NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	1276/Med21/518P
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	**Nalendra Appanna** of Hamilton, registered medical practitioner **Practitioner**

HEARING held at Hamilton on 23 to 25 August 2022

TRIBUNAL	Ms T Baker (Chair) Dr S Moeed, Dr L Chapman, Dr K de Silva, Mr S Youn (Members) Ms D Gainey (Executive Officer) Ms H Hoffman (Stenographer)
APPEARANCES	Dr J Coates and Ms A Lane for Professional Conduct Committee (the PCC) Mr H Waalkens KC and Ms S Beattie for the Practitioner

DECISION OF THE TRIBUNAL

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Introduction

[1] A panel of the Health Practitioners Disciplinary Tribunal (**the Tribunal**) convened in Hamilton on 23 – 25 August 2022 to hear a charge laid by a Professional Conduct Committee (**PCC**) of the Medical Council of New Zealand against the practitioner, Dr Nalendra Appanna. The charge arose from a relationship he formed via an online app called Seeking Arrangement.

The Charge

[2] A full copy of the charge is attached as Appendix A to this decision. Particulars 1, 2, 3 and 5 alleged that Dr Appanna inappropriately blurred professional boundaries between his personal life and professional life by providing health services and having sexual contact and/or a relationship with Ms Y, engaging in sexual activity at his medical practice, and refusing to delete video footage of their sexual activity.

[3] It was further alleged in particular 4 that Dr Appanna breached a patient's privacy and/or his professional obligations by forwarding to Ms Y an image of a female patient in an operating theatre.

[4] And finally, particular 6 alleged that Dr Appanna disclosed personal and/or health information about Ms Y to a reporter from Stuff Limited without her consent and/or at a time when a complaint was under consideration by a PCC.

Evidence

[5] The Tribunal received an Agreed Bundle of Documents containing:

(a) Documents obtained during the course of the PCC investigation, including:

(i) A schedule of text messages between Dr Appanna and Ms Y between 15 May and 12 July 2019, collated from Vodafone data

(ii) A screenshot of a message sent by Ms Y on 21 June 2019

(iii) Ms Y's medical records from her GP from 1 May to 31 July 2019

(iv) Laboratory Order form dated 15 May 2019

(v) STI test results dated 5 December 2019

(vi) Correspondence from the Ministry of Health confirming no record of any dispensing data of prescriptions written by Dr Appanna for Ms Y

(vii) Correspondence from the National Cervical Screening Programme confirming it did not receive any test samples for Ms Y in May 2019

(viii) Correspondence from Ms Y's medical centre confirming no patient records were sent to other doctors

(ix) Correspondence from Waikato DHB to the PCC, confirming Dr Appanna had not made any referrals to the Pain Service for Ms Y

(x) An affidavit sworn by Dr Appanna on 13 September in support of his application for an order staying the Medical Council's order for interim suspension

(xi) An affidavit sworn by Dr Appanna in support of his appeal regarding interim suspension

(b) Dr Appanna's responses to the PCC

(c) Media publications and associated documents

(d) Relevant Medical Council Statements and Guidelines.

[6] A Supplementary Bundle of Documents containing:

(a) Retrospective notes on Ms Y's disclosure at a Sexual Assault Support Service

(b) Screenshots of text messages from Dr Appanna to "Office Mobile" asking for Ms Y's WWH[1] records to be obtained

(c) Medical records Dr Appanna received from Waikato DHB

(d) Ms Y's STI swab results.

[7] The Tribunal heard from the following witnesses:

(a) Ms Y, who was the key witness of fact. She provided a brief of evidence which was read to the Tribunal and she was available for questioning.

[1] Assumed to be Waikato Women's Health

(b) Dr Lynne Harvey, the convenor of the PCC, who also provided a brief of evidence outlining the PCC's investigation and produced relevant documents and Dr Appanna's responses. She joined the hearing by audio-visual link, read her brief and was available for questioning.

(c) Dr Simon McDowell, called as an expert to give his opinion on Dr Appanna's conduct. His evidence was accepted and he was not required for questioning.

(d) Mr Matthew Shand, a former journalist who was summoned to answer questions relevant to particular 6, the allegation that Dr Appanna disclosed personal and/or health information about Ms Y to a reporter from Stuff Limited without her consent and/or at a time when a complaint was under consideration by a PCC. He also produced his notes of interview.

[8] Although Dr Appanna had filed a brief of evidence before the hearing, at the end of the PCC case, Mr Waalkens advised that Dr Appanna would not be giving evidence.

[9] Most of the factual particulars alleged in the charge were not disputed. Dr Appanna did not accept that he had performed a cervical smear or that he had disclosed Ms Y's personal or health information.

[10] Dr Appanna's defence of the charge was primarily aimed at whether the conduct amounted to professional misconduct.

Ms Y

[11] Most of Ms Y's evidence was not in dispute.

[12] Dr Appanna and Ms Y met via an online dating app and website called Seeking Arrangement. Ms Y explained that this is an online platform where older, wealthy men ("Sugar Daddies") pay young women ("Sugar Babies") to meet and spend time with them. It does not always involve sex but can be something simple like being paid to go out for a coffee.

[13] Ms Y joined Seeking Arrangement as a way to earn some extra money. Dr Appanna first contacted her in May 2019. Her name on the app was "[ ]". Dr Appanna's username was "W_olf" and according to his profile he was looking for a "sub" to enter into a "dom-sub" relationship with him. That is one where one partner is more dominant and powerful while the other partner submits to them.

[14] Ms Y first met with Dr Appanna on or around the evening of 15 May 2019. The plan was to meet up for drinks and a chat. Dr Appanna collected her from the bus stop by her house that evening and drove them to a bar and restaurant. On the way they drove past a clinic which Dr Appanna pointed to and said that he worked at. Ms Y then understood that he was a doctor, but she did not know what kind of doctor he was.

[15] During drinks and conversation, they began talking about sexual contact and the arrangement that they might have. Dr Appanna told Ms Y that he required everyone he has sexual contact with to have an STI test.

[16] Dr Appanna offered to pay for the STI test but then he said he could do the test now if she wanted to. He told her he was a gynaecologist and could do it at his office. Ms Y was agreeable to having an STI test.

[17] Dr Appanna drove her to his clinic and showed her around his work. There was no-one else at the office. Dr Appanna performed an STI test by using a speculum and a long swab. As discussed later, Ms Y said that she had also been given a smear, but that was denied by Dr Appanna.

[18] Dr Appanna then said he did not want to wait for the test results to come in and said that they could always take a pill if she had anything.

[19] Following that Dr Appanna tied Ms Y to a chair next to the bed and then used vibrators on her for the purpose of achieving orgasm. He also performed oral sex on her that evening.

[20] Dr Appanna then took Ms Y home. On 21 May he messaged her to tell her that everything had come back clear.

[21] Ms Y and Dr Appanna then met on Wednesday nights at his office around 6.30 or 7 p.m. While there they would have drinks and Dr Appanna would make videos of him using sex toys on her. There was one session where she performed oral sex on him but other than that it was usually him performing sexual acts on her. They never had sexual intercourse.

[22] Dr Appanna did not give her cash payments for the times that they met but he did once give her $100 for food.

[23] The Tribunal also received a copy of a contract which contained all the rules that Dr Appanna expected of a “sub”. The contract was not ever signed by Ms Y.

[24] Under cross-examination, Ms Y agreed that they met no more than 5 times. In between times they would message each other through text, Facebook or Kik, which is an instant messaging app that automatically deletes messages when you log out of the account.

[25] Dr Appanna would film their sexual activity on a tripod that he had at his clinic. At the beginning of each recording, he would get Ms Y to state that she consented to the sexual acts that he was doing. These included acts such as spanking her with different objects or using things like vibrators and toys on her. After filming Dr Appanna would then put the video on his work computer and would play it back and watch it.

[26] Ms Y suffers from a chronic health condition that affects both her digestive and reproductive systems. Because of this she is often in pain. She elaborated that after a caesarean and subsequent surgeries she has been left with adhesions from which she has not recovered, giving her dietary and other physical health issues. She said she was not being seen by anyone who could help her. She said that for many years she had been "pretty much bedridden" and she was only just getting to a point with the appropriate people where she could have a "pretty decent quality of life". She said it had been a very long journey.

[27] Dr Appanna was aware of Ms Y's health issues because she told him about it before they met. She would tell clients at the beginning so that they knew that she might not be able to meet up sometimes. She felt positive on finding out that he was doctor.

[28] On one occasion Ms Y tried to cancel their plans to meet up because she was too sore to do anything and did not feel like doing anything sexual. Dr Appanna talked her into coming out anyway and said that he would look after her and he wouldn't expect her to do anything. They met at his clinic and talked on the couch. He said, "You know I'm a doctor, I can prescribe you anything you want aye?". Ms Y said that it was like him flaunting his doctor's powers to her, telling her how powerful or important he was and what he could do for her if they stayed "friends".

[29] Dr Appanna suggested painkillers and then went into his office and got a pill for her to take. This was a midazolam tablet, the nature of which was described in Dr McDowell's evidence. She took the first half while at Dr Appanna's office and the second half once she got home. She then went to sleep.

[30] Around June 2019 when Dr Appanna was working in Australia, he sent Ms Y a photo of a patient in an emergency operating situation on the operating table. Ms Y thought it was odd, and forwarded it to a nurse friend of hers, asking if it was normal for a doctor to send a photo like that.

[31] In around July 2019, Ms Y "started to realise that things were quickly getting really dark" and she wanted out. What was meant by that was not elaborated on.

[32] Ms Y messaged Dr Appanna and asked whether he would delete her videos if she wanted him to. She cannot remember what he said but he did not agree to.

[33] On 12 July 2019 Ms Y asked Dr Appanna to delete the videos. He declined but offered to edit the video out so there was only sound left. Ms Y was not happy with this. Dr Appanna also made reference to a pain clinic referral, that he had offered to make her. He sent her a text saying, "But I'm not deleting videos hon, have your notes for referral if you still want me to?"

[34] Ms Y said "No" and decided to go to the Police about it. She was interviewed on 19 August 2019. She and Dr Appanna ceased contact after that.

[35] In August 2019 Ms Y went to the Midland Sexual Health Support Services as she was fearful that Dr Appanna was going to release the videos. While there she met with Dr Kate Taylor, who then notified the Medical Council of Ms Y's reported conduct by Dr Appanna.

[36] In around July 2020 Ms Y received a phone call out of the blue from a journalist at Stuff.co.nz. He told her that he had interviewed Dr Appanna about the relationship and that he wanted to sit down with her to clarify some details. Ms Y had not given the journalist her phone number and the number is not available online. She did meet with the journalist.

[37] Ms Y produced a copy of an article dated 8 August 2020 entitled "Bondage doc's career in tatters". The journalist's name was Matt Shand and it was published on *Stuff.*

[38] In cross-examination, Ms Y accepted that the media already had some of her medical information as a result of Dr Appanna's appeal to the District Court regarding his interim suspension. A copy of further messages from between Ms Y and Dr Appanna was produced to the Tribunal. These were of some initial communication

between the two from Dr Appanna's Kik account where Ms Y was using a pseudonym. She did not believe that her phone number was accessible through the Kik app.

[39] Ms Y agreed that from the start she was aware that Dr Appanna was looking for dom-sub relationship. She was aware that Dr Appanna was expecting sex on their first meeting and she was a willing participant.

[40] Ms Y accepted that she was playing a part to keep Dr Appanna interested. When asked if she misled him in that regard, she said, "I would agree with that, not entirely but I would say that that is true, yes." She also agreed that she was playing a part and intentionally giving Dr Appanna the impression that she was going to sign the dom-sub contract when she had no intention of doing so.

[41] As for whether Dr Appanna had fallen for her, as evidenced by the text communication between the two, Ms Y said that words are just words, that people say anything to get what they want. She accepted that he may have thought that he was "falling" for her and that it was reciprocated.

[42] Ms Y was asked about the suggestion that Dr Appanna was offering medical services in exchange for sex. She said that there was no hard agreement, but said, "It was just the body and the verbal language that was being used that was leading me to believe that that is 100% what was going to happen". Ms Y did not accept that it was only an impression she had gained, but her prior statement in an interview with the PCC on 17 October 2019 was put to her when she has used the words that Dr Appanna had her "under the impression" that if she did what he wanted he would be able to help her with medical things. She accepted in cross-examination that it was no more than an impression she had gained, but not that she might have been mistaken in her impression.

[43] Ms Y agreed that she had difficulty remembering the details of her relationship with Dr Appanna, but she did not agree that the reason that no money was paid to her was because she had not signed the dom-sub contract. They did not sit down and have a conversation about money.

[44] Ms Y was further questioned about the night of their first encounter. She knew she had drunk some wine and did not remember how much. She said it went straight to her head because she does not usually drink wine. Ms Y was asked about her recollection that Dr Appanna had taken a cervical smear. She agreed that he used a

speculum and that she may have had two, not one swabs. She said that he had commented on her cervix. When it was suggested to Ms Y that Dr Appanna would have been able to visualise her cervix, she questioned why he would be looking at her cervix in the course of conducting an STI test.

[45] Ms Y was unsure if she had had a smear test since the night in question. She was unaware if she has got anything wrong with her cervix, but she did not accept that Dr Appanna had not commented on her cervix. She said, "No, it did happen but, you see, the thing is, it's obviously not something that ruins my day-to-day life because I didn't even know it was there until he told me and that's why he was like 'I can remove it if it starts causing problems for you' but obviously it's never caused problems for me because I never needed it investigated further but that 100% truly did happen."

[46] Ms Y did not accept that it was her idea for Dr Appanna to perform the STI test, rather than her go to Family Planning. She said it was no big deal for her to have gone to a clinic. She agreed that she did not want the results sent to her GP. She accepted that the fact that there were no results from a cervical smear was consistent with one not having been taken. She accepted that she had not suffered any harm from the STI test being performed.

[47] On the matter of the midazolam, Ms Y was sure that it was not provided to her after they had engaged in sexual activity. She said she was too sore to do anything, which was why Dr Appanna gave her the midazolam. She still did not feel well and so she "was sent home". She did not want to be referred to the A&E clinic because she thought they would just give her Panadol and send her home.[2]

[48] Ms Y did not recall Dr Appanna raising several different types of pain relief with her. She did not accept that the offer of midazolam was a genuine attempt to try to help her with her pain. She thought that it was so that she would be well enough to do what he wanted her to do. It was put to Ms Y that there was no hint in her text messages at the time about this midazolam administration suggesting that he was doing it for a wrong purpose, that she appeared to have been genuinely grateful. She said that she was not going to turn around and not be agreeable when she was trying to achieve a goal.

[2] In closing, Mr Waalkens noted that in the text exchange between the parties on 23 May there was reference to the use of a wand. These messages were not put to Ms Y in cross-examination.

[49] Ms Y agreed that no harm was done through the provision of the midazolam and that Dr Appanna did not ever prescribe any medication. She did not accept that he never offered to do so.

[50] Ms Y agreed that the offer to refer her to a pain clinic was a genuine attempt to help her.

[51] Mr Waalkens questioned Ms Y about the video footage that Dr Appanna had retained. She said it was not communicated to her that the reason Dr Appanna wanted to keep an audio recording was because it included her consent to their activity. It was put to Ms Y that Dr Appanna deleting part of the audio track might not avoid her making a false complaint about consent, and that is why he wanted to retain an audio recording of the whole thing. She replied, "That's fair, yes".

Dr Lynne Harvey

[52] Dr Lynne Harvey is a registered medical practitioner and is the convenor of the Professional Conduct Committee that was appointed by the Medical Council to investigate the conduct of Dr Appanna. The investigation commenced on 8 October 2019. A charge was laid in this Tribunal on 24 May 2021.

[53] Dr Harvey outlined the process of the investigation and information gathered. This included a full log of incoming and outgoing calls and text messages between Dr Appanna and Ms Y's respective mobile numbers. This was collated into a spreadsheet which was produced by Ms Y.

[54] The PCC requested from the Ministry of Health all dispensing information in respect of prescriptions written by Dr Appanna for Ms Y. The Ministry confirmed that there was no record of any dispensing of medications.

[55] The PCC obtained the laboratory order form completed by Dr Appanna on 15 May 2019 for Ms Y and the results of the vaginal swab that was collected. The National Cervical Screening Programme advised the PCC that it had not received any smear test results for Ms Y.

[56] The PCC obtained clinical notes from Ms Y's general practice medical centre, who confirmed that those records had not been sent to any other doctors or providers between 1 May and 31 July 2019.

[57] The PCC also communicated with Waikato District Health Board who advised that the Pain Service had not received any correspondence or referrals from Dr Appanna.

[58] Dr Harvey produced copies of Dr Appanna's:

(a) affidavit dated 13 September 2019 which was filed in the District Court in support of his application for an interim order staying the Medical Council's decision to suspend,

(b) affidavit dated 21 January 2020 which was filed in the District Court in support of his appeal.

(c) responses provided during the PCC's investigation in 2020.

[59] In his letter dated 30 April 2020 to the PCC Dr Appanna said:

> From the outset, I do want to repeat what I have said earlier that I do very much regret the relationship that I entered into with Ms Y. Our intimate/sexual relationship was entirely consensual. …
>
> I can see that there is also no dispute that it was only after we had commenced an intimate/sexual relationship that I provided some medical services to Ms Y. I accept that I have not acted in keeping with the Medical Council's guideline called Providing care to yourself and those close to you. I did not, at the time think this was so. The provision of the STI test and the providing of a half tablet of Midazolam arose as part and parcel of our personal relationship, rather than the converse. I would also like to emphasise some other points relating to the STI test. As Ms Y explained to you in her interview … it is normal when entering a new relationship to have a sexual health check. I had offered to pay for her to have the check done elsewhere. I made sure she received the test results…
>
> As for the half tablet of Midazolam, I was told by Ms Y that she was in pain. I had offered to take her to a 24-hour A & E clinic, but she declined. She told me she had been to that practice many times and they were unable to do anything for her. She readily accepted my offer to give her some pain relief and appeared grateful that I did so. Half a tablet amounts to a quarter to one-half of the standard dose range that is recommended by the manufacturer – that is, it was a low dosage. I also offered to refer her to a pain clinic. Ms Y initially agreed but later declined.
>
> This was most certainly not a case of my entering into a sexual relationship with a patient. That said, I accept that having provided some medical services to Ms

> Y, I did taint our personal relationship with services of a professional nature. This was an error of judgement on my part and one for which I am very much regretful of (*sic*). …
>
> I completely reject any suggestion that I undertook a smear examination for Ms Y. This happened at no time. Had I done so, there will be a medical record of the results. There are none because the examination did not happen in the first place. Ms Y is mistaken.
>
> I also accept it was inappropriate for me to send Ms Y the photographic images of the obstetric case in Australia that I had attended to under an emergency situation. In saying that, I did ask for permission to take the photograph (which was given) before I took it. At the time I had been working long hours, I was sleep deprived and, frankly, exhausted. I do not really know why I did it. I have never done this or anything remotely like this before.

[60] Dr Harvey also produced a copy of an item from Dr Appanna's blog. This is referred to as Naylin's blog. The post is entitled Ethics and Journalism and is dated 8 August 2020. This was in response to the *Stuff* article that had appeared on the same day.

[61] In cross-examination Dr Harvey confirmed that the blog was later taken down. She also confirmed that in the media publicity surrounding Dr Appanna's District Court appeal, discussed the issue of midazolam, providing of an STI swab, Dr Appanna's denial that he had undertaken a smear and his offer to assist her with a referral to the Pain Clinic.

[62] On the matter of the STI test, Dr Harvey agreed that there were two swab results which indicates that two swabs were taken, and that when taking a swab for an STI text it is possible to visualise the cervix.

[63] In answer to questions from the Tribunal, Dr Harvey said that midazolam is not medication that GPs ordinarily use or have access to. She understood that it is hypnotic and that although it used to be widely available, it is now limited more to pre-anaesthetic sedation-type procedures.

Dr Simon McDowell

[64] The Tribunal received a brief of evidence from Dr Simon McDowell, an obstetrician gynaecologist based in Wellington. He trained in O and G with the Royal Australasian and New Zealand College of Obstetrics and Gynaecology and also

completed some speciality training in reproductive endocrinology and infertility. He has a post-graduate diploma in obstetrics and medical gynaecology through Otago University and a Masters in reproductive medicine through the University of New South Wales. He completed his general obstetrics and gynaecological training in 2012 (FRANZCOG) and his sub-speciality qualification in 2015.

[65] Dr McDowell currently practises in general public and private roles. He is a generalist obstetrician gynaecologist at Capital & Coast District Health Board, a specialist at Fertility Associates and he also operates privately at Wakefield Hospital, all based in Wellington. As part of his Fertility Associates role, he also consults in Gisborne.

[66] For three years up until early 2020 Dr McDowell was the lead training supervisor for RANZCOG trainees through Capital & Coast District Health Board. He has also been a supervisor for sub-speciality trainees in reproductive endocrinology and infertility. He is actively involved with training general O and G registrars. He performs presentations and teachings for general practitioners and other speciality colleges. Dr McDowell is currently a board member of the Fertility Society of Australia and New Zealand. He is also a part of Ha Hono Wāhine which is a subcommittee of RANZCOG. Finally, he has completed a RANZCOG course to be an expert witness.

[67] No issue was taken with Dr McDowell's expertise.

[68] Dr McDowell referred to the Medical Council statement on professional boundaries in the doctor patient relationship, November 2018 which says:

> Doctors are responsible for maintaining appropriate professional boundaries in their doctor-patient relationship.
>
> Doctors are responsible for maintaining sexual boundaries in the doctor-patient relationship.
>
> It is never appropriate for a doctor to engage in a sexual relationship with a patient.

[69] Dr McDowell observed that Ms Y was not an existing patient of Dr Appanna. He said a person becomes a patient when they receive care, or awaiting for care. This requires the patient to become registered with the clinic at hand. Ms Y received care from Dr Appanna and that a clinic examination was undertaken with a view to taking

smears and swabs. Enquiry was made into obtaining her clinical records, and referral to a pain clinic was offered. While Ms Y did not appear to have been a patient of Dr Appanna in the strict sense (i.e. she was not formally registered to his practice), some of his behaviour and communications were more in keeping with a doctor-patient relationship. In Dr McDowell's opinion, the lines between professional boundaries and personal boundaries became very blurred.

[70] In Dr McDowell's opinion the decision of Dr Appanna to offer STI screening to Ms Y was inappropriate. Dr McDowell said this is an invasive clinical examination and should only ever occur in the context of a doctor-patient relationship. It appeared that STI screening was offered and undertaken to facilitate a sexual relationship with Ms Y. Dr McDowell referred to the *Medical Council statement on Providing Care to Yourself and Those Close to you*, November 2016:

> You must not treat yourself, family members, or those close to you in the following situations: performing invasive procedures.

[71] In Dr McDowell's opinion Ms Y could be defined as someone close, as a sexual relationship was intended, and for that reason undertaking STI screening was inappropriate. Although he offered for screening to be performed elsewhere, he should not have given Ms Y the option of having him perform the test. Patients at low risk of sexual transmitted infection could undertake self swabs, meaning an intimate examination is unnecessary. This would have been an option, but even so would not have been appropriate. Self-swabs should only be undertaken in the context of a doctor-patient relationship, and it again appears that these would have been performed with the aim to facilitate a sexual relationship.

[72] On the matter of commenting on an abnormality on Ms Y's cervix, Dr McDowell noted that a doctor may note an abnormality of the skin, or perhaps an unusual mass and advise the issue to be reviewed by the patient's GP. A speculum had to be placed to view the cervix with the intent of taking swabs. While it is appropriate to comment on a perceived abnormality, Dr Appanna should not have been performing the examination in the first place. The incidence of "fingering" during the examination is a very clear example of the blurring of professional and personal boundaries.

[73] Dr McDowell also expressed concerns at having sexual relationships out of hours at Dr Appanna's place of work. He thought it constituted poor judgement. In

Dr McDowell's view, his gynaecological peers would take a dim view of this especially given his practice is gynaecology. The combination of performing a set specialised medical procedure and having sexual relationships in the same interaction at a professional place of work entirely changes the landscape. This merits extreme poor judgement, boundaries are totally blurred. Dr McDowell opined that Dr Appanna for at least some of the time was behaving like Ms Y's doctor.

[74] Dr McDowell said that Midazolam is not an appropriate medication for analgesia. It may be used to facilitate undertaking an uncomfortable or painful procedure, and should only be provided to someone in the context of clinical interaction. There should be documentation of the drug being given, discussion regarding side effects, adverse effects and possible interactions with existing medications. If Midazolam is given for sedating purposes for a procedure this is charted, dated and signed by the doctor prescribing and the nurse administering the medication. Dr McDowell noted that the Midazolam was administered at Dr Appanna's private practice and again the situation looks more like a patient-doctor interaction. Dr McDowell would not consider Midazolam an appropriate drug to give in an emergency situation unless it was to aid a procedure such as relocating a joint dislocation. If Dr Appanna believes sedating medications were the only option, then he should have taken Ms Y to the emergency department for assessment.

[75] Dr McDowell noted that the midazolam appeared to be of benefit but there is certainly a sense of consent to taking the medication.

[76] Dr McDowell observed that Dr Appanna appeared to have provided medical opinions for Ms Y:

(a) He commented on an abnormality on her cervix;

(b) Discussed and offered referral to a pain clinic; and

(c) Provided medical therapy for her when she was in pain.

[77] Dr McDowell said family members and friends of gynaecologists and medical practitioners will often discuss their personal medical matters, though occasionally a medical practitioner may comment on something having observed an area of concern. These generally reflect informal discussions. A doctor may then advise the person to visit their general practitioner. They may provide a recommendation regarding a

specialist, and Dr McDowell would consider that reasonable. Providing a referral may also be reasonable in certain situations, such as when an individual may refuse or neglect to see their GP to obtain a referral, but a medical practitioner would need to be very careful with this, having considered the nature and extent of the personal relationship.

[78] Although Dr Appanna's provision of medical advice appears to be in the interests of helping Ms Y, a referral to the pain clinic would not have been appropriate as it would require a complex and detailed referral. To this end he would need the medical records, and looking at or requesting medical records is only appropriate in the context of a doctor-patient relationship.

[79] Dr McDowell referred to the Medical Council statement on sexual boundaries:

> A key difficulty arises from a power imbalance inherent in the doctor-patient relationship. The doctor-patient relationship is not equal, whether seeking assistance, guidance or treatment. In some situations, the patient may become dependent on the doctor emotionally and be vulnerable to an inappropriate relationship with their doctor.

[80] In Dr McDowell's opinion this statement is relevant when considering the aspects of Dr Appanna's behaviour or more of a doctor and patient. This therefore leads to a power imbalance, which was evident between Dr Appanna and Ms Y, in Dr McDowell's opinion.

[81] The Medical Council statement *Providing Care to Yourself and Those Close to You* says:

> You must not treat yourself, family members or those close to you in the following situations:
>
> - Prescribing or administering medication with a risk of addiction or misuse.
> - Prescribing psychotropic medication.
> - Prescribing controlled drugs as specified and described under the Misuse of Drugs Act 1975.

- Issuing repeat prescriptions where you do not have appropriate information available to review the suitability of the repeat prescription.
- Undertaking psychotherapy.
- Issuing certificates including but not limited to medical certificates for time off work or school, medical certificates assessing fitness to drive or dive, medical certificates regarding a mental disorder, and death certificates.
- Conducting medical assessments for third parties such as ACC and private insurers.
- Performing invasive procedures.

[82] In Dr McDowell's opinion, a vocationally registered gynaecologist needs to and should be very aware of boundaries and inherent power imbalances when becoming actively involved in a sexual partner's medical problems. There is a clear power imbalance in these relationships. In this situation Ms Y was reliant on Dr Appanna for conveyance of medical results, advice on what to do regarding a possible cervical abnormality, and referral to a chronic pain service. She had a complex medical background, chronic pain issues, and a specialised medical practitioner taking interest in her medical wellbeing may have been appealing. Dr Appanna must have or should have at least been aware of the possibility of this sentiment. It should have prompted even more care and consideration regarding how he undertook his relationship with Ms Y.

Matthew Shand

[83] Matthew Shand appeared on a summons issued on 11 July 2022. The summons was issued by the Tribunal on application by the PCC. Mr Shand was therefore a witness for the PCC.

[84] In 2020 Mr Shand was a journalist. He left that position in 2021. The Tribunal ordered on 11 July 2022 that he produce:

> any papers, documents, records, or things in their possession or under their control that contain or refer to any information provided to Stuff by Dr Appanna about the woman referred to in the Stuff article as 'a woman [Dr Appanna] met

through the Sugar Daddies website' and referred to in the article as the 'sugar baby'.

[85] In evidence Mr Shand confirmed that he was the journalist who wrote an article published on 8 August 2020 by Stuff, entitled "Bondage Doc's Career in Tatters", copy of which was included in the evidence before the Tribunal. Mr Shand brought his notes to the Tribunal and they were produced. They were in shorthand and he provided a long-hand transcript and gave an oral explanation of the context of the notes and that they were an aide memoire, rather than a verbatim record of his discussions with Dr Appanna.

[86] Mr Shand said that a few months before the article was published, Dr Appanna had contacted Mr Shand to tell his side of the story, following an earlier news item in the Waikato Times. They met in a café and had a conversation about whether he wanted to go ahead with it. This was not an interview.

[87] After some more conversations they arranged an interview, which was followed up by a series of phone calls and clarifications. Mr Shand could not remember exactly how many, but estimated half a dozen to ten times, maybe more.

[88] Mr Shand said that Dr Appanna told him the name of the woman who is referred to in the article and gave him her contact telephone number. Dr Appanna told Mr Shand that he had performed and STI swab on her and that he had supplied a pill. Mr Shand said that Dr Appanna told him he had administered a painkiller.

[89] Mr Shand confirmed that he was shown copies of text messages between Dr Appanna and Ms Y, and in particular, he had been shown a screen with the correspondence on Kik (which had been produced to the Tribunal in a supplementary bundle). These views showed the number for Ms Y, who was using the name [ ]. Mr Shand said he had asked him for the phone number and Dr Appanna showed him the screen and he wrote it down.

[90] In answer to questions from the Tribunal, Mr Shand could not recall when he had found out that [ ] was also Ms Y.

Dr Nalendra Appanna

[91] Dr Appanna filed a brief of evidence but did not give evidence before the Tribunal. Mr Waalkens said that the Tribunal could consider it, but expected Dr Coates

to object. Dr Coates submitted that the brief of evidence should remain before the Tribunal and be treated in the same way as the prior statements that were before the Tribunal. It was submitted that there are things in the various statements that are non-contentious and agreed they provide useful background context information for the Tribunal. However, on matters where there is a clear conflict, then it is a matter for the Tribunal as to how much weight it should place on Dr Appanna's denials, given that he was not available to answer questions from the PCC and the Tribunal.

[92] Dr Coates commended the approach taken in a previous Tribunal decision:[3]

> The Tribunal does, however, accept the submission that the PCC and has approached the statements provided by [the practitioner] with caution, given there was no cross-examination testing of him, but has accepted any concessions by him in those statements or in any interviews recorded in the bundle on their face value.

[93] Mr Waalkens took no issue with this approach.

[94] In the statement prepared for the Tribunal, Dr Appanna said that at no time did he promote himself to Ms Y as a medical practitioner, but they spoke of it when the topic of his occupation came up in conversation.

[95] Dr Appanna said that it was Ms Y who had asked him to perform the STI test when she learned he was a doctor. He accepted that it was most unwise for him to do this.

[96] Dr Appanna denied performing a smear, noticing something wrong with Ms Y's cervix or that he touched her in a sexual way while doing the swab.

[97] Dr Appanna accepted that providing Ms Y with half a tablet of midazolam was unwise. He said it amounted to 3.25mg which he considered would help her by taking the edge off her pain. He offered her alternative medication in the first instance, but she told him that it would not work. Dr Appanna said that he did this as her friend, not as her doctor.

[98] Ms Y told him that she had tried to get an appointment with a pain clinic but that she had been unable to progress this. He offered to refer her to a pain clinic. He did not tell her that he had sent a referral to a pain clinic for her. Dr Appanna said that he was

[3] *Walker* 752/Nur15/321P at [49]

only ever doing her a favour in this regard. He did not accept that he was acting as her doctor.

[99] Dr Appanna denied telling Ms Y that he could prescribe her anything she wanted.

[100] Dr Appanna said that the reference in his text to the deletion of the videos and having her notes for referral were two quite separate matters.

[101] Dr Appanna said that the patient, midwife and anaesthetist in the image that he had sent to Ms Y from Australia had all consented to him taking the photo. He said he was significantly sleep deprived. He did not offer that as an excuse but as an explanation for a poor decision on his part. He did not accept that it was a breach of the patient's privacy or a breach of his professional obligations.

[102] Dr Appanna completely rejected any suggestion that he disclosed personal information or health information about Ms Y to a reporter from Stuff. He said that the reporter had a significant amount of information about the situation, most of which can be found in the District Court decision. Dr Appanna said, "I did not give him Ms Y's telephone number or any other details about her. Her assumption that I provided it to him is completely incorrect".

Findings

[103] The burden of proof is with the PCC.

[104] The standard of proof is the civil standard, that is the balance of probabilities. In *Karagiannis* 181/Phar08/91P the Tribunal said:

> In the recent decision of *Z v Complaints Assessment Committee* [2008] NZSC 55, the majority of the Supreme Court stated that in civil proceedings in New Zealand (including disciplinary proceedings) there is a civil standard, the balance of probabilities, which is applied flexibly according to the seriousness of matters to be proved and the consequences of proving them. The Court endorsed the classic passage of Dixon J in *Brigginshaw v Brigginshaw* (1938) 60 CLR 336, 361-362 to the effect that the affirmative of an allegation must be made out to the reasonable satisfaction of the fact finder. Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the Tribunal".

[105] The PCC referred to *Rabih v Professional Conduct Committee of the Dental Council*[4] as the leading authority for the test for credibility. The High Court said "no issue could be taken" with the following principles applied by the Tribunal, adopting a passage from an earlier Tribunal decision,[5] where it was said:

> 26. The test for "credibility" was stated by a Canadian appellate court (in *Farynia v Chorny* [1952] 2 DLR 354 (BCCA)) as being that the real test of the truth of the story of a witness must be at harmony with the preponderance of the probabilities which are practical, and which an informed person would readily recognise as reasonable in that place and in those conditions.
>
> 27. Accordingly, the Tribunal, where relevant, must consider such factors as:
>
> (a) The manner and demeanor of the witness when giving evidence.
>
> (b) Issues of potential bias, that is, to what extent was evidence given from a position of self interest.
>
> (c) Internal consistency or, in other words, whether the evidence of the witness was consistent throughout, either during the hearing itself, or with regard to previous statements.
>
> (d) External consistency or, in other words, was the evidence of the witness consistent with that given by other witnesses.
>
> (e) Whether non-advantageous concessions were freely tendered.
>
> 28. Essentially, what is involved is an analysis of all the evidence, rather than merely asserting that one party rather than another is to be believed.

[106] Dr Appanna did not give evidence. Ms Y's was the only direct witness of the events in particulars 1 to 5. Mr Shand was the only witness heard on the allegation in particular 6.

[107] Each of the particulars of the charge of professional misconduct required a finding on factual allegations as well as an evaluative judgment of whether the conduct blurred boundaries or was unprofessional. The following findings cover both the factual and qualitative allegations contained in the charge. The decision on whether or not the established particulars reach the disciplinary threshold is found later in this decision under the heading Professional Misconduct.

Particular 1 – provision of health services and sexual contact on 15 May 2019

[108] The first particular concerns Dr Appanna's conduct during his first encounter with Ms Y on 15 May 2019. The general allegation is that he "inappropriately blurred the

[4] [2015] NZHC 1110

[5] Referred to as *Mr Y*, 197/Phar08/99P. Name suppression was lifted in the penalty decision, *May*

boundaries between his personal life and his professional practice", and that he did that "by using his position and expertise as a medical practitioner, specialising in gynaecology, in connection with his personal sexual practices."

[109] More specifically, it is alleged that Dr Appanna provided health services to, and had sexual contact with, Ms Y, in circumstances outlined in 8 sub-particulars. The first three of those have no bearing on his professional life. It is accepted that Dr Appanna and Ms Y met after connecting on an App called "Seeking Arrangement" (particular 1(a)); that they agreed to engage in sexual activity (particular 1(b); and that he told her before engaging in sexual activity he wanted her to undergo an STI test (particular 1(c)). The Tribunal finds no inappropriate blurring of boundaries of use of his position and expertise as a medical practitioner specialising in gynaecology, in connection with his personal sexual practices. Finding a sexual partner online, agreeing to have sex and requesting an STI text are all activities that any individual may engage in; they have no bearing on Dr Appanna's position and expertise as a medical practitioner.

[110] The next five sub-particulars are in a different category and are highly relevant to Dr Appanna's position as a gynaecologist.

[111] There is no dispute that Dr Appanna took Ms Y to his medical practice and performed a swab for an STI test (particular 1(d). The Tribunal was not satisfied on the balance of probabilities that a cervical smear swab was undertaken. There is no documentary evidence that one was taken or sent for testing. Two results were returned for the STI. The Tribunal finds it is more likely than not that Ms Y believed a smear was taken because of the use of the speculum and the fact that two swabs were taken, as well as the comments about her cervix, as discussed below.

[112] The Tribunal found on the balance of probabilities that Dr Appanna commented on an abnormality on Ms Y's cervix (particular 1(e) and told her that he could arrange to remove the abnormality (particular 1(f)). The Tribunal found it was likely that Dr Appanna, as a gynaecologist made these comments. This is consistent with his specialty. It is also consistent with his desire to make it known to Ms Y when he collected her from the bus stop that he was a doctor, and his decision to send her a photograph of his patient. Before they met in person, Dr Appanna had told her he was a high-profile person. It is part and parcel of his need to impress her with his

knowledge and expertise. The Tribunal accepts the PCC submission that her evidence is "at harmony with the preponderance of the probabilities which are practical".

[113] The Tribunal found Ms Y a fair and articulate witness. Although somewhat diffident in her examination-in-chief, and more forthright under cross-examination, there was little attempt to claim naivete or being a victim. She readily agreed that it was appropriate to have an STI test, that in her text communications with Dr Appanna she said what she thought he wanted to hear, that she was not put off by Dr Appanna's desire to have dom-sub relationships and said that initially she was genuinely interested in the lifestyle.

[114] Ms Y did not seem prone to embellishment or exaggeration. The impetus behind her complaint to the Police was her concern that Dr Appanna had not deleted the video footage of their sexual encounters. Her only other grievance was that she had not received the medical assistance that she thought Dr Appanna had offered. In that sense, she was a witness for the PCC, rather than the complainant. The allegations in the charge that was laid before the Tribunal were largely incidental to her concern.

[115] The Tribunal found that while performing the STI test on Ms Y, Dr Appanna 'fingered' Ms Y in a sexual manner (particular 1(g)). This allegation was not challenged in cross-examination. In closing, Mr Waalkens submitted that Ms Y had clearly aligned the fingering allegation to when the smear was taken and that did not happen. Further, that if the Tribunal found that the fingering did occur, it can only have happened during the swab test and that the evidence establishes that was completely unrelated to any medical care and was part and parcel of the sexual relationship, not professional. Mr Waalkens submitted that taking a swab or testing an STI was not a health service because Ms Y accepted it was not a medical procedure and it was simply to check to see whether she had an STI for the purposes of having a sexual relationship. It was part and parcel of engaging in a sexual relationship.

[116] The Tribunal accepts Ms Y's evidence that fingering occurred while Ms Y was on the examination bed and finds that it was while Dr Appanna was taking a swab for an STI test.

[117] It is difficult to imagine a person who is not a provider of a health service using a speculum to take a swab of a woman's vagina. Dr Appanna is a gynaecologist who offered to perform a test for Ms Y. Even if the Tribunal accepted that Ms Y asked him to

do it, that was because he is a doctor. Moreover, had he not been in the position of a health provider, Dr Appanna would not have been able to send the swab off for testing and receive the result on her behalf. Included in the Laboratory Order Form signed by Dr Appanna was a clinical reference to "PV[6] discharge". In the Medical Council Statement on *Providing Care to Yourself and Those Close to You*, "care" is defined as:

> Anything that is done for a diagnostic, preventive, cosmetic, therapeutic or other health-related purpose. This includes, but is not limited to: prescribing medication and other substances; **ordering and performing tests**; conducting physical examinations; and providing a course of treatment. (emphasis added).

[118] It was not disputed that after completing the STI test the couple engaged in sexual activity. The transition between clinical services and sexual contact was swift and seamless. There was a blurring of Dr Appanna's personal and professional life and that he used his position and expertise as a medical practitioner specialising in gynaecology in connection with his personal and sexual practices, in that he provided health services to Ms Y. Particulars 1(g) and (h) are established.

Particular 2 – provision of health services and sexual contact between 15 May 2019 and 12 July 2019

[119] Again, the general allegation in particular 2 is that Dr Appanna inappropriately blurred the boundaries between his personal life and his professional practice, by using his position and expertise as a medical practitioner, specialising in gynaecology, in connection with his sexual relationship with Ms Y, in that he provided health services and/or offered to provide health services to Ms Y. The timeframe for this particular covers a two month period.

[120] The Tribunal found that each of the sub-particulars in particular 2 was established. Particular 2(a) is that Dr Appanna told Ms Y that he could help her with medical matters. Examples of this are found in further sub-particulars. Dr Appanna has not denied that he offered to refer her to a pain clinic (particular 2(f)) and asked her permission to obtain her clinical records to enable that referral (particular 2(g)) Both of these are examples of his offer to help. There is no other evidence of offers to help with medical matters aside from this. Particular 2(a) is therefore subsumed by these particulars.

[6] Per vagina

[121] It is further not denied that Dr Appanna provided Ms Y with test results and gave her a Class C controlled drug, being Midazolam. Particulars 2(c) and 2(e) are established.

[122] There is also evidence of the provision of medical advice. In the text communication on 17 May 2019, he asked her if antispasmodics help and told her that buscopan is an antispasmodic. The Tribunal accepts the PCC submission that the texts capture only a small amount of what was discussed between them, and they corroborate Ms Y's evidence that Dr Appanna provided her with medical advice. Further, it is logical that in the course of providing her with medical services, such as the provision of the midazolam that her gave her some medical advice. Particular 2(d) is established.

[123] Dr Appanna has denied telling Ms Y that he could prescribe her anything she wanted (particular 2(b)). The Tribunal did not have the advantage of hearing from Dr Appanna in person. Ms Y was certain he did tell her this. She said, "It definitely happened. It's not something I would just make up." As noted above, the Tribunal found Ms Y to be a credible witness. We attach more weight to her evidence that was subject to cross-examination and questions from the Tribunal and accept her account. The Tribunal also accepts the PCC submission that it is reasonable to conclude that he would have offered to help Ms Y, including prescription of medication, given he has admitted to being "smitten",[7] he knew she had a history of chronic pain, and it was impacting on their relationship. Particular 2 (b) is established.

[124] The blurring of boundaries arises from the fact that Dr Appanna offered and provided health services to someone with whom he was sexually intimate.

[125] The PCC highlighted some aspects of the proposed contract between the parties that referred to health issues and Dr Appanna's professional expertise. The expectation that Ms Y would undergo blood tests or swab testing if requested does not specify that Dr Appanna would perform this. It was open to Ms Y to go elsewhