.

[29] The decision now deals with the individual particulars in time sequence order.

Particular 3 – [ ] 2014 – failure to come within a reasonable timeframe

[30] The allegation is that the Practitioner, while rostered as the on-call [ ], failed to come to the hospital within a reasonable timeframe when asked by Dr E to attend to see a patient, Ms L. This was not the subject of the original complaint against the Practitioner but arose from investigations carried out by the PCC.

[31] Evidence in respect of this particular was given by Dr E but there was no evidence adduced from Ms L. The facts were that at approximately 1:56 pm on [ ] 2014 Ms L arrived at the Emergency Department with an injury to [ ]. A scan was carried out at 3:36 pm and around 4:15 pm Dr E reviewed the patient and the CT scan results which indicated she had a [ ] with a significant [ ].

[32] Dr E formed the view that this was a [ ]-threatening condition and that the patient needed an urgent [ ]. The Practitioner described that process as involving a small incision around [ ] and he said that the process rarely needed to be performed in the circumstances of this case and noted that he had never previously had occasion to perform "*in such circumstances*" in his 37 years of practice.

[33] Both Dr E and the Practitioner said that Dr E called the Practitioner at about 5:00 pm that day. Based on the information given to him, the Practitioner considered it was necessary for him to review Ms L in person and he told Dr E he would return to carry out an assessment.

[34] Dr E said that the Practitioner advised that he had just arrived home but would come back to the hospital "*in a little while*" which Dr E understood to mean that he was on his way "*shortly*". Dr E said the patient was prepared for surgery but while waiting for the Practitioner to arrive the patient's condition deteriorated with increasing pain and nausea. Dr E telephoned the Practitioner again and asked him if he should proceed with the surgery himself but was told not to do this as the Practitioner was not far from hospital and wanted to assess Ms L himself to determine whether the procedure was needed and he wanted to measure her [ ]. When the Practitioner arrived at the hospital the patient was reviewed. The Practitioner timed this at about 5:45 pm and Dr E at around 6:00 pm. The latter is the time indicated by the

hospital records. In any event it was apparently shortly after the second telephone call.

[35] The Practitioner said that that examination confirmed that the patient's presentation was stable and that the procedure was not necessarily required but he performed the [ ] in any event, erring on the side of caution. Dr E's version of that was that the Practitioner agreed that a [ ] was "u*rgently needed*" (which was denied by the Practitioner).

[36] On the day following the event, [ ] 2014, a Report was filed with the hospital. This was from one Dr N, an Emergency Department medical doctor and referred to the events as an "*incident*". Objection was taken on behalf of the Practitioner to that Report being received and considered. It did form part of the agreed bundle of documents on the basis referred to above. The Tribunal does accept it despite Dr N's not being present for cross-examination, although the weight given to it must be balanced accordingly.

[37] The details in that Report accord with the evidence of Dr E in the matter, particularly that the Practitioner was "*immediately paged*" and as to the presentation of the patient to Dr E. It also records that "*1 hr after initial conversation*" the Practitioner was paged again while the patient was clinically deteriorating and he answered "*after a delay*".

[38] The Report notes that Dr E explained to the Practitioner that the patient was "*now in much more pain/nausea and complaining of difficulty [ ]*"; and also notes that the Practitioner was "*only 5 mins away*". The Report refers to the measure of [ ] on the Practitioner's arrival as high and the Practitioner's assessment of the need for immediate surgical decompression and the procedure which was performed.

[39] The submissions for the PCC were that the condition for the patient deteriorated after the first contact between Dr E and the Practitioner and that evidence of the delay in the Practitioner's attendance at the hospital was borne out by the actions taken by Dr E. Preparing the patient for surgery and indicating preparedness to carry out that surgery by Dr E himself supported a finding that the Practitioner did not attend the hospital within a reasonable timeframe. The Practitioner lived, it was said based on the evidence, within 10 to 15 minutes' drive of the hospital and a delay of over 1 hour in attending the hospital to carry out an urgent assessment and surgery

was, it was submitted, unacceptable. This delay placed patient safety at risk. The Practitioner's account was implausible, it was said, given that the Practitioner did in fact carry out the [ ]. Hearsay evidence from the Practitioner of an opinion expressed by a colleague in [ ] should be disregarded, it was said.

[40] Evidence had been given about the period of time that the Practitioner had been at the hospital after Ms L's arrival and the Practitioner expressed concerns that he was not contacted while he was there. The Tribunal accepts that the sequence of events as given in evidence does not indicate any undue delay on the part of the hospital staff or Dr E in contacting the specialist, the Practitioner; and that it would be unusual for the specialist to be contacted soon after the patient had first presented.

[41] The submissions for the Practitioner referred to the timing of presentation at 1:56 pm and the first call from Dr E to the Practitioner at around 5:00 pm. It was accepted that Dr E had asked whether he ought to perform the procedure to relieve swelling and of the Practitioner's response of wishing first to assess the patient. It was submitted that the report of Dr N the following day is hearsay and inadmissible. After having referred to aspects of the evidence, the submissions were that on the issue of timing "*nothing is certain*". It was said that the Tribunal is not permitted to fill the gap left by the absence of any expert evidence on the allegation made in this matter. Given the extent of Ms L's presenting injury and the impact on her [ ], it was inconceivable that she should not require specialist input and that should have been sought while the Practitioner was for some time only approximately 50 m away. He had access to a [ ] which could have provided key information.

[42] The Practitioner denied that the PCC had established there was any professional misconduct on his part, either as malpractice or negligence or as conduct bringing discredit to his profession.

Discussion

[43] The Tribunal is satisfied that the facts are sufficiently made out as alleged in this particular of the Charge, namely that the Practitioner was rostered as the on-call [ ] and was asked by Dr E to attend to see his patient, Ms L. The issue is whether he came to the hospital within a reasonable timeframe in the circumstances.

[44] The Tribunal accepts that the sequence of events as given in evidence does not indicate any undue delay on the part of the hospital staff or Dr E in contacting the specialist, the Practitioner; and that it would be unusual for the specialist to be contacted soon after the patient had first presented. The fact that he was not asked to come for some time after Ms L had presented at the Emergency Department with her complaint does not excuse any delay on the Practitioner's part.

[45] It was the Practitioner's responsibility as the on-call [ ] to respond to the request made to him by Dr E who was the Emergency Department specialist on duty at the time. There could have been room for argument that the time that had elapsed between presentation and request for specialist assistance was an indicator of the severity of the presentation, but that is negated by the evidence of Ms L's worsening condition.

[46] The Practitioner was asked at about 5:00 pm to attend and Dr E explained to him his concerns for the [ ]-threatening condition that Dr E considered needed an urgent [ ].

[47] The Practitioner did not attend for about 1 hour that is not until about 6:00 pm. In that time Ms L's condition was worsening such that Dr E considered performing the surgery himself. He had understood, however, from the Practitioner's response that his arrival was imminent; but his concerns led him to call the Practitioner again for immediate assistance and to ask if he should perform the procedure himself.

[48] The Tribunal prefers the account of events on critical matters that was given by Dr E to the explanation and evidence offered by the Practitioner. Dr E's evidence had internal consistency; and it was quite appropriate that as the deteriorating condition progressed, he would become increasingly concerned for the patient and the fact that the Practitioner had not yet attended as requested and as he had said he would. There is the self-interest on the Practitioner's part in seeking to avoid any responsibility in the matter.

[49] The Practitioner described the situation as "*compartment syndrome*" and the [ ] for the patient was at risk. This was a situation requiring the Practitioner to drop everything and attend urgently.

[50] On the Practitioner's own evidence his employment agreement required normal immediacy of reply to calls between 15 and 30 minutes and 60 minutes in this case was way in excess of that, particularly given the urgency. The Practitioner produced

as part of his evidence the national referral guidelines criteria for an [ ] (titled [ ]) which categorises presentations, summarises the criteria for each category, and gives examples (not exhaustive). The Tribunal perceives that the condition for Ms L in this case was in Category 1 "*Immediate*" where the criteria "*Trauma not able to be treated conservatively*" applied. That is further evidence of the urgency with which this matter should have been treated by the Practitioner.

[51] It seems that in this case there was a measure of frustration for the Practitioner that he had not been approached for specialist consultation while he was at the hospital and within easy consultation reach but rather that he was being consulted when he had made his way home. The Practitioner did respond by attending but in the Tribunal's view not quickly enough. The Tribunal can make an assessment based on the factual evidence and the position expressed by Dr E: and does not need to have expert evidence as to standards.

[52] The Charge is that of a failure "*within a reasonable timeframe when asked*" and the Tribunal finds that the Practitioner did not attend within that timeframe in the circumstances. The patient's [ ] was at significant risk and fortuitously she suffered no ill consequences of the delay.

[53] The Tribunal finds that this is negligence on the Practitioner's part and finds that this was an act which brought discredit to his profession. This separately warrants disciplinary sanction (and cumulatively with certain other particulars referred to below).

Particulars 1, 4 and 5 – [ ] 2016 – rudeness and verbal abuse; failure to attend within a reasonable timeframe and inability to be contacted

[54] It is appropriate that these particulars be dealt with together because they involve the same sequence of events.

