NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	**1222/Med21/516P**
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 the Medical Council of New Zealand**
	Applicant
AND	**DR D, registered medical practitioner, formerly of X**
	Practitioner

HEARING held via audio visual link on 24 August 2021

TRIBUNAL	Ms T Baker (Chair) Dr J Tait, Dr K De Silva, Dr D Read, Mr T Burns (Members) Ms D Gainey (Executive Officer)
APPEARANCES	Mr S Waalkens and Ms E Bransgrove for Professional Conduct Committee (the PCC) Mr A Holloway for the practitioner

TRIBUNAL DECISION

Introduction

[1] A panel of the Tribunal convened on 24 August 2021 to hear a charge laid by a Professional Conduct Committee (PCC) of the Medical Council of New Zealand against the practitioner, Dr D. The charge arose from three convictions from [ ] 2020.

[2] The parties agreed the facts and that the conduct amounted to professional misconduct in that the conduct is likely to bring discredit to the profession under section 100(1)(b) of the Health Practitioners Competence Assurance Act 2003 (**the Act**), but there was disagreement as to whether the convictions reflect adversely on the practitioner's fitness to practise under section 100(1)(c).

[3] Dr D chose not to attend the hearing but was available by phone if required. He was represented by his counsel, Mr Holloway.

The Charge

[4] The PCC charged that:

1. On [ ] [ ], Dr D was convicted and sentenced in the [ ] District Court, having pleaded guilty to:
    a. Two charges of assault on a person in a family relationship pursuant to section 194A of the Crimes Act 1961, being an offence punishable by a term of imprisonment not exceeding two years, in that on [ ] Dr D assaulted - Ms D, being a person that has been in a family relationship with [ ];and
    b. One charge of threatening behaviour pursuant to section 21(1)(a) of the Summary Offences Act 1981, being an offence punishable by a term of imprisonment not exceeding three months, in that on [ ] Dr D with intent to intimidate Ms D threatened to injure her [ ].
2. The convictions particularised above either separately or cumulatively:
    a. Amount to professional misconduct in that the convictions have brought or are likely to bring discredit to the medical profession pursuant to section 100(1)(b) of the Act; and/or
    b. Reflect adversely on Dr D's fitness to practise as a medical practitioner pursuant to section 100(1)(c) of the Act.

The relevant facts

[5] The parties filed an agreed summary of facts which was signed by Dr D.

Background

[6] Dr D graduated with a Bachelor of Surgery and Bachelor of Medicine in from the University of [ ] in [ ]. He obtained registration with the Medical Council of New Zealand (**the Council**) in the general scope of practise on [ ] 2005, but this has always been limited to Urgent Care.

[7] At the relevant time Dr D was employed at [ ] as an Urgent Care Doctor. He is currently working at [ ] in [ ].

[8] The charges of assault carry a maximum penalty of two years' imprisonment. The one of threatening behaviour carries a maximum penalty of three months' imprisonment.

[9] The sentence imposed in the District Court was:

(a) 12 months' supervision for the assault charges and a protection order under section 123B of the Sentencing Act 2002;

(b) Conviction and discharge on the charge of threatening behaviour.

The conduct

[10] The certified copy of the Court record was provided to the Tribunal, as was the Police Summary of Facts, which outlined that on [ ] at 6.14pm, Dr D and his then wife became engaged in a domestic dispute while at home. Dr D became upset and poured two cans of beer and one cider on his wife. She ended up on the floor and he tore her shirt. He lifted her shirt and prodded her with a fork while calling her fat, causing scratches on her torso. He also pulled her by the arm causing a bruise on her upper arm.

[11] During the dispute Ms D called for an ambulance. During the phone call, the ambulance communications staff heard Dr D making comments saying he would shoot police if they arrived.

[12] At approximately 8.00 pm police had a visual of Dr D's kitchen from outside on a neighbouring property when they observed him put both hands around Ms D's neck area

for at least five to seven seconds before moving out of view. During this incident, ambulance communication staff were still on the phone and heard Dr D threatening to kill Ms D.

[13] Ms D received scratches to her torso from the fork and a bruise on her upper arm. On [ ] 2020, Dr D formally notified the Council of the convictions.

Previous convictions and PCC investigation

[14] Dr D has three previous convictions for driving with excess blood alcohol (EBA) under section 56(1) of the Land Transport Act 1998. The offences occurred in [ ], [ ] and [ ] respectively.

[15] Following the third EBA conviction in [ ], Dr D was sentenced to three months' community detention and disqualified from driving indefinitely. He disclosed this charge to the Council, but the two previous convictions were only brought to the Councils' attention after it became aware of a media article on the subject.

[16] Following a PCC investigation into the [ ] conviction, the Council resolved to review Dr D's fitness to practise by way of ongoing monitoring by a Health Committee. It also advised Dr D to familiarise himself with the Council's statement on *Good Medical Practice* and to continue making progress with his psychologist.

Events since these convictions

[17] Dr D's employment with [ ] ended on [ ] [ ], the day after the offending. He voluntarily surrendered his practising certificate soon after this.

[18] On [ ] 2021 the Health Committee approved Dr D's return to work subject to an agreement signed on [ ] 2021. On [ ] 2021 Dr D returned to work as a medical practitioner for the first time since [ ] [ ]. His role at [ ] in [ ] has been approved by the Health Committee and complies with the [ ] 2021 agreement.

Health Committee history

[19] The Health Committee's monitoring began in 2018 for alcohol use disorder and depression. The monitoring programme included Dr D seeing his treatment team (GP, Addiction Specialist and Counsellor) as often as recommended, remaining abstinent from

alcohol and undergoing blood testing at a frequency determined by the Health Committee.

[20] Following the recent offending, the Health Committee requested a psychiatric report to advise on Dr D's current mental health and alcohol use. A copy of a psychiatric report dated [ ] 2020 was provided in the agreed bundle of documents for the Tribunal.

[21] Dr D completed his sentence of supervision in [ ] 2021. He is complying with the Health Committee's requirements.

Admissions

[22] As well as admitting the above facts, Dr D admitted the particulars of the charge, accepted the convictions either separately or cumulatively amounted to professional misconduct and that the convictions have brought or are likely to bring discredit to the medical profession under section 100(1)(b) of the Act. He did not accept that the convictions either separately or cumulatively reflected adversely on his fitness to practise under section 100(1)(c).

Grounds for discipline

[23] Having found the factual allegations established, the Tribunal must now be satisfied that the charge of professional misconduct is made out. The grounds on which a health practitioner may be disciplined are set out in section 100 of the Act. The relevant provisions are:

> **100 Grounds on which health practitioner may be disciplined**
>
> (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—
>
> (a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or
>
> (b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred; or

(c) the practitioner has been convicted of an offence that reflects adversely on his or her fitness to practise.

(2) The Tribunal may make a finding under subsection (1)(c) only if the conviction concerned—

(a) …; or

(b) has been entered by any court in New Zealand or elsewhere for an offence punishable by imprisonment for a term of 3 months or longer.

[24] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct".[1]

[25] The Tribunal has adopted the test for bringing, or likely to bring "discredit to the practitioner's profession" from the High Court decision on appeal from the Nursing Council. The Tribunal must ask itself:[2]

> … whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the [profession] was lowered by the behaviour of the [practitioner] concerned.

[26] Determining professional misconduct is approached in two steps. This has been expressed:

(a) The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can reasonably be regarded by the Tribunal as constituting malpractice and/or negligence and/or conduct having brought or likely to bring discredit to the profession.

(b) The second step in assessing professional misconduct requires the Tribunal to be satisfied that the practitioner's acts or omissions require a disciplinary sanction In *F v Medical Practitioners Disciplinary Tribunal*[3] the Court of Appeal, in considering the disciplinary threshold under the Medical Practitioners Act 1995 said:

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1 Collins English Dictionary 2nd Edition. Definition consistently accepted Tribunal decisions.

2 *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28]

3 *N*oted at 2005 3 NZLR 774

> In cases of both professional misconduct and conduct unbecoming it will be necessary to decide if there has been a departure from acceptable standards, and then to decide whether the departure is significant enough to warrant sanction.

[27] The High Court endorsed the earlier statement of Elias J in *B v Medical Council* [2005] 3 NZLR 810 that "the threshold is inevitably one of degree". This was further discussed in *Martin, HRE v Director of Proceedings* where the High Court said:[4]

> … While the criteria of "significant enough to warrant sanction" connotes a notable departure from acceptable standards, it does not carry any implication as to the degree of seriousness. Given the wide range of conduct that might attract sanction, from relatively low-level misconduct to misconduct of the most reprehensible kind, the threshold should not be regarded as unduly high. It is certainly a threshold to be reached with care, having regard to both the purpose of the HPCAA and the implications for the practitioner, but the measure of seriousness beyond the mere fact that the conduct warrants sanction is a matter to be reflected in penalty. The degree of seriousness does not form part of the Tribunal's enquiry at the second stage of the two-step process.

[28] This two-step test has been adopted by this Tribunal since its first decision, *Nuttall* 8/Med04/03P issued in 2005.

[29] As for section 101(1)(c), it is well-established that the term "fitness to practise" extends beyond competence issues. In *Professional Conduct Committee v Martin*, L 27 February 2007, CIV 2006-485-1461, Justice Gendall stated at [46]:

> "Fitness" often may be something different to competence … aspects of general deterrence as well as specific deterrence remain relevant. So, too, is the broader consideration of public and communities' confidence and the upholding of the standards of the nursing profession.

[30] The Tribunal accepts the following principles summarised in the Tribunal's decision of *Sathe* 568/Den13/246P (6 September 2013):

(a) It is not necessary that a relevant conviction conclusively demonstrates that the practitioner is unfit to practise, although there is a high threshold to be met – namely, the conviction must raise serious questions about whether a practitioner is fit to practise (*Martin* 45Nur05/19P).

[4] *Martin v Director of Proceedings* [2010] NZAR 333 at [32]

(b) A determination of "fitness to practise" does not relate solely to the practitioner's clinical ability of confidence:

(c) It includes a consideration of whether the practitioner's conduct was immoral or unethical (*Murdoch*, 76/Phys06/45P).

(d) It involves a consideration of character (*Pellowe,* 137/Phar07/74P).

(e) If a conviction is likely to bring discredit to the profession, this may well indicate that it reflects adversely on fitness to practise, but is not in itself determinative (*Pittwood*, 84/Ost 06/42P).

PCC Submissions

[31] For the PCC, Ms Bransgrove highlighted the following comments in the District Court Judge's sentencing notes:

(a) The offending was a "serious domestic event" and a "prolonged attack … that carries high culpability." After weighing all aggravating and mitigating factors, the overall gravity of the offending was "moderately serious".

(b) Regardless of whether Dr D was convicted, the matter would be brought to the attention of the Medical Council of New Zealand (the Council). While it was accepted that the Council may look more favourably on Dr D's situation if he was granted a discharge without conviction, she did not consider this was a "tangible relevant consequence when all matters are going before the Medical Council in the normal course" and was not "out of all proportion to the gravity of the offending."

(c) Ms D was "emotionally and mentally broken" and had been seriously affected as a result of the offending.

[32] The PCC also referred us to the following Tribunal decisions on the question of whether conduct adversely affects a practitioner's fitness to practise. In considering a

medical practitioner's conviction for dishonestly using a document in *Hodgson*[5] the Tribunal summarised its position in interpreting 'fitness to practise' as follows:

> This Tribunal and the Courts have both previously considered the meaning of 'fitness to practice' under s 100(1)(c) of the Act, in relation to other practitioner conviction charges. It is clear from this body of case law that conduct which offends the law will usually be regarded as adversely affecting the practitioner's fitness to practise. This is certainly the case in relation to any conviction for a dishonesty offence. 'Fitness to practise' in the context of a conviction is not restricted to consideration of the practitioner's clinical ability. It involves a wider consideration of whether the practitioner's conviction reflects adversely on their overall fitness to practise, because the conduct leading to the conviction was either immoral, unethical or otherwise failed to uphold the law.

[33] Similarly, the Tribunal found in *Edwards* 748/Pod 15/325P that the practitioner's convictions for violence related offences, even though they were unrelated to his professional practice, inevitably reflected adversely on his fitness to practise, and said:

> A conviction for a serious assault, even one such as this which is unconnected with his or her professional practice, must inevitably reflect adversely on a practitioner's fitness to practise to one extent or another.

[34] The PCC submitted that, when the circumstances are viewed together, the Tribunal can be satisfied that the convictions reflect adversely on Dr D's fitness to practise. In particular:

(a) The assaults and threatening behaviour against Ms D occurred over a lengthy period of time (around two hours);

(b) The assault involved the use of a weapon, namely a fork, and associated belittling commentary;

(c) It also involved putting both hands around Ms D's neck for five to seven seconds; and

(d) The offending resulted in physical injuries to Ms D's torso and upper arm. She is also described as suffering serious mental and emotional affects as a consequence of the assaults.

[5] 740/Med 15/315P

[35] When evaluating the seriousness of the offending itself, Her Honour Judge Hinton considered that Dr D's actions were not a "spur of the moment reaction" and that they carried "high culpability." Ms Bransgrove submitted that determination of fitness to practise involves moral considerations "and conduct which offends the law or is immoral or unethical, must affect adversely on the practitioner's fitness to practise".

[36] Referring to *Edwards*,[6] the PCC submitted that cases involving violence (and especially domestic violence) will almost always reflect adversely on the practitioner's fitness to practise. The public has a legitimate expectation that medical practitioners will behave in a morally and ethically acceptable way. The PCC submits that this high standard was not met by Dr D and his behaviour fundamentally undermined the trust and confidence the public must have in a medical practitioner. The PCC submits that all three of Dr D's convictions are of the kind that adversely affect his fitness to practice and is conduct which the public would consider to be immoral and in breach of the conduct standards expected of doctors. The PCC therefore submitted that Dr D's convictions amount to misconduct under s 100(1)(c) of the Act, either separately or cumulatively, and for the same reasons are likely to bring discredit to the profession.

Practitioner submissions

[37] Mr Holloway confirmed that it was accepted that Dr D had been guilty of professional misconduct under section 100(1)(b) of the Act (the first stage); and that his conduct was significant enough to warrant disciplinary sanction (the second stage). The only issue was whether Dr D's convictions reflect adversely on his fitness to practise (section 100(1)(c)).

[38] In *Martin*, the Tribunal said:[7]

> In the Tribunal's view, the phrase "reflects adversely on fitness to practise" does not require prosecuting authorities to prove that the conviction in question should automatically result in the practitioner being stopped from practising their profession. Nevertheless, those asserting that a conviction reflects adversely on a practitioner's fitness to practise carry a high onus. The words "reflects adversely

[6] PCC v Edwards 748/Pod 15/325P
[7] PCC v Martin, L 45/Nur 05/19P at [17]

on fitness to practise" describe a high threshold which is satisfied when a conviction prima facie raises serious questions about whether or not a practitioner is fit to practise their profession.

[39] In one of the most recent Tribunal decisions dealing with section 100(1)(c), in *Bowman*[8] the Tribunal said:

> It is well established by this Tribunal that the term "fitness to practise" in the context of section 100(1)(c) of the HPCA Act extends beyond competence issues. It includes conduct that, considered objectively, will have a negative impact on the trust and confidence which the public is entitled to have in the practitioner and the profession as a whole, including conduct which falls below the standard legitimately expected of a member of the relevant profession, whether of a clinical character or not. As such, the Tribunal must consider whether the offending impacts on wider standards of professional conduct and confidence in the profession.

[40] It was not contested that offending unrelated to professional practice may reflect adversely on fitness to practice, but Mr Holloway submitted that not every instance of violent offending must meet the threshold for section 100(1)(c). As the Tribunal said in *Janssen* 441/DH 11/190P, something more is required. In that case the Tribunal held it was required to consider both the offence and other factors such as:

(a) Seriousness of the charge;

(b) Connection with the health professional's role;

(c) Nature of offence e.g. dishonesty, sexual offending;

(d) Need to maintain standards.

[41] Mr Holloway submitted the case was finely balanced. Dr D had owned up to his actions from the beginning and not sought to minimise them. He and his wife were arguing in the context of an unhappy marriage. During that argument he prodded her with a fork, pulled her arm, tore her shirt and put his hands around her neck area (there was no allegation of strangulation whatsoever).

Discussion

[8] PCC v Bowman 1080/Phar 19/460P

[42] By not laying a disciplinary charge for each conviction they are notified of, the various responsible authorities and their appointed professional conduct committees recognise that not every conviction reflects adversely on a practitioner's fitness to practise. The Tribunal also accepts this position and must make this assessment whenever deciding whether or not to uphold a charge under section 100(1)(c).

[43] The Tribunal has considered the previous Tribunal and High Court decisions and asked, "Do two convictions for assault on a person in a family relationship and one for threatening behaviour, separately or cumulatively raise serious questions about whether or not a practitioner is fit to practise their profession?" It is possible that there will be cases where a conviction for an offence involving violence does not meet that threshold, but in its substantive decision for *Janssen* 441DH11/190P, [9] the Tribunal said:

> The charge is under the Crimes Act[10] and is potentially very serious. Violence is a serious issue in our Society. Society generally abhors violence.

[44] Perhaps in a bygone era family violence raised no such questions, but when considering whether these convictions in the 21st century reflect adversely on a practitioner's fitness to practice, the answer has to be "yes". As the Tribunal said in its penalty decision of *Janssen* 441DH11/190P:

> The Tribunal has said on many occasions that violence will not be tolerated in health professionals. This is so even when the violence does not occur in the course of a health professional's work.

[45] It does not mean that the practitioner is not fit to practise, but the Tribunal considers such convictions clearly reflect adversely on Dr D's fitness to practice.

[46] As acknowledged by the parties, there is a certain overlap with the question of discredit to the profession under section 100(1)(b). The Tribunal is in no doubt that reasonable members of the public, fully informed of the facts and circumstances of this offending would consider the reputation of the medical profession is lowered by Dr D's

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9 At [21]

10 Section 202C, assault with a weapon

conduct. The Tribunal is also satisfied that the misconduct is sufficiently serious to warrant a disciplinary sanction.

Penalty

[47] Having found the charge is established, we may now consider whether the conduct requires a disciplinary sanction for the purposes of protecting the public and maintaining professional standards. Section 101 provides for the following penalties:

(a) Cancellation of registration.

(b) Suspension of registration for a period not exceeding three years.

(c) Conditions imposed on practising certificate.

(d) Censure.

(e) Payment of costs of the Tribunal and/or PCC.

[48] In *Roberts v Professional Conduct Committee,*[11] His Honour Justice Collins discussed eight relevant factors in determining an appropriate penalty in this jurisdiction. These factors have been summarised in the decision of *Katamat v Professional Conduct Committee* [2012] NZHC 1633:

1. Most appropriately protects the public and deters others;
2. Facilitates the Tribunal's "important" role in setting professional standards;
3. Punishes the practitioner;
4. Allows for the rehabilitation of the health practitioner;
5. Promotes consistency with penalties in similar cases;
6. Reflects the seriousness of the misconduct;
7. Is the least restrictive penalty appropriate in the circumstances; and
8. Looked at overall, is a penalty which is "fair, reasonable and proportionate in the circumstances".

[11] [2012] NZHC 3354 at [44] to [51]

PCC submissions

[49] The PCC submitted the following aggravating factors which the Tribunal should take into account when determining appropriate penalty:

(a) Seriousness of the offending: Dr D's offending involved a "prolonged attack" against Ms D over approximately two hours. The sentencing Judge considered Dr D's actions were "not a spur of the moment reaction" and that they carried "high culpability". Dr D was heard by ambulance communication staff threatening to shoot police and threatening to kill Ms D. Ms D received scratches and a bruise as a result of Dr D's assault on her.

(b) Effect on the victim: Although Ms D's victim impact statement has not been made available to the Tribunal, Judge Hinton discerned from the statement that the offending had seriously affected her.

(c) Previous convictions/disciplinary history: As outlined in the PCC's submissions on liability, Dr D has had three previous convictions for EBA and undergone a previous PCC investigation.

[50] The PCC acknowledged the following mitigating factors:

(a) Dr D accepted responsibility for his actions by entering guilty pleas to all three charges and also accepted responsibility during the course of the PCC's investigation in relation to the convictions.

(b) Dr D has expressed remorse over the offending.

(c) Dr D has no previous convictions for violence.

(d) Dr D has engaged with rehabilitation to address the offending and its underlying causes, including completing the Hokata Whakamoe Patu Men's Non-Violence Programme, and complying with the requirements of his Health Committee agreement.

[51] The Tribunal was referred to the following cases:

(a) *Janssen* DH11/09, where the practitioner assaulted a man at a casino, hitting him over the head with an empty bottle, and throwing a wine glass

at him which smashed in his face. She was convicted for assault with a weapon, and sentenced to 100 hours of community work and ordered to pay reparation of $200. The Tribunal said that while Ms Janssen had received a serious conviction, from the sentence imposed "it can be seen that although serious, the assault was at the lower end of the scale". The Tribunal considered that given the one-off nature of Ms Janssen's offending and that she had clearly worked hard to rehabilitate herself, the appropriate penalty was suspension of her registration for three months, conditions, censure and costs.

(b) *Petcher* 99/Nur07/54: a registered nurse was convicted on charges of assaulting a female, assault with a weapon and burglary. He received a sentence in the District Court of 300 hours community work and supervision for one year. He had assaulted a former partner by punching her in the face with a closed fist, grabbing her around the throat with both hands, squeezing her neck and slapping her across the face. He was convicted and discharged for this offending. Approximately five months later, Mr Petcher entered the home of the same woman by smashing a window, damaged her belongings and wall with a hammer and ransacked the kitchen. He later returned to the house, smashed the window of the door and advanced on the victim, holding a piece of broken glass to her throat. For these offences, Mr Petcher was sentenced to 300 hours of community work and one year of supervision. The Tribunal considered that in the circumstances, a penalty short of cancellation of Mr Petcher's registration was appropriate. The Tribunal imposed a six-month suspension, a full competency review before Dr Petcher's registration was restored, imposed conditions upon recommencement of his practice, censured him and ordered he pay costs.

(c) In *Bowman* Phar19/460P a pharmacist was convicted of one charge of common assault and one charge of a threatening act, having gone to his neighbours' home with a can of petrol and a box of matches, threatening to burn their house down if they did not turn down the noise. A physical

struggle ensued, during which Mr Bowman covered his neighbour and another man in petrol. Mr Bowman was restrained until police arrived. The Tribunal was satisfied that the convictions reflected adversely on Mr Bowman's fitness to practise. When considering penalty, the Tribunal noted Mr Bowman's unblemished professional and personal record, that he had accepted responsibility for the offending and taken some steps to gain insight into his outburst. It determined that the appropriate penalty was censure, conditions and costs.

(d) In *Edwards* Pod15/325P a podiatrist was convicted of assault of his ex-wife's new partner by punching him 5 or 6 times in the head and scratching his eyes. The Tribunal ordered censure, completion of an anger management course, and 40% costs.

[52] It was submitted that *Petcher* is the most factually similar in that it also involved an assault on a female, the use of a weapon and the placing of the defendant's hands around the victim's throat, however the PCC submits that Dr D's conduct was overall less serious than that of Mr Petcher. This is reflected in the maximum penalty available for Mr Petcher's charges (two, ten and five years imprisonment). In addition, while there was an element of using a weapon in Dr D's case (prodding with a fork), he was not convicted of this as a separate offence, and although he was seen placing his hands around Ms D's "neck area", there is no indication that he squeezed her throat as was the case in *Petcher.*

[53] The PCC submitted that Dr D's culpability was of a similar level to that in *Edwards* and *Bowman*. Unlike the cases cited above, Dr D has not had an unblemished record, with three prior convictions for EBA as well as a previous investigation with a PCC, and that these factors increase the seriousness of Dr D's overall misconduct, and his culpability.

[54] The PCC submitted the following penalty would be appropriate:

(a) censure

(b) conditions, that

(i) for a period of two years Dr D is required to advise his current and/or future employers of the Tribunal's decision and its orders; and

(ii) For a period of three to five years Dr D is to continue to engage with and meet all conditions set by the Council's Health Committee; and

(iii) Conditions imposed are entered alongside Dr D's registration profile on the Council's website.

[55] It was submitted that publication of conditions is required for the Medical Council to meet its obligations under section 157B of the Act, which requires the Council to issue a naming policy which sets out when an order or direction about a medical practitioner will be published on the Register. The purpose of the naming policy is to:

(a) Enhance public confidence in the medical profession for which the Council is responsible and its disciplinary procedures by providing transparency about their decision-making processes;

(b) Ensure that medical practitioners whose conduct has not met expected standards may be named where it is in the public interest to do so; and

(c) Improve the safety and quality of health care.

Practitioner submissions

[56] In an affidavit sworn in support of his application for name suppression, Dr D told us that on being convicted for the present offences, he immediately resigned from work and withdrew from medicine, as it was the responsible thing to do.

[57] Dr D then suffered a relapse and began drinking. He became very depressed, living in a caravan and unable to find alternative work. This was compounded by the Covid lockdown in 2020.

[58] Since then, things have slowly improved. Dr D eventually found some manual work and then engaged with the Council's Health Committee. He provided the Tribunal with statements from members of his treatment team: his GP, a psychologist, an SMO with the DHB Mental

Health and Addiction Service involved in Dr D's treatment, and the facilitator of the non-violence programme which Dr D participated in as part of his sentence.

[59] For the practitioner, Mr Holloway traversed the penalty principles outlined above, and in particular, it was submitted that the first proposed condition seemed punitive (in a case where punishment is not a relevant consideration). Mr Holloway noted that Dr D's current employer is already aware of these events.

[60] There was no objection to the proposed second condition, noting that Dr D is already required to and wants to remain engaged with the Health Committee, but it may not be practical. The benefit of the Health Committee process is that it can be responsive to health needs and take a therapeutic approach. For example, were Dr D to consume alcohol in the future, the Health Committee would likely respond by requiring him to stop work and undergo a period of treatment and sobriety before it supported a return to work, but the imposition of the second condition would make the consumption of alcohol an immediate disciplinary matter. Imposing this condition as part of the disciplinary penalty takes the flexibility from the Health Committee.

[61] Mr Holloway submitted that the third condition also seemed punitive and unconnected with protecting the public. It would also be impossible to reconcile with a non-publication order. The only restrictions are those imposed and managed by the Health Committee. It is the Health Committee which is best placed to decide how much publicity is necessary and desirable, keeping in mind Dr D's recovery, health and privacy. Dr D is already required to disclose the Health Committee's role to current and future employers. The public does not need to know that Dr D has a health condition — particularly one that is being appropriately managed and is unconnected with the Charge.

[62] In reply, the PCC submitted that the purpose of advising his employers is to hold Dr D to account; that it would be concerning if he did not advise future employers. The second proposed condition is a type of safety net, bearing in mind that the respondent now has 6 convictions and a history of alcohol abuse. And the third conditions is important because any further breach would result in discipline.

Decision

[63] The Tribunal issued an oral decision on penalty and costs and deferred the question of name suppression.

[64] The Tribunal has been careful to impose a penalty that is appropriate given that the practitioner has been punished by the courts for the conduct which led to these conditions. The impact on the victim was taken into account at that time. However, this is a serious matter which we have found is likely to bring discredit to the profession and the conviction which reflects adversely on Dr D's fitness to practise. A censure under section 101(1)(d) is appropriate to mark the Tribunal's disapproval of the practitioner's conduct. This is consistent with the purpose of maintaining standards for the profession.

[65] The Tribunal acknowledges that the practitioner has engaged with the Health Committee. There is no evidence before the Tribunal that alcohol was a factor in this offending, and they are not alcohol-related offences in the way that driving with excess blood or breath alcohol is. The Health Committee have mechanisms for escalating matters if required, and the Tribunal prefers to leave the matter of his rehabilitation in relation to alcohol in their hands.

[66] There is some merit in ensuring Dr D tells his employers both current and future of this disciplinary decision, as part of his accountability and rehabilitation. It is important that prospective employers are aware of his criminal and professional disciplinary history. Therefore the Tribunal has imposed a condition on Dr D's practising certificate under section 101(1)(c) for a period of 3 years from 24 August 2021 that he inform his current, prospective and future employers of this decision.

[67] The Tribunal has not imposed a condition regarding annotation of the register. Section 157 of the Act provides the responsible authority with the power to publish any order it has made, and the Tribunal to do the same with its orders. Sections 157A to I concern the requirements of naming policies for the authorities. In accordance with section 157(2), it is customary for this Tribunal to direct the publication of its decisions. The Tribunal does not understand that the existence of a naming policy in anyway binds the Tribunal or that the effect of section 157B is that the Tribunal must order annotation of the register.

[68] Overall, the Tribunal has endeavoured to impose a penalty that is the least restrictive in the circumstances and supports the practitioner's ongoing rehabilitation so that he can continue to provide health services to the public.

Costs

[69] *In Vatsyayann v Professional Conduct Committee of New Zealand Medical Council* [2012] NZHC 1138 Priestley J confirmed the Tribunal's identified relevant considerations for costs:[12]

(a) professional groups should not be expected to bear all the costs of the disciplinary regime, and members who appeared on charges should make a "proper contribution" towards costs;[13]

(b) costs are not punitive;[14]

(c) the practitioner's means, if known, are to be considered;[15]

(d) a practitioner's defence should not be deterred by the risks of a costs order;[16] and

(e) in a general way 50 per cent of reasonable costs is a guide to an appropriate costs order subject to a discretion to adjust upwards or downwards.[17]

[70] For the practitioner, it was submitted that orders as high as 50% are rare indeed, and that a nominal award is appropriate, taking into account:

(a) Dr D has limited financial resources. He has recently moved into rented accommodation but was living in a caravan prior to that and earning money labouring [ ].

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[12] At [34]

[13] *Groom v NZ Psychologists Board* HC Wellington CIV-2003-485-2175, 5 April 2004; *Vasan v Medical Council of New Zealand HC Wellington* AP43/91, 18 December 1991

[14] *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139 (HC) at 195

[15] *Kaye v Auckland District Law Society* [1998] 1 NZLR 151.

[16] Above, note 13

[17] *Cooray v Preliminary Proceedings Committee* HC Wellington AP 23/94, 14 September 1995 (Doogue J)

(b) He does not have indemnity cover, so will need to pay any award of costs himself.

(c) He has already been punished for his criminal offending.

(d) He has signed an Agreed Summary of Facts and agreed not to appear to help reduce costs.

[71] When a charge is not defended, the costs are automatically significantly reduced. When the Tribunal orders a percentage of costs, that reduction is already included in the calculation. Therefore, the Tribunal agrees that there should be downward movement, and it does not follow that it should be a significant reduction. That is especially so where, as here it would be difficult to defend the fact of a conviction.

[72] However, the Tribunal does make some reduction from a starting point of 50%, taking into account the practitioner's co-operation and efforts to expedite matters. A further reduction is made because of his lost income for over 12 months. It is recognised that he is getting himself back on his feet both professionally and personally.

[73] The Tribunal therefore imposed costs of $11,000, representing approximately 30%. This is to be divided equally between the Tribunal and the PCC.

Name suppression

[74] Dr D applied for suppression of his name on the following grounds:

(a) Publicity of Dr D's name risks damage to Dr D's health; damage to his professional relationships; and damage to his ability to work in his chosen profession.

(b) Publicity of Dr D's name risks making rehabilitation impossible or much harder to achieve.

Principles

[75] Both parties provided helpful submissions on the law regarding non-publication of names and other information in this jurisdiction.

[76] Section 95(1) of the Act provides that all Tribunal hearings are to be in public.[18] Section 95(2) provides:

> (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.

[77] Therefore, in considering and application prohibiting publication, the Tribunal must consider the interests of the practitioner, his wife and their sons, and the public interest. If we think it is desirable to make an order for non-publication, we may then exercise our discretion to make such an order.

[78] The public interest factors have been established:[19]

(a) Openness and transparency of disciplinary proceedings;

(b) Accountability of the disciplinary process;

(c) The public interest in knowing the identity of a health practitioner charged with a disciplinary offence;

(d) Importance of free speech (enshrined in section 14 of the New Zealand Bill of Rights 1990); and

(e) The risk of unfairly impugning other practitioners.

[79] There has been much discussion of the principle of open justice in the Courts and legal commentary. The principle of open justice has been described as a fundamental principle of common law and is manifested in three ways:

> [F]irst, proceedings are conducted in 'open court'; second, information and evidence presented in court is communicated publicly to those present in the court; and, third, nothing is to be done to discourage the making of fair and accurate reports of judicial proceedings conducted in open court, including by the

[18] This is subject to section 97 which provides for special protection for certain witnesses

[19] As set out in *Nuttall 8Med04/03P* and subsequent Tribunal decisions

media. This includes reporting the names of the parties as well as the evidence given during the course of proceedings.[20]

[80] In *Erceg v Erceg*[21] the Supreme Court said:

> [2] The principle of open justice is fundamental to the common law system of civil and criminal justice. It is a principle of constitutional importance, and has been described as "an almost priceless inheritance". The principle's underlying rationale is that transparency of court proceedings maintains public confidence in the administration of justice by guarding against arbitrariness or partiality, and suspicion of arbitrariness or partiality, on the part of courts. Open justice "imposes a certain self-discipline on all who are engaged in the adjudicatory process – parties, witnesses, counsel, Court officers and Judges". The principle means not only that judicial proceedings should be held in open court, accessible by the public, but also that media representatives should be free to provide fair and accurate reports of what occurs in court. Given the reality that few members of the public will be able to attend particular hearings, the media carry an important responsibility in this respect. The courts have confirmed these propositions on many occasions, often in stirring language.
>
> [3] However it is well established that there are circumstances in which the interests of justice require that the general rule of open justice be departed from, but only to the extent necessary to serve the ends of justice.

[81] The disciplinary process needs to be accountable so that members of the public and profession can have confidence in its processes.[22]

[82] The public interest in knowing the identity of a practitioner charged with a disciplinary offence includes the right to know about proceedings affecting a practitioner, but also the protection of the public and their right to make an informed choice.[23]

[83] The High Court has said the statutory test for what is desirable is flexible:[24]

> 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 the

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[20] Jason Bosland and Ashleigh Bagnall, 'An Empirical Analysis of Suppression Orders in the Victorian Courts: 2008-12 (2013) 35 *Sydney Law Review* 674.

[21] *Erceg v Erceg* [2016] NZSC 135.

[22] *Nuttall* 7/Med04/03P para [26], referring to *Director of Proceedings v Nursing Council* [1999] 3NZLR 360*; Beer v A Professional Conduct Committee* [2020] NZHC 2828 at [40]

[23] *Nuttall* 8Med04/03 para [27], [28], referring to *Director of Proceedings v Nursing Council* [1999] 3NZLR 360

[24] *A v Director of Proceedings* CIV-2005-409-2244, Christchurch 21 February 2006 at [42] (also known as *T v Director of Proceedings* and *Tonga v Director of Proceedings*)

> 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 include in favour of the private interests of the practitioner. After the hearing, by which time the evidence is out and findings have been made, what is desirable may well be different, the more so where the professional misconduct has been established.

[84] We acknowledge the stress caused by disciplinary proceedings can adversely affect a practitioner's mental wellbeing. As France J observed in *Dr X v Director of Proceedings*,[25] the "inevitable embarrassment" caused by publicity of disciplinary proceedings does not usually overcome the imperatives behind publication. France J considered that there must be something more "sufficiently compelling" than stress or embarrassment to justify suppression of a practitioner's identity.

[85] The more serious the offending, the greater the stress to the family, but at the same time, the public interest factors may also have greater weight. Where the established conduct has an unethical and/or sexual component there is an added embarrassment and humiliation for a practitioner's family if their name is associated with it, and yet there may be strong public interest factors in publication. That includes flushing out any unknown similar complaints.

Practitioner submissions

[86] Mr Holloway submitted that Dr D's private interests do exert greater relative force in the balancing exercise to be conducted under section 95. He referred to the fact that Dr D is under the care of the Health Committee. He takes fluoxetine and was assessed by a mental health crisis team in [ ] 2020 after experiencing suicidal ideation.

[87] Mr Holloway referred to the letters in support from Dr D's health team. His GP said, "I would have grave fears that [publication] would see him spiral into depression once again, with the associated risks of relapse of alcoholism too" . According to Dr D's psychologist, "… publication of his name, might trigger a degree of depression and increase the need for psychological support", and his addictions specialist said, "Publicity of his case would, in my opinion, be a huge and unnecessary stress for him and would serve no useful purpose and could well undermine his progress … I am sure

[25] *Dr X v Director of Proceedings* [2014] NZHC 1798 at [14]

members of the Tribunal are aware of the potential for relapse of the condition he has and will know that stress may be a potent contributor to relapse".

[88] Mr Holloway submitted that this evidence establishes on the balance of probabilities that non-publication is necessary to protect Dr D's health and eliminate a stressor that would otherwise risk a relapse of his alcohol use disorder. Suppressing Dr D's name would be both compassionate and desirable in the sense of being a wise decision for this Tribunal to make. Dr D has already lost everything — his wife and family, his long-held employment and colleagues, his home and friends in [ ] and, for a time, his profession. His future is the one thing he has left. Mr Holloway submitted that Dr D has done the work necessary to become well, sober and to atone for his criminal convictions. Having overcome all this, he has sought out a humble and private life in another town, where he has recommenced work in an urgent care clinic. He is understandably in dread of being publicly shamed all over again.

PCC submissions

[89] The PCC opposed name suppression for Dr D but did not oppose it for his wife. It was acknowledged that the practitioner has taken a number of positive steps towards rehabilitation, but there is an inevitable stress and embarrassment that comes with publicity, and the information is not sufficiently compelling to displace the presumption in favour of reporting and justify suppression. In particular:

(a) Dr D's identity has already been made public, through the criminal process. While there may not have been any media articles to date in relation to his criminal convictions, those decisions were not suppressed and there is nothing to prevent the media publishing his criminal convictions relating to this offending in future given there was no name suppression in the criminal jurisdiction before the District Court.

(b) There are strong public interest factors in favour of open justice given the nature of the offending, and suppressing details of this type of offending would send the wrong message to the community. There is a

good reason for the strong principles of openness and transparency. It is submitted that there is an even greater need for transparency to the community given that Dr D may be required to treat victims of domestic violence.

(c) Furthermore, Dr D has three previous criminal convictions relating to drink driving, which were well publicised at the time. Therefore, his concerns should be given less weight.

(d) Given the potential for her to be identified, the PCC has sought the views of Dr D's former wife, who has said that she is neutral on the application.

(e) The PCC also acknowledged Dr D's concerns about whether this might impact on his ability to work, in particular, with his current employer, [ ], and observed that there was no evidence before the Tribunal that his current employer would not be prepared to support him.

(f) Although the PCC has some sympathy for Dr D's situation, the appropriate forum for orders for non-publication was in the District Court.

(g) The fact of these convictions has not prevented Dr D from finding work.

[90] The Tribunal asked for further information about Dr D's employment contract and the possible impact of publication on Dr D's employers and employment, which was provided.

Decision

[91] The Tribunal acknowledges that Dr D is committed to his profession and has undertaken appropriate rehabilitation and worked with the Medical Council to ensure he is currently fit to practise. It is also recognised that the offending occurred over two years ago in [ ].

[92] Although there was no media publication at the time of the convictions, there was no suppression. If the Tribunal grants suppression, members of the public present in the court at that time, as well as others with knowledge of events, such as his family and former employers may wonder what other consequences there were for him as a medical practitioner. Suppression may create an impression that Dr D's professional regulator has taken no action.

[93] Dr D provided a statement signed by the CEO and the medical director of [ ], the company which owns the practice where Dr D works. They speak of the difficulties in attracting practitioners and say that in the 6 months he had been with them, he has proven an asset. They confirm that he has complied with his ongoing supervision and Medical Council requirements and they hear nothing but great reports from his colleagues and patients. They expressed absolute confidence in his abilities as a doctor. Their concern is that if his name is published, the media will publicly chastise him. Identical statements were made by the Regional Manager.

[94] The Tribunal has reservations that Dr D's employment would be "untenable" if his name were published, but acknowledges that media attention at this stage would cause difficulties which might make Dr D's health deteriorate or drive him to quit his role.

[95] Mr Holloway also referred to *B v B*,[26] where Blanchard J observed:

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

[96] That passage regarding the impact of publication on rehabilitation should be considered in the context of the landscape of nearly 30 years ago, where public hearings of disciplinary charges were not the norm. Although case was heard under

[26] B v B HC Auckland HC4/92, 06 April 1993 at 99

the provisions of the Dental Act 1988, which provided for hearings to be held in public, and there were provisions in that statute to deal with name suppression, this was quite different from the situation with some other professions where the legislation stipulated that the hearings were in private.[27] In other instances, the legislation was silent on whether hearings of complaints were in public. There was some provision for publication of orders in professional publications,[28] but no explicit provision for non-publication of names.

[97] The enactment of the Medical Practitioners Act 1995 echoed the more transparent approach to professional discipline found in the Dental Act 1988, and all registered health professionals were treated alike with the enactment of the Health Practitioners Competence Assurance Act 2003, which took effect more than 10 years after *B v B* was issued. The first High Court decision on name suppression under the present Act was *Tonga v Director of Proceedings.*[29] In that case the practitioner remained in the profession, and the High Court did not allow an appeal against the Tribunal's refusal to grant permanent name suppression. The quote above at paragraph 83 has been repeatedly cited with approval including by the Full High Court in *Daniels v Complaints Committee 2 of the Wellington District Law Society* [2011] 3 NZLR 850.[30]

[98] That said, in the present case, the Tribunal has been persuaded by a combination of factors that it is desirable that there is an order for non-publication of his name and identifying details under section 95(2)(d). It is significant that:

(a) There is evidence of an underlying mental health issue that predates the present hearing (including alcohol dependency which has manifested in convictions). The current risk of harm to Dr D's mental wellbeing is not based solely on stress related to the proceedings; and

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[27] See, for example, Nurses Act 1977 section 43 (7), Chiropractors Act 1982 section 33(7).

[28] For example, section 65 of the Medical Practitioners Act 1968 provided for publication of orders in the Medical Journal of New Zealand at the discretion of the Disciplinary Committee or the Medical Council

[29] Above, note 24

[30] At [60]

(b) The practitioner has undergone a complete break from practice following the events that were the subject of the convictions before the Tribunal; and

(c) Has worked with the Medical Council's Health Committee, complying with conditions imposed; and

(d) The practitioner has provided evidence of the potential impact of publication on his mental health; and

(e) Has provided evidence that there is a shortage of medical practitioners in his are of practice and geographical region; and

(f) A relapse of his health issues therefore carries a risk to the public, through his deteriorating fitness or adverse publicity that pressures him to leave. That would cause him hardship, but also would have an adverse impact on the public; and

(g) Although the convictions reflect adversely on his fitness to practice, they do not directly relate to his clinical practice.

[99] Although it is finely balanced, in this instance, having weighed the public interest factors outlined above and also the public interest in retaining Dr D's professional services in his public role, and his personal interests, the Tribunal has found it is desirable to order suppression of his name and has exercised its discretion to grant the order.

Results and Orders

[100] The Tribunal found that the practitioner's conduct is an act likely to bring discredit to the profession and is therefore professional misconduct under section 100(1)(b) and the convictions reflect adversely on his fitness to practice under section 100(1)(c).

[101] Under section 101(1)(c), the Tribunal imposed a condition on the practitioner's practising certificate for a period of 3 years from 24 August 2021 that he inform his current, prospective and future employers of this decision.

[102] The practitioner is censured under section 101(1)(d).

[103] A contribution of costs of $11,000 are ordered under section 101(f).

[104] The practitioner's name and identifying details are permanently suppressed under section 95(2)(d)

[105] Under section 157 2) of the Act the Tribunal directs the Executive Officer:

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

(b) To request the Council to publish either a summary of, or a reference to, the Tribunal's decision in its professional publications 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 Wellington this 22nd day of February 2022

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T Baker
Chair
Health Practitioners Disciplinary Tribunal