[55] On [ ] 2016 a patient, Ms A, presented at the hospital at which the Practitioner was the on-call [ ]. She was seen by the Emergency Department and particularly Dr Y. Ms A presented at 4.01 pm with a complaint of "*deteriorating [ ]*" from having been [ ] and triaged such that she should be seen within around one hour.

[56] Dr Y saw the patient at 5:28 pm (some 1.5 hours later). From that consultation it became apparent that Ms A had previously presented 4 days earlier on [ ] 2016 at

that Emergency Department with concerns for [ ] in [ ] which had earlier had a [ ] following a [ ]. Having read the notes, Dr Y elected to call Dr R who was the on-call [ ] at the [ ] hospital because he had seen the patient on [ ] 2016. This was despite the on-call [ ] for the presenting hospital being the Practitioner.

[57] Dr Y obtained further information from Dr R who expressed concern that the patient may be developing a rejection of [ ] which was a very serious [ ]-threatening problem; and who expressed the view that the patient was extremely complex and required assessment by an experienced [ ].

[58] Dr Y then contacted the Practitioner at approximately 7:00 pm, explained the patient's presentation and advised him that she considered that the patient needed to be seen by an [ ] that evening.

[59] Dr Y gave evidence of the exchanges that she had with the Practitioner who she said "*sounded annoyed*" and who made repeated reference to the fact that he was "*just sitting down to dinner*". She said he also complained that he had left the hospital at 5:00 pm and that "*he thought it was ridiculous that he had not been called earlier*".

[60] After further exchanges, including Dr Y's explanation as to why she had spoken with Dr R, Dr Y said that the Practitioner responded that he did not see why he should see the patient especially "*as she has come so late, when I am now sitting down to dinner. If she is going to come so late then I will see her around eight*". And then "*this is really not acceptable".* Dr Y said that she said to the Practitioner that, if he felt so strongly about the timing of the patient's presentation, he should discuss this with her to which the Practitioner replied "*I am taking it up with you, not her*". When Dr Y asked the Practitioner why that was he replied, she said, in a sarcastic tone "*well if you don't know that then you obviously haven't been practising medicine for very long*".

[61] Dr Y categorised to the Practitioner that she thought this was verbal abuse which was denied and Dr Y concluded by saying to the Practitioner:

> "*Just to be clear, can I check that you have a problem with the fact that I am phoning you, the [ ] on-call for this hospital, to see a patient with an acute [ ]-threatening problem, especially when another [ ] consultant has stated that the patient should see an experienced [ ] tonight*?";

to which, Dr Y said, the Practitioner replied in the affirmative.

[62] Dr Y protested the Practitioner's behaviour and communication and asked for the name of his Head of Department. There were the exchanges between Dr Y and the Practitioner concerning complaints.

[63] Evidence to the Tribunal from Dr R confirmed his having assessed the patient on [ ] 2016 and covered his interactions with Dr Y on [ ] 2016 as outlined above.

[64] The Practitioner said that he arrived at the hospital at about 7:50 pm (which he did not consider was an unreasonable timeframe – to which particular 4 refers) and was surprised to see that the patient awaiting his review was Ms A. Ms A had been a patient of his whom he had seen around 20 times over the years and with whose [ ] issues he was very familiar. He then learned that Dr R had assessed Ms A four days earlier and this

> "*provided some explanation as to why Dr R did not call him to discuss [the patient] himself given he was not her usual [ ] and was not familiar with her history*".

[65] The Practitioner's review confirmed that Ms A was suffering from a [ ] from her [ ] and he prescribed for her and arranged to see her the following morning, [ ] 2016, for review.

[66] The Practitioner said he tried to find Dr Y that same evening "*to try to clear the air after [their] conversation but was informed that her shift had ended*" which in fact had occurred at 8:00 pm.

[67] On Friday, [ ] 2016, Dr Y began work at 8:00 am and noted that Ms A was due to see the Practitioner at 11:00 am that day and had a follow-up appointment on [ ] 2016 with her Auckland-based [ ].

[68] When Dr Y met up with the Practitioner at 11.45 that morning, the Practitioner's evidence was that he said he wanted to apologise for the tone of his conversation the night before and offered his apologies for the tone of his communication. Dr Y confirmed there was the discussion but gave a different account of what was said and expressed the view she did not consider the explanation justified the Practitioner's behaviour from the night before but thought that that was not the time or place to seek a resolution of her concerns and she did not respond to that.

[69] There were professional discussions between the Practitioner and Dr Y concerning the patient. Dr Y said that the patient was very anxious about the [ ] and she asked

the Practitioner for the plan if she re-presented at the Emergency Department over the weekend. The Practitioner said to Dr Y that, because he had seen the patient many times before, he would be happy to see the patient over the weekend if she returned.

[70] Arrangements were made for contact if needed. The Practitioner told Dr Y that the Emergency Department should "*phone his rooms*"; that his rooms were not open over the weekend but the hospital switchboard would have his number; and that he should be contacted "*via the Hospital switchboard*".

[71] During that Friday afternoon Dr Y had increasing concern regarding the deteriorating [ ] for the patient. She attempted to contact the Practitioner on his long-range pager but was unsuccessful. She tried other means of contacting him, including calling his private rooms and via the Hospital switchboard but was unable to locate him.

[72] Dr Y made other arrangements for the patient including admission to hospital under the care of a medical physician and contact with the on-call [ ] registrar for [ ] hospital.

[73] For his part the Practitioner said that it was while he was out for a walk on the Friday afternoon that Dr Y attempted to contact him but he did not have his mobile with him as he had left it at his house. He was not a anticipating a call from Dr Y but on his return from his walk noted there had been incoming attempt to contact him. On inquiry, he was informed by the hospital operator that no one was looking for him. The Practitioner said that his private rooms were not open on a Friday and there would be no reason for staff to be present.

[74] There has been some further action on the Practitioner's part following these events. He said he made the attempt to find Dr Y to apologise at the end of Thursday, [ ] 2016, but she had left. Following an investigation process with his employer District Health Board the Practitioner realised these "*highlighted that communication is a two-way street*" and he offered to the General Manager of Clinical Services that he would be happy to offer Dr Y a second apology; but nothing ever came of this. At the hearing the Practitioner, before he gave evidence, and before Dr Y was re-examined by counsel, asked to be permitted to speak direct to Dr Y and he then did apologise to her for the way he had spoken to her in [ ] 2016.

[75] The Practitioner has been engaged in a course of learning for better communication. He attended part of this course in [ ] 2017 and part in [ ] 2019 and it gave him, he said, "*a lot of good insights into the way different personality types interact and is something [he is] mindful of in [his] practice*".

Particular 1 – rude and verbally abusive telephone call

[76] The allegation is that on [ ] 2016, the Practitioner was rude and verbally abusive towards Dr Y during the telephone called regarding the care of the patient, Ms A, when he was the on-call [ ]. The detail of that call is set out above. No other evidence was given about the content. It was just the two parties involved.

[77] The submissions for the PCC included:

a) That Dr Y's evidence remained largely consistent throughout and she was firm and certain about recall. This was consistent with an initial complaint made on [ ] 2016 which was produced to the Tribunal.

b) That assertiveness on Dr Y's part should not be mistaken for being unreasonable or argumentative.

c) That Dr Y consistently disagreed with any suggestion she had a crusade against the Practitioner.

d) That Dr Y's evidence described the Practitioner as having sounded angry during the telephone call as indicated by tone and volume of his voice which was characterised by Dr Y as a verbal abuse.

e) That Dr Y's evidence is affirmed by evidence from the Clinical Head of the Emergency Department at the hospital, Dr G, who said that he believed she was upset from the conversation because she had felt as if she had been spoken down to and not treated like a fellow specialist.

f) That evidence from Dr G also confirmed that the Practitioner was difficult at times.

[78] The submissions for the Practitioner included:

a) That the particulars need to be viewed in the context in which they occurred.

b) That there was a misunderstanding arising from the telephone conversation which then proceeded in a "*less than ideal manner*".

c) That the two statements from the MCNZ relied on by the PCC, *Good Medical Practice* and *Unprofessional Behaviour and the Health Care Team*, defined "*unprofessional behaviour*" to include "*chronic and repetitive inappropriate behaviour"* or "*single or intermittent severe impulse control problems that are out of proportion*…".

d) That unsubstantiated rumours or gossip to establish "*chronic and repetitive*" behaviour should be ignored.

e) That the cases relied on by the PCC were all more serious than the present case and were cases where there had been a demonstrable risk of harm to the public.

f) That by comparison with *Mendel*[17] the acts in question in this case were significantly less severe and more similar to the recent decision *Dr Y v PCC*[18].

Discussion

[79] The Tribunal accepts the evidence on these exchanges from Dr Y. The Practitioner was a senior colleague as was Dr Y. Any misunderstanding about the identity of the patient was irrelevant to the expectations of the Practitioner's exchanges with Dr Y. The amount of time that may have elapsed before the contact between Dr Y and the Practitioner is also irrelevant.

[80] What the Practitioner had to deal with at the time was that a fellow specialist, this time in the Emergency Department, contacted him concerning a patient who had presented and for whom she had concerns about the presentation and in respect of whom she formed the view that the patient needed to be seen by an [ ] that evening.

[81] The Practitioner was irritated because he had just sat down to dinner and said so a number of times; and because he questioned why his services had not been called on when he was still at the hospital.

[82] It is accepted that that was all in the context of what would have been a wider discussion but nevertheless the Tribunal accepts that it did occur and there were the exchanges as outlined in her evidence by Dr Y.

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[17] 977/Med 17/394P

[18] 1062/Med18/430P

[83] It was indicative of his attitude that the Practitioner said, as Dr Y gave in evidence: "*if she is going to come so late then I will see her around eight*". That is not part of the Charge but it does indicate the irritation that the Practitioner was experiencing. The later exchanges with Dr Y concerning the Practitioner's availability to respond included "*I am taking it up with you, not her*"; [in a sarcastic tone] "*well if you don't know that then you obviously haven't been practising medicine for very long*"; and the affirmative response to Dr Y's clarification question recorded above at paragraph 61 all indicated to the Tribunal an inappropriate response to questions from a fellow specialist.

[84] Dr Y's evidence on the exchanges were confirmed by the evidence of Drs R and G to whom Dr Y reported the matter; in the Safety First Report entered [ ] 2016 by Dr Y; and in her letter of complaint to the MCNZ on [ ] 2016.

[85] The Guidelines provided by the MCNZ are not obligatory on the Practitioner but, as was said by the Tribunal in *Emmerson* noted above, they are there for good and proper reasons and are promulgated by the MCNZ pursuant to its obligations under section 118 of the HPCA Act to set standards of ethical conduct to be observed with the overall purpose of protecting the public and maintaining standards in the profession.

[86] *Good Medical Practice* requires that a practitioner treat colleagues "*courteously, respectfully and reasonably*" and the Tribunal finds that that did not occur in this case. The extract from *Unprofessional Behaviour and the Health Care Team* reads:

> "*Chronic and repetitive inappropriate behaviour that adversely affects the effective functioning of other staff and teams is unprofessional. The American Medical Association describes this as 'disruptive behaviour'. It is a 'style of interaction with other doctors, medical staff, patients, family members or others that interfere with patient care'. Single or intermittent severe impulse control problems that are out of proportion to precipitating stressors would also be considered unprofessional behaviour*".

[87] Those Guidelines give help to the Tribunal in assessing the Charge brought against the Practitioner in this context. The Tribunal finds that the exchanges that the Practitioner had with Dr Y were not courteous, respectful or reasonable and were out of proportion to the precipitating stressors. The Practitioner may have had his

frustrations with the events that unfolded and he had a misunderstanding of the true patient situation, but that is no excuse for his having spoken to Dr Y in the way that he did. The reference to Dr Y's not having been practising medicine for very long was a significant put-down to her and unacceptable. It placed Dr Y in the situation that she may have had to call on Dr R who was a 2 hour drive away to deal with the matter; and that would have been unacceptable. It would not have taken long for the Practitioner to have inquired further of Dr Y as to the background to the patient or the reason that she contacted Dr R about this patient and that would have clarified matters.

[88] Dr Y said that she always gives a patient's name and public health number in circumstances such as that and the Tribunal prefers her evidence to that of the Practitioner.

[89] Even if she did not use those words, however, the Practitioner himself said that he knew most persons in the area with significant [ ] problems and he could have made the inquiry about the identity of the patient and clarified the matter.

[90] A significant factor is that the Practitioner realised that what he had said or the way he had said it was inappropriate and he sought to apologise for that that day and shortly after. Furthermore, he apologised to Dr Y at the hearing; and the Tribunal treats that as an acceptance by him that there was inappropriate communication at the time. A timely apology, particularly if that could have been properly managed, might well have resolved the matter not requiring the Charge before the Tribunal.

[91] The Tribunal finds that the exchanges that the Practitioner had with Dr Y were both rude and verbally abusive towards her and they were conduct which brought discredit to his profession. The Tribunal does not find that there was malpractice or negligence by the Practitioner in this respect.

[92] The Tribunal has considered whether, in light of the various tests promulgated by the cases included in submissions from the parties, these acts on the Practitioner's part warrant disciplinary sanction and has concluded that on their own they do not. There was discredit brought to the profession. Unprofessional, rude or discourteous communications between Practitioners can affect the protection of the public and the quality of health care that is given to them. It was, however, in this case only between the practitioners in question and only on the one occasion. No harm was

done to the patient (although there may have been potential for harm) and no other persons were aware of the exchanges that had taken place. Things can be said between professionals in the stress of the moment but, as noted above, what the Practitioner said to Dr Y was disproportionate to those stressors.

[93] For Dr Y's part she had a patient that she considered needed being seen by a specialist [ ] and was being confronted by the Practitioner with the responses mentioned. For his part the stressors for the Practitioner appeared to be the unfortunate timing that he had left the hospital by then and that he was eating. His responses to Dr Y were disproportionate to those stressors.

[94] This is not of sufficient severity to warrant disciplinary sanction on its own but does warrant such sanction cumulatively with other particulars found to be made out below.

Particular 4 – failure to come within a reasonable timeframe when requested

[95] The PCC relied on the evidence of Dr Y to support this allegation. The facts are set out above. Setting aside the communication issues already dealt with, the timeframe for the Practitioner to return to the hospital to see the patient had been discussed between him and Dr Y as being at 8:00 pm that night. There was no evidence that that timeframe was unreasonable in the circumstances, even given the concerns that Dr Y may have had about the risks to the patient. Apparently she acquiesced in that timeframe as being appropriate and the matter was left at that. Dr Y then spoke to the patient and said that the Practitioner would be in to see her at around 8:00 pm and passed that information on to Dr E who was the Emergency Department consultant in charge at the time and others. She also advised Dr R of the arrangement for the Practitioner to see the patient and there was no suggestion in any of those exchanges that this was untimely.

[96] Submissions for the Practitioner referred to the absence of expert evidence on this topic of timeliness in respect of this particular.

[97] The Tribunal concludes that there was a time frame agreed between the Practitioner and Dr Y and this was complied with by the Practitioner. The Tribunal does not find this particular of the Charge to be made out.

Particular 5 – [ ] 2016 – inability to contact by cellphone despite advices

[98] Again the facts are set out above. The issue was that the Practitioner had told Dr Y about his availability over the weekend whereas the concerns as things developed for contact of him arose on the afternoon of [ ] 2016.

[99] The Tribunal interprets the discussion between the Practitioner and Dr Y concerning his availability did relate to the period after he had finished speaking with her and the end of the ensuing weekend, and includes the Friday afternoon.

[100] The Practitioner was not on call that weekend but was prepared to make himself available because he knew the patient and was ready to assist if necessary. He may have been trying to "*make good*" for his earlier behaviour towards Dr Y. Clearly the understanding was that he would have made himself available from the time he said that until the time that resources were available after the weekend for reference for expert [ ] advice and assistance.

[101] In fact, the Practitioner returned home at 12:00 noon on [ ] 2016 and went for a walk. He said that, unusually, he had failed to take his mobile with him as he had left it in his briefcase at his house, not anticipating a call that afternoon. When he returned from his walk and saw that a blocked number had tried to call him he made the inquiries to ascertain who that might have been.

[102] The Tribunal accepts the submission for the PCC that it would have been clear to any one that the expectation was that the Practitioner could be contacted from the point he left the hospital on [ ] 2016 through to the following Monday. The reality then is that the Practitioner was not available during that Friday afternoon.

[103] On the Practitioner's behalf reference was made to other email exchanges and documents which, it was said, did not in any way allege that the Practitioner informed Dr Y that he would be contactable later in the afternoon of Friday,[ ] 2016 following the conversation.

[104] Specific attention was drawn to a Safety First Report entered [ ] 2016 from Dr Y which included that she specifically asked the Practitioner "*what the plan should be should [the patient's] [ ] to deteriorate further or should she re-present to the ED over the weekend ([ ])*". It was said that that was Dr Y's own definition of the period in

question but the Tribunal does not accept that. Clearly the intention was to make some arrangement for on-call availability for the whole period after the consultation concluded through to the following Monday.

[105] The Tribunal assesses that there was an agreed understanding about accessibility for the Practitioner for consultation concerning this patient which included the period of Friday afternoon [ ] 2016. The Practitioner did not comply with that and is standing by not having had his mobile with him while he was on his afternoon walk. (The evidence from witnesses referred to a "*mobile*", "*cellphone*", "*long-range pager*"; but the essence of the evidence was that the Practitioner could not be contacted in the manner he had said he would be able to be).

[106] The Tribunal does not consider this is malpractice or negligence on his behalf or conduct having brought or having been likely to bring discredit to his profession.

[107] The Charge in respect of this particular is not found to be made out.

Particular 6 – [ ] 2017 – refusal to see patient in timely manner

[108] This particular also arose because of the initial complaint by Dr Y. On [ ] 2017 she was working at the Emergency Department at the hospital and the patient, Mr I, presented with [ ] irritation and pain and was suffering from [ ] and [ ]. The patient was seen by the house surgeon, Dr J. Dr Y reviewed Dr J's assessment and formed the opinion that there was sufficient clinical concern to warrant the patient's being seen by an [ ] that day.

[109] Dr Y said that Dr J called the Practitioner who was the on-call [ ] and she was nearby. She said that Dr J explained the examination to the specialist and summarised previous medical history. Dr Y said that Dr J reported to her that the Practitioner said he was unable to see the patient that day as he was in theatre and would see him in 2 or 3 days, but did not specify where he would see the patient. Dr Y said that Dr J reiterated to the Practitioner the concern that the patient be reviewed that day so that early treatment could be started if needed and said that the Practitioner again stated to Dr J that he would not be able to see the patient that day as he was in theatre.

[110] Dr Y said that she took the phone from Dr J and spoke directly to the Practitioner reiterating that she thought the patient needed to be seen that day and offering to

contact an [ ]in [ ] to arrange for the patient to be seen there if the Practitioner was not able to see him in [ ]. The Practitioner said that he would see the patient but was busy in theatre. He expressed the view that he did not think the patient needed to be seen that day. He said that he would take the patient's cell phone number but hung up before doing so, necessitating Dr J's calling him back with that number.

[111] There was no evidence to the Tribunal from Dr J and no evidence from any expert witness as to standards.

[112] In his evidence the Practitioner referred to the call he had had and said that, based on the information provided by Dr J, he did not think that same day review was clinically necessary and the patient did not meet National Referral Guidelines Criteria for an [ ] Referral, immediate or otherwise (producing a copy of those Guidelines). He said that the [ ] the patient was suffering from could not be transferred to the [ ] and his symptoms on their own fell far short of justifying an immediate assessment. He said he told Dr J that he was happy to review the patient in 2 or 3 days when he had an available appointment.

[113] The Practitioner described the conversation with Dr Y as being that she "*forcefully insisted*" that he review the patient that day and reiterated the prospect of infection to the [ ]. The Practitioner agreed to review the patient later that day to alleviate Dr Y's concerns but he informed her, he said, that he was confident that he did not think that same day assessment was justified.

[114] His evidence was that he reviewed the patient at the end of his theatre list that day; the patient had a [ ], which is a [ ] and no action was required.

[115] He said that he did not accept that he refused to see the patient in a timely manner and was unclear as to what would have been *"timely"* in the context of presentation, believing it was up to him to determine the urgency of the assessment required. He said he was "*confident that had [the patient] been assessed by a GP or [ ] no referral to [him] would have eventuated as he had no serious issue*".

[116] Although not relevant to the particular of the Charge, the Practitioner also said that he had concern about Dr Y's comment that she would send the patient elsewhere if he did not review the patient and wrote to the Head Emergency Department Clinician expressing that concern.

[117] The submissions for the PCC:

a) Acknowledged that the Practitioner was practising in difficult circumstances, being the only [ ] at a rural hospital; but submitted that a Practitioner taking up a role in such an area should expect to receive phone calls from more junior doctors.

b) Acknowledged that Dr Y accepted there was no obligation on a specialist personally to review every patient they are contacted about.

c) Submitted that the Practitioner should be expected as a specialist to explain the reasoning of his decision when he had been asked to come in; and in the absence of this his colleagues in the Emergency Department would have been left in the dark as to the clinical reasons for his not needing to see the patient.

d) Submitted that the question of whether immediate attention is needed is a collaborative decision as is the urgency of presentation, as accepted by the Practitioner in his evidence.

e) Submitted that the fact that the patient's infection was not able to be transferred to his [ ] did not detract from the Practitioner's failure to assess the patient and "*or provide any meaningful treatment advice*".

[118] The submissions for the Practitioner:

a) Denied that the Practitioner had ever refused to see the patient.

b) Referred to the context in which the events had occurred being 3 days after Dr Y's interview with the PCC regarding her previous interactions with the Practitioner to which particulars 1, 4 and 5 above referred.

c) Referred to authority on the question of obligation to call witnesses.

d) Submitted that the particular of the Charge was not made out.

Discussion

[119] Particular 6 refers to an initial refusal to see a patient in a timely manner. That requires an assessment by the Tribunal of the evidence that is given about the condition of the patient and the standards that must be met in achieving "*timeliness*".

[120] The PCC has relied on the hearsay evidence from Dr Y about Dr J's exchanges with the Practitioner, but there was also her own exchange. It has also relied on her

assessment as to the timeliness required in the Practitioner's response to the concern raised.

[121] The Tribunal is not satisfied on the evidence that there was a need for timeliness to see this patient by the specialist [ ] in the circumstances. That is borne out by the facts and the Tribunal is prepared to accept the Practitioner's assessment from what he was told on the phone of the need for timeliness in his response.

[122] He formed the view that there could be no transmission of the infection to the [ ] and that there was no risk and he formed the view about the timeliness that was required in his response. The fact that he did agree to go to see the patient later does not of itself amount to a refusal to see initially in any manner that is contrary to standards.

[123] This is all a question of communication. The submissions for the PCC effectively acknowledged that. What was wanting was an adequate explanation from the Practitioner to Dr J and/or Dr Y of the reason why he did not think there was need for him to see the patient with the urgency that they were requesting. It seems that that explanation was not clearly conveyed or understood and it also appears to the Tribunal that Dr Y's position on the matter was that her assessment of urgency was what counted and that the Practitioner had to respond to that. That is the basis on which the PCC has presented the particular of the Charge.

[124] The Tribunal does not find this particular of the Charge made out by the PCC as malpractice or negligence on the Practitioner's part or as any act or omission which brought or was likely to bring discredit to his profession.

Particulars 2 and 7 – 2017[ ] –"brusque" telephone call with colleague and refusal to provide treatment advice

[125] These particulars address first an allegation that the Practitioner was "*brusque*" towards a colleague during a telephone called regarding the care of a patient, Ms T; and secondly that he refused to provide treatment advice during a telephone call regarding the care of that patient.

[126] The evidence was given first from Dr B, who had previously been a house surgeon in the Emergency Department at the hospital. He said that on 2017 while he was working on the evening shift he examined the patient, Ms T, who presented with [ ]

and he described her history. He said he had not at the time heard of the disease for which she had previously been treated so he asked a number of consultants in the Emergency Department but none had heard of it either. He described the steroid treatment she had been on which was on a decreasingly downward titration. He acknowledged he was a junior house surgeon at the time with limited experience but carried out the most comprehensive examination and history he could.

[127] Dr B said that the patient said that she had called the Practitioner's private rooms earlier that day and had been told by the receptionist to go to her GP or [ ] for a referral back to the hospital; but because it was the end of the week she came straight to the Emergency Department. Dr B's supervising consultant, Dr C, with whom he discussed the case, asked him to call the Practitioner, the on-call [ ] at the time. Dr B said that he called the Practitioner and spoke to him on the phone and explained the results of his examination and concerns. He said that the Practitioner did not really give him treatment advice but told him to organise a follow-up appointment with whomever had previously treated the patient and that he was unable to give treatment advice himself because he had not seen or examined the patient himself.

[128] Dr B said that the Practitioner did not ask any clarifying questions and that he "*got the impression that [the Practitioner] did not want to be involved if he did not have to*". Dr B said that, although they went over the patient's situation a number of times, he still did not know what he should do with the patient and so consulted with Dr C who was sitting beside him. Dr C suggested he called the [ ]-based [ ] who was on duty but Dr B instead spoke to the patient again for further detail and called the Practitioner back. He said that "*we ended up back in the same conversation [and that the Practitioner] told [him] that he felt like he could not give any more treatment advice*".

[129] Having spoken to his supervising consultant because of his concerns that the presentation and history needed some kind of treatment that night, Dr B called the [ ] on-call [ ]for further advice; he spoke with Dr R there and was quickly advised to give the patient a very high dose pulsemethylprednisolone, or, if that could not be arranged, a very high dose of prednisone.

[130] That was the course that followed that night. Arrangements were made for the patient to go to [ ] (some 2 hours drive away) the next day with friends or family and the patient, Dr B said, saw the [ ] [ ] and was administered with methyl prednisolone.

[131] The evidence to the Tribunal from Dr C affirmed what had been said by Dr B in his evidence and said that he overheard much of what was said between Dr B and the Practitioner including that the Practitioner was unable to offer any advice as he did not have the patient records available to him and that on information available he did not think the patient's [ ]was acutely at risk.

[132] Dr C said that the Practitioner advised Dr B to find out who the patient's current [ ] care provider was and to write a referral letter to that person; and that he, the Practitioner, felt he was unable to give further advice based on the limited information available.

[133] Dr C confirmed Dr B's evidence that Dr R advised that the symptoms may represent a reactivation of the patient's [ ] disease and that she should be started on high-dose steroids immediately. He also confirmed that the patient was transported to [ ] and seen by Dr R the next day.

[134] Dr C said that he was concerned about the reluctance of the Practitioner to provide advice or see the patient as this may have had the potential to cause an adverse patient outcome. He produced to the Tribunal a Safety First Report dated [ ] 2017 that he had written to the District Health Board. That contemporaneous record affirmed what Dr C had said in evidence.

[135] Evidence was also given on this topic by Dr R. He confirmed Dr B's call on [ ] 2017 and advices given, saying that Dr B said that the Practitioner "*had refused to see the patient, and had instead advised him to refer the patient to a local [ ]*". Dr R said he was "*concerned that the patient had reactivation of a known [ ] condition called [ ] and required urgent management*". He described that condition as "*an aggressive [ ] condition, and delay in correctly diagnosing and initiating intensive immunosuppressive therapy can result in [ ]*". He said it was difficult for a non-specialist to assess and also for a specialist confidently to assess and treat a patient on the basis of a non-specialist review over the telephone.

[136] Dr R said that he recommended that Dr B give a dose of pulse methylprednisolone or, if that could not be arranged, a dose of prednisone. When he saw the patient the

following day, Dr R said that he believed the correct course of management had been applied.

[137] In his evidence the Practitioner said that he had seen this patient a few times over the years and was aware of her history from the [ ] disease she suffered from. He was aware that she was receiving specialist input into her care from a medical [ ] specialist based in [ ] but had not himself personally seen her for a number of months and was not actively involved in her then current clinical care.

[138] He said that when Dr B telephoned him concerning the patient, he asked Dr B whether there had been any sudden changes or deterioration in her [ ]that day and Dr B confirmed that there had not been. The Practitioner said he did not feel he was able to give Dr B treatment advice at that time based on the patient's symptoms and [ ] test alone and more comprehensive investigations and scans were needed. Access to equipment was not, the Practitioner said, available at the hospital after hours and the Practitioner said that he considered there was nothing to be gained from assessing the patient that night, given the reassurance that her [ ] was stable and that she did not have an acute issue. Administering steroids would, he said, mask her presenting symptoms and potentially obscured the results of the diagnostic scans the next day.

[139] His advice to Dr B, he said, was that he should contact the secretary for the [ ] who had been managing the patient with a plan that he could see her the following morning with as much current information as possible.

[140] The Practitioner said that he asked Dr B how the patient had come to present to the Emergency Department first because he was unsure why she presented that evening if she had a two-week history of symptoms with no changes or deterioration and secondly because he did not consider the Emergency Department was the appropriate forum to make treatment arrangements for the patient with her complex history.

[141] The Practitioner said that the following morning when he asked for an appointment to be organised for the patient he was surprised to learn that she had gone to the [ ] hospital for assessment.

[142] Subsequent to the events of that day the Practitioner resumed, he said, managing the patient's care in conjunction with another practitioner.

Particular 2 – brusqueness towards the colleague

[143] It was the submission for the PCC that Dr B's account of the tenor of the phone call was consistent with the lack of advice being provided given the Practitioner's failure to ask clarification questions and his "*terse tone*". Otherwise the submissions focus on particular 7.

[144] The submissions for the Practitioner referred to Dr B's evidence that the exchanges he had with the Practitioner were "*terse*" and then "*strained*" and "*confused*".

[145] The Tribunal does not find this particular made out as malpractice, negligence, or conduct bringing discredit to the Practitioner's profession. The content of the conversation as alleged in particular 7 is of more importance and the Tribunal does not find that there was any element of brusqueness in the exchanges.

Particular 7 – refusal to provide treatment advice

[146] In his evidence the Practitioner did not accept any **refusal** to provide Dr B with treatment advice but acknowledged that he did not provide him with treatment advice for the patient "*because [he] did not consider [he] was in a position to do so without the benefit of the diagnostic tests that were not available to [him] afterhours*". He made sure, he said, to ask Dr B whether the patient had had any sudden changes in [ ] which he reported she had not. The Practitioner was satisfied therefore, he said, that the patient did not have an acute problem and it would be better to wait to perform diagnostic tests before administering medications that had the potential to mask her symptoms or indeed may not have been necessary.

[147] The submissions for the PCC were that the failure by the Practitioner to provide treatment advice to Dr B had put the patient at risk. She had already [ ]. It was implausible, it was submitted, that the Practitioner advised Dr B that he would see the patient the next day at the hospital. Reference was made to the exchanges on that question:

> "Q. And are you aware that he turned up the next morning to actually go and see Ms T who are make an appointment to see her?
> A. No, I am not aware of that.
> Q. But if that were the case, and that's going to be

> Dr H's evidence, then that is consistent with what he says he told you about getting the information so that he could see her the next day, isn't it?
> A. That would be but then I wouldn't have organised other follow-up for her and gone to such lengths to organise it elsewhere.

[148] If Dr B had been aware that the Practitioner could see the patient in [ ] the next day he would not have gone to the effort of arranging for her to be seen in [ ]. She would have needed friends or family to transport her in an approximately 2 - hour motor car journey.

[149] The PCC relied on the evidence of Dr C that, due to the inadequacy of the advice that Dr B had been given, he recommended that Dr R was called.

[150] The submissions referred to Dr R's evidence that the failure to provide advice or assistance on the Practitioner's part put the patient at risk. [ ] can happen, he said in evidence, within a day in some cases; and his advice included immediate administration of steroids and an urgent consultation. His prognosis was that there was a reactivation of [ ] that required treatment and this could have been picked up on a [ ] examination.

[151] The PCC submitted that both Dr B and Dr C were clear that no treatment advice was provided by the Practitioner as is acknowledged by him in his own evidence. The Tribunal should not over-focus, it was submitted, on differences in the history given by the patient when she was seen by different practitioners because she was a patient with a complex history of [ ] issues who reported to the Emergency Department in line with previous treatment advice.

[152] Given the risks in place both Dr B and Dr C were of the view, it was submitted, that treatment advice was needed that day. Dr B was unable to get that advice from the Practitioner but did get it from Dr R.

[153] The submissions for the Practitioner focused on the allegations in the particular, emphasising that there was no allegation that the Practitioner failed to appreciate the seriousness of the patient's condition or that he failed to prescribe an appropriate plan. The Practitioner's clinical judgment is not, it was submitted, in fact in issue at all. The allegation of "*refusal*" refers to something that is materially different from an ability to give treatment advice. This carries "*a materially more prejudicial implication*" than any inability to give treatment advice. There is no

evidence, it was submitted, that the Practitioner refused to provide treatment advice.

Discussion

[154] The Practitioner may have had his own views on the immediacy and urgency of treatment for the patient on that day. It seems that he did not explain in detail to Dr B why he did not think there was the urgency or immediacy. That placed Dr B in the position of having continued uncertainty about urgency and having to consult with Dr R. The advice given by Dr R was straightforward and easily carried out. That was for the dose of pulse methylprednisolone if available or otherwise prednisone. Any immediate risk to the patient was thereby averted.

[155] The Tribunal does not accept that administration of that medication was not necessary because of advices given to Dr B which he passed on to the Practitioner, leading him to conclude that the patient did not have an acute problem. Administering medications may have masked her symptoms but first that was not explained by the Practitioner to Dr B and secondly was not as important as ensuring that this patient did not completely [ ] for which there was some risk.

[156] The Tribunal does not need to have expert evidence on what advice the Practitioner should have given Dr B on this occasion. It can conclude that from the evidence of the witnesses referred to above, especially that of Dr C as to what exchanges had occurred and the evidence of Dr R as to what he thought was the proper course to be followed.

[157] The particular of the Charge does not deal with the quality of advice given by this [ ] specialist to the house surgeon but rather alleges a refusal to provide that advice. The word "*refusal*" implies some positive action on the part of the Practitioner in respect of his response to a request for, or the need for, advice. Dr B was needing advice from the Practitioner which eventually he got from Dr R.

[158] As the more junior and less experience practitioner he had presented the position for the patient to the Practitioner and that called for a detailed express response from the Practitioner explaining the position and giving reasons for why he was responding in the way that he did. The response in fact given by the Practitioner as outlined in the evidence of Dr B fell far short of that. It was not "*brusque*" as alleged

in particular 2 but it was completely inadequate and left Dr B, the junior house surgeon in the Emergency Department, no better off.

[159] The Tribunal finds that that was malpractice and negligence on the Practitioner's part and was conduct which brought, or was likely to bring, discredit to his profession. It is professional misconduct which warrants disciplinary sanction to maintain standards in the profession and to protect the public.

Penalty

[160] Those findings having been communicated to the hearing, because of shortage of time, submissions on penalty were provided in writing according to timetable.

PCC submissions

[161] The position of the PCC is that orders should be made censuring the Practitioner; that he practise in accordance with certain proposed conditions for a period of two years; that he pay a contribution towards costs; and that there be publication of the Tribunal's decision.

[162] Having referred to relevant principles and authorities the submissions for the PCC first addressed the question of unprofessional behaviour in the context of particular 1. Particular 2 was not found made out and need not be considered. The submissions revisited the merits of the Charge and considered comparable cases but did not address any appropriate penalty in the context that particular 1 was not found to be made out as warranting disciplinary sanction separately nor the extent it should be taken into account cumulatively with other particulars found made out.

[163] As to the particulars categorised as "A*vailability when rostered as on-call doctor*", that is particulars 3 and 7 (the other particulars, 4, 5 and 6, having been dismissed), the submission was that these were serious departures from standards expected of medical practitioners. Reference was made to the risks to the health of the patients and the urgent specialist input required. The submissions referred to issues arising in respect of liability with references to Guidelines from the MCNZ and these have been canvassed above.

[164] One case cited on penalty was *Robertson*[19], a case of a midwife who arrived late at a maternity facility after the child had been delivered stillborn by the on-duty midwife, a delay of some 1.5 hours. The midwife was censured, fined $2,080.00 with conditions imposed for supervision and to undergo a standards review. The Tribunal does not find that case helpful because the facts are so different.

[165] Reference was made to the aggravating factor that the offending was over a period of three years, although the Tribunal's view is that the incidents in themselves were well spaced and cannot be regarded as any pattern of misconduct. Rather they indicate that the stressors of his practice as consultant [ ] were heavy for the Practitioner to manage.

[166] Mitigating factors mentioned were the length of time since the events in issue had occurred, the Practitioner's long employment history with no previous disciplinary issues, his subsequent resignation from the District Health Board and his being no longer involved in on-call work, his having worked at the time subject to an onerous on-call roster, and his engagement in a communication course in [ ] 2017 and [ ] 2019 following concerns having been raised regarding his interaction with colleagues.

[167] The conditions proposed by the PCC submissions were for completion of an education programme addressing medical ethics, professional interactions and communication with colleagues to be completed within 18 months and to be supervised by a vocationally registered peer with all costs being met by the Practitioner; and that the Practitioner advise any current or future employers of the Tribunal's decision for a period of 2 years.

[168] Given that the Practitioner is no longer providing on-call services, the submissions were that it could be expected that a further occurrence of similar incidents is unlikely. They do, however, it was said, also raise concerns about his interactions with colleagues generally which the proposed conditions would address.

[19] 130/Mid07/63D

Submissions for Practitioner

[169] The penalty submissions for the Practitioner were that the appropriate penalty orders to be made were for censure and an appropriate contribution towards the PCC costs and Tribunal resourcing costs.

[170] The submissions highlighted that penalty consideration should only address those particulars found to be made out and no account should be taken of any evidence that amounts to rumours or gossip about the Practitioner. Comparable cases were referred to, namely *Mendel*[20], *Drury*[21] and *Ms N*[22] in the context of unprofessional behaviour. Distinctions were emphasised.

[171] As to the two particulars found to be made out as professional misconduct, particular 3 - failure to come within reasonable timeframe – and particular 7 - refusal to provide treatment advice - the submissions were:

a) That it would be improper to assess the seriousness of the Practitioner's conduct through the lens of that the patients were suffering from "*acute, [ ] conditions that required urgent specialist input*". This is as had been submitted for the PCC. There was no expert evidence in respect of these particulars nor any evidential basis to assess clinical urgency of these patients' presentations. Reference was made to the time lapse between when the respective patients presented at the Emergency Department before the Practitioner was asked to assess or give treatment advice.

b) That there was no evidence of "*persistent lateness in responding to work calls*" to which the MCNZ guidelines refer.

c) That any refusal to provide treatment advice does not amount to a failure to be accessible.

d) That of the cases relied on by the PCC, *Robertson* could be distinguished on its facts; and, while *Dr S* was acknowledged as an analogous to the present case, there were significant distinguishing factors relevant to penalty.

e) That the fairness, reasonableness and proportionality of a penalty must be assessed in light of the specific circumstances of the conduct and the

[20] 996/Med17/394P
[21] 500/Psy12/216P
[22] 412/Nur11/182P

Practitioner to which it relates; and the remedial actions that the Practitioner has taken since the events ought to carry significant weight when determining penalty.

f) That all three discreet events occurred in the Practitioner's interactions with the Emergency Department at the hospital, were the subject of Safety First alerts which prompted investigations, none of which resulted in formal adverse findings against the Practitioner. (That is noted by the Tribunal, but its role is to consider the seriousness of the professional misconduct on its own terms.)

g) That the Practitioner's working arrangements provided important context. In *Mendel* the stressed and busy working environment was taken into account. In *Dr S* the dysfunctional nature of the surgical unit was accepted as a mitigating factor.

h) That there were other mitigating factors including limited collegial support, and the immense pressure on the Practitioner trying to balance patients' acute needs with the Practitioner's public clinics and other commitments.

i) That there were rumours circulating about the Practitioner that he was not aware of but "*plainly had a bearing on how he was perceived by colleagues at the time [of the events behind the charge]*".

j) Emphasis was placed on the Practitioner's current professional position including his having resigned from his role at the hospital in [ ] 2019.

k) That there were no concerns from the Practitioner's other public work, his private practice, or from interactions with local general practitioners or [ ] colleagues.

l) That the decision announced to the hearing had a profound effect on the Practitioner as was apparent at the time.

m) That the Practitioner has now effectively halved his work load from 5 days per week to 2.5 days and he has lost the opportunity to teach medical students, something of which he had spoken with pleasure.

n) The apology offered by the Practitioner to Dr Y during the hearing was referred to and the attempts he had made to that end previously.

o) That the Practitioner has participated in the 2-part communication course referred to and

p) That an apology is a mitigating factor that should be taken into account by the Tribunal (*Samiyulla* 169/Phys08/90D and *Mrs S* 954/Nur17/404P).

[172] The conditions proposed on behalf of the PCC were discussed. No issues have arisen with the Practitioner's practice and outside interactions with the Emergency Department are unlikely to recur in a private setting. The Practitioner's working obligations have substantially lessened and he has good professional relationships with his general practitioner and [ ] colleagues.

Discussion

[173] The available penalties for the Tribunal are[23]:

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 (which does not apply here).

f) Costs.

[174] The eight factors normally taken into account on the basis of authorities[24] are:

a) What penalty most appropriately protects the public

b) The important role of setting professional standards.

c) A punitive function.

d) Rehabilitation of the health professional.

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

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[23] Section 101 of the HPCA Act

[24] *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; CIV 2013-485-47 at paragraph 65 - 66

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.

[175] In *A v* Professional *Conduct* Committee[25] the High Court said[26]:

> *"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."*

[176] The circumstances of those particulars of the Charge found made out by the Tribunal are set out above. The unprofessional behaviour of the Practitioner towards his colleague, Dr Y, took place in telephone exchanges where she was seeking his assistance as the on-call specialist in [ ]. There were misunderstandings on the Practitioner's part as to the identity of the presenting patient. These could have been clarified by him by relevant pointed questions which should not have been difficult for him.

[177] The Practitioner was under the stress of the obligations on him as on-call specialist. Those were the consequences of his having undertaken the commitments to his employer that he did. They are no excuse for his having spoken to his colleague in the way that he did. Communication between all health practitioners involved in the care of a patient should be courteous and constructive. There is no room for impatience or impatient responses. There needs to be time taken to ensure adequate communication. This is certainly the case in communications between specialists of different callings. One is relying on the other for some help, in this case Dr Y in making her inquiry of the Practitioner, and the Practitioner giving the help

[25] Auckland HC; CIV 2008 - 404 –2927; 5/9/08; Keane J; para 81.

[26] Para 82

needs first to ensure he or she has adequate information by making inquiry as necessary and secondly explaining the course of action that the specialist proposes or advises so that this is understood by the other party.

[178] In this case exchanges should have occurred between the Practitioner and Dr Y which would have clarified the identity of the patient on the one hand and the reason why Dr Y consulted with Dr R rather than going straight to the Practitioner. There would have been clarification of the time lapse between presentation of the patient and the call on the Practitioner.

[179] The Practitioner formed the view that the situation was such that he could attend at the hospital at 8:00 p.m. that night and deal with the matter and that was the agreed response time between him and Dr Y.

[180] All those matters could have easily been the subject of dialogue between the two specialists had each taken the time to communicate adequately.

[181] The other two particulars found made out, particulars 3 and 7, are more significant. In respect of the patient to whom particular 3 refers the Tribunal has found that the Practitioner did fail to go to the hospital within a reasonable timeframe when asked by Dr E to do so. The patient had presented with what Dr E considered to be a [ ]-threatening condition given her previous history. When he described this to the Practitioner he was assured by the Practitioner that he would return to deal with the matter. He did not do so as quickly as he should have and that caused concern on Dr E's part of such that he actively considered undertaking a procedure himself to relieve the patient's presenting condition.

[182] There was a measure of want of adequate communication, but there was also delay in prompt response as the on-call [ ]. There was no expert evidence adduced by the PCC that this delay placed the patient at risk, but conversely there was no need for there to be any such risk if the Practitioner had responded in a timely fashion. He did return and indeed was apparently close to having done so when the second call was made to him and that stands in his favour in considering penalty.

[183] Communication is a factor also in respect of the patient to whom particular 7 refers. Had the Practitioner explained his thinking clearly to Dr B (and the Tribunal is mindful of the way that communication was described), then there would have been no need for Dr B to have made the arrangements for the patient to travel elsewhere next day.

Had there been clear discussion about the possible use of pulse methylprednisolone or prednisone and the Practitioner's views on this, Dr B would have been better informed. The Practitioner's misconduct in this respect has been found by the Tribunal to be a refusal on his part to provide the treatment advice that was needed as noted above.

[184] This whole affair sadly reflects inadequate processes. First there were the communication issues to which the decision refers between the professionals themselves. Then when the Practitioner sought the opportunity to apologise to Dr Y that was not available to him. Instead the matter has resulted in complaints and process. That led to investigation of other matters than those which had been the subject of the original complaint by Dr Y, particularly the [ ] 2014 and [ ] 2017 events to which particulars 2, 3 and 7 referred. The Tribunal ignores the [ ] event in this context referred to in particular 6 because that particular has been found not made out.

[185] It appears to the Tribunal that part of the contribution to the events and how they have been dealt with lies with the pressure that the Practitioner was placed under by his employment conditions and resolution of these matters by the Practitioner's employer in ways other than have occurred may well have produced a better result.

[186] This is not a case that calls for consideration of cancellation of registration or any suspension. These were not sought by the PCC and would not be appropriate. In none of the cases to which the PCC referred was this an outcome for the Practitioner (although in *Ms N* there would have been a suspension, but the circumstances of that case were significantly different from the present case).

[187] This is certainly a case where there should be an order for censure to express the Tribunal's disquiet about the events and the professional misconduct found against the Practitioner. That is ordered below.

[188] The Tribunal does not consider that the conditions proposed by the PCC need to be ordered. The first is for completion of an education programme to address medical ethics, professional interactions and communications within colleagues. This is sought to be ordered within 18 months of the decision. The view of the Tribunal is that that is not necessary because the Practitioner has already had the two-part

course in communication referred to above and he has had the time and experience of this prosecution and charge process to reflect and undertake his own self-learning.

[189] The Practitioner is a senior health practitioner who will have had the ongoing professional development requirements for his career and the Tribunal does not consider that there is need for the education programme proposed.

[190] The second proposed condition is for advice to current or future employers of the decision for a period of 2 years. That is not necessary either. The Practitioner appears not to be currently employed but rather self-employed and that will perhaps continue for the next 2 years at least. In any event, the lessons have been learned by the Practitioner and there should be no need for perceived concerns on the part of any prospective employer of repetition of the conduct to which this decision refers.

Costs

[191] The PCC sought an order for contribution by the Practitioner to the PCC costs, and stating the usual principles. It said that its estimate of costs totalled $73,475.19. Detail was given and the Tribunal finds that those costs and that amount are reasonable for the total Charge brought. In addition there are the costs of resourcing the Tribunal which were estimated to total $75,187.94. Again the Tribunal finds that those are reasonable costs and there was no objection from either party to that. This is a total of $148,663.13.

[192] The submissions from the PCC conceded that some allowance should be made in respect of aspects of the Charge not found made out, but did submit that this was more than just an exercise in mathematics; and that ultimately the Charge was found to be made out. It had sought a contribution of 50% to its total costs and the resourcing costs for the Tribunal.

[193] The Practitioner accepted that there would be an order for costs but resisted the amount sought by the PCC. It was said that ordering a 50% contribution to costs was relatively rare. Reference was made to those particulars not found made out.

Reference was made to *Cooper*[27] where only 1 of 8 particulars was found to be made out and that that justified reduction in the costs order.

[194] A mathematical calculation followed which was to take 50% of the PCC costs ($39,237.60) and to take 2/7ths of that resulting a sum of $11,210.80. The 2/7ths proportion was because 2 out of 7 particulars were, it was said, found to be made out. As to Tribunal costs, it was submitted that the same formula should be applied resulting in an order against the Practitioner of $10,741.10.

[195] Reference was also made to the fact that a further 2 of the original 9 particulars were abandoned by the PCC 5 working days before the hearing and the PCC investigation costs and associated costs must account in part to those particulars.

Discussion

[196] Section 100(1) if of the HPCA Act provides:

> **101 Penalties**
> (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) …
> (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, as the case may be:
> (iv) the hearing by the Tribunal.

[197] The normal approach for the Tribunal based on the authorities[28] is to start with a 50% contribution. That, however, is a starting point and other factors may be taken into account to increase, reduce or mitigate that proportion. The balance of costs of the prosecution after the orders for costs must be met by the profession itself. As was said in *O'Connor v Preliminary Proceedings Committee*[29]

> *"It is a notorious fact that prosecutions in the hands of professional bodies, usually pursuant to statutory powers, are very costly and time consuming to those bodies and such knowledge is widespread within the professions so controlled. So as to alleviate the burden of the costs on the professional*

[27] 872/Med16/351P
[28] Including *Cooray v Preliminary Proceedings Committee*; AP23/94 14 September 1995 per Doogue J
[29] *O'Connor v Preliminary Proceedings Committee* AP280/89 23 August 1990

> *members as a whole the legislature had empowered the different bodies to impose orders for costs"* [referring to legislation applicable before the establishment of the Tribunal under the HPCA Act]

[198] In Vatsyayann *v PCC*[30] *the* Court said[31]

> *"[34] So far as the 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."*

[199] In *Winefield*[32] the *Tribunal* held that costs of some 30% of actual costs were appropriate having regard to:

a) The hearing being able to proceed on an agreed statement of facts.

b) Co-operation of Mr Winefield.

c) The attendance of Mr Winefield at the hearing.

d) Consistency with the level of costs in previous decisions.

e) Costs not paid by Mr Winefield would fall on the profession as a whole.

[200] The approach that the Tribunal has taken based on the cases is first to consider the amounts that should be taken into account in considering an order for costs. It accepts that the costs claimed by the PCC for all of its costs, namely $73,475.19, is a reasonable sum for those costs.

[201] There needs to be, however, a reduction taking into account first that 2 particulars were abandoned by the PCC, and secondly those particulars found not to be made out. Particular 1 is somewhere in between, having been found to be made out as misconduct but not of sufficient severity separately to warrant disciplinary sanction. The two particulars found made out as professional misconduct warranting

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[30] *Vatsyayann v Professional Conduct Committee* [2012] NZHC 1138

[31] at [34]

[32] Phar06/30P

disciplinary sanction, particulars 3 and 7, are serious matters and required significant consideration by the Tribunal.

[202] Weighing all these matters up the Tribunal has concluded that the appropriate starting point for consideration of a contribution to costs is 50% of the total of the costs of the PCC and of resourcing the Tribunal. That total is $148,663.13 of which 50% is $74,331.57.

[203] The next question is to consider what proportion or percentage of those costs the Practitioner should be ordered to make by way of contribution. As noted from the authorities above 50% is a starting point contribution and can be increased or reduced depending on the circumstances.

[204] This is a case where the Tribunal considers that there should be an increase in that percentage. The hearing lasted 5 days and there then needed to be time for submissions on penalty in writing and consideration by the Tribunal. The decision records above the Tribunal's disquiet that other courses may well have resolved the issues which have arisen in a way which would not have incurred significant costs.

[205] The Tribunal is left with a Charge with originally 9 particulars then reduced to 7 particulars, of which 3 have been found to be made out, one of which not separately to warrant disciplinary sanction.

[206] The Practitioner has defended every issue raised by the Charge despite his acknowledgement in the case of Dr Y that his behaviour warranted apology.

[207] The assessment of the Tribunal is that the Practitioner should be ordered to pay 60% contribution towards the reasonable costs of prosecuting and hearing the particulars found to be made out (namely $74,331.57 as noted above) and that amounts to almost $45,000.00. That is the contribution that the Practitioner is ordered to pay below.

Non-publication of name

[208] The PCC sought an order for non-publication of the names and identifying details of the patients involved in the Charge. That was not opposed by the Practitioner. That is appropriately an order to be made and is made below.

[209] The Practitioner sought an order for non-publication of his name or identifying details. That was opposed by the PCC. No affidavit was sworn in support of the

application and the Practitioner relied on certain references and other material supplied in the context of the Charge and a further written reference from a consultant at the hospital. The identifying details were said to include the Practitioner's scope or place of practice.

[210] It was said that the Practitioner's interests outweighed any public interest in publication of his name or identifying details, particularly given that some 3 – 6 years have passed since the events the subject of the Charge found made out.

[211] The submission emphasised the need to consider desirability and principles enunciated in *John v Director of Proceedings*[33]. Rehabilitation should be, it was submitted, at the forefront of approach to the penalty imposed and publication of the Practitioner's name would be inimical to that objective.

[212] Reference was made to the Practitioner's long and successful career and his contribution to the profession and community and the changes that he has made since resigning from hospital practice. Publication would be harmful to his patients it was said and reference was made to his personal circumstances. It was emphasised that non-publication of his name would be of help to his rehabilitation.

[213] In reply the PCC referred to extracts from *M v Police*[34]:

> *" in general the healthy winds of publicity should blow through the workings of the Courts. The public should know what is going on in their public institutions. It is important that justice be seen to be done".,*

R v Liddell[35] (reaffirmed in *Lewis v Wilson & Horton Limited*[36]):

> *"the starting point must always be the importance in a democracy of … open judicial proceedings",*

Y v Attorney-General[37]:

> *"A professional person facing a disciplinary charge is likely to find it difficult to advance anything that displaces the presumption in favour of disclosure".; and*

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33 [2017] NZHC 2843
34 (1991) 8 CRNZ 14
35 [1995] 1 NZLR 538
36 [2003] 3 NZLR 546
37 [2016] NZCA 474

McCaig v PCC[38] where the High Court upheld the Tribunal's decision to decline name suppression for a practitioner. She had committed professional misconduct by forging and falsifying a reference and a professional evaluation form, with the court saying:

> *"There must be some compelling reason why, in a particular case [the principle of open justice] needs to be suspended. That is no different for professionals and for anyone else".*

[214] The PCC also noted:

a) That there was no affidavit evidence supporting the application.

b) That there was limited explanation of how publication could jeopardize the claimed consequences for the Practitioner's partner or impact on his father's health, noting that there was little detail in a letter from his general practitioner.

c) That there was public interest in potential patients being able to make an informed decision on whether they wish to enter into or remain in the Practitioner's care, citing *Singh v Director of Proceedings*[39].

Discussion

[215] 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:*
>
> *…*
>
> *(d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person*."

[38] [2015] NZHC 3063

[39] [2014] NZHC 2848

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

[217] 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, in this case the Practitioner, and the Tribunal must consider both:

a) The interest of any person and

b) The public interest.

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

a) Openness and transparency of disciplinary proceedings[40].

b) Accountability of the disciplinary process[41].

c) Public interest in knowing the identity of a health practitioner charged with a disciplinary offence[42].

d) Unfairly impugning other practitioners.

[219] The Tribunal notes that part of the submission for the PCC relies on extracts from judgments in other jurisdictions. They are noted. There are also these statements of principle:

Panckhurst J in *Tonga v Director of Proceedings*[43]

> *"[F]ollowing an adverse disciplinary finding more weighty factors are necessary before permanent suppression will be desirable. This, I think, follows from the protective nature of the jurisdiction. Once an adverse finding has been made, the probability must be that public interest considerations will require that the name of the practitioner be published in a preponderance of cases. Thus, the statutory test of what is "desirable" is necessarily flexible. Prior to the substantive hearing of the charges the balance in terms of what is desirable may incline in favour of the private interests of the practitioner. After the hearing, by which time the evidence*

[40] *M v Police* (1991) 8 CRNZ 14; *R v. Liddell* [1995] 1 NZLR 538; *Lewis v. Wilson & Horton Ltd*. [2003] 3 NZLR 546; *Director of Proceedings v I* [2004] 3 NZLR 569

[41] *Director of Proceedings v Nursing Council* [1999] 3 NZLR 360

[42] *Director of Proceedings v Nursing Council* [1999] 3 NZLR 360; F v *Medical Practitioners Disciplinary Tribunal* (Auckland High Court; AP21 – SW01; 5/12/01; Laurenson J

[43] *Tonga v Director of Proceedings* (Christchurch High Court; CIV 2005-409-2244; 21/2/06; Panckhurst J; para 42.

is out and findings have been made, what is desirable may well be different, the more so where professional misconduct has been established".

Blanchard J in *B v B*[44]:

> *"In normal course where a professional person appears before a disciplinary tribunal and is found guilty of an offence, that person should expect that an order preventing publication of his or her name will not be made. That will especially be so where the offence found to be proved, or admitted, is sufficiently serious to justify striking off or suspension from practice."*

Gendall J in *Anderson v PCC*[45]

> *"Private interests will include the health interests of a practitioner, matters that may affect a family and their wellbeing, and rehabilitation. Correspondingly, interests such as protection of the public, maintenance of professional standards, both openness and "transparency" and accountability of the disciplinary process, the basic value of freedom to receive and impart information, the public interest knowing the identity of a practitioner found guilty of professional misconduct, the risk of other doctors' reputations being affected by suspicion, are all factors to be weighed on the scales.*
>
> *"Those factors were also referred to at some length in the Tribunal. Of course publication of a practitioner's name is often seen by the practitioner to be punitive but its purpose is to protect and advance the public interest by ensuring that it is informed of the disciplinary process and of practitioners who may be guilty of malpractice or professional misconduct. It reflects also the principles of openness of such proceedings, and freedom to receive and impart information*."

[220] Blanchard J in *B v B*[46] went on, however, to say:

> *"But where the orders made by a disciplinary tribunal in relation to future practice of the defendant are directed towards that person's rehabilitation and there is no striking off or suspension but rather, as here, 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 the decision and counterproductive. It may simply cause damage which makes rehabilitation impossible or very much harder to achieve."*

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[44] Auckland High Court HC4/92; 6/4/93; Blanchard J; p 99
[45] Wellington High Court; CIV 2008 – 485 – 1646; 14/11/08; Gendall J; paras 36 and 37
[46] Op cit at [99]

[221] There must be a balance reached between any interest of the Practitioner himself and the public interest in identification of the Practitioner in the context of the Charge as found to be made out against him. The need for openness in disciplinary proceedings such as these is emphasised in the extracts referred to above.

[222] Also to be emphasised, however, are the interests of the Practitioner and the need for his adequate rehabilitation. Strong account must be taken of the particulars found to be made out against the Practitioner and any need to be publicity about identification of the Practitioner in the context of those particulars. Particular 1 involved telephone communications between specialists on one occasion. There is no need for publication of the name of the Practitioner in that context. It is presently unlikely that he will be an on-call [ ] in the future and other specialists need not know of the detail of that communication in the context of his identity. Particulars 3 and 7 relate to timeliness of response from the Practitioner as the specialist and failure to provide treatment advice in that role. Again, the reality is that the Practitioner is less likely to be in circumstances that call for the type of response to which those particulars refer as he is no longer an on-call [ ]. There is no risk to the public if the Practitioner is not identified as the practitioner involved in these matters now.

[223] An important consideration is implication of others practitioners. In this case there is the very precise detail of the Practitioner's role as an on-call specialist on the one hand, an [ ] on the second hand, and the location of the hospital in which these events took place on the third hand. The decision is made below that the detail of his scope and his specialty and location of the hospital are suppressed and there is therefore less likelihood of identification or implication of any other practitioner.

[224] The Tribunal has noted what is said concerning family connections of the Practitioner. There was no supporting affidavit evidence to confirm that. Normally matters of that kind would not be taken into account in the absence of any compelling evidence.

[225] If there is the order for non-publication as sought by the Practitioner, then he will be able to continue with his practice as an [ ] and the rehabilitation process that is needed into that profession.

[226] Weighing up the competing interests it is the decision of the Tribunal that there should be an order permanently for non-publication of the name and identifying

details of the Practitioner including his scope of practice, his specialty, the location of the hospital at which he worked and the location of the venue of the Tribunal hearing.

Result and orders

[227] The Charge is found made out to the extent of the particulars referred to above.

[228] The Practitioner is censured.

[229] The Practitioner is ordered to pay the sum of $45,000.00 towards the cost of the PCC and resourcing of the Tribunal, to be divided equally between them.

[230] There are permanent orders for non-publication of:

a) The names and identifying details and particulars of the affairs of all patients referred to in the proceeding.

b) The name and identifying details and particulars of the affairs of the Practitioner, his scope of practice, his specialty, the hospital at which he worked, and the venue of the hearing of the Tribunal.

[231] 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 August 2020

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David M Carden
Chairperson
Health Practitioners Disciplinary Tribunal

SCHEDULE

Pursuant to s 81(2) and 91 of the Act the Committee charges Dr H as follows:

Unprofessional behaviour towards colleagues

1. On [ ] 2016, Dr H was rude and verbally abusive towards a colleague, Dr Y, during a phone call regarding the care of a patient, Ms A, who presented at [ ] Hospital when Dr H was the on-call [ ];

2. On [ ] 2017, Dr H was brusque towards a colleague, Dr B, during a phone call regarding the care of a patient, Ms T, who presented at [ ] Hospital when Dr H was the on-call [ ];

Availability when rostered as on-call doctor

3. On [ ] 2014, Dr H, while rostered as an on-call [ ], failed to come to the hospital within a reasonable timeframe when asked by Dr E to attend to see a patient, Ms L;

4. On [ ] 2016, Dr H, who was the on-call [ ], failed to come to the hospital within a reasonable timeframe when asked by Dr Y to attend to see Ms A;

5. On [ ] 2016, Dr H was unable to be contacted on his cellphone, despite telling Dr Y that he could be contacted over the weekend regarding the care of Ms A;

6. On [ ] 2017, Dr H, while rostered as an on-call [ ], initially refused to see in a timely manner a patient, Mr I, who had presented at the Emergency Department;

7. On [ ] 2017, Dr H refused to provide treatment advice to Dr B during a phone call regarding the care of Ms T, who presented at [ ] Hospital when Dr H was the on-call [ ].

The conduct alleged above at paragraphs 1 to 7 amounts to professional misconduct in that, either separately or cumulatively, it:

(a) amounts to malpractice or negligence in relation to his scope of practice pursuant to section 100(1)(a) of the Act; and/or

(b) has brought or is likely to bring discredit to the profession, pursuant to section 100(1)(b) of the Act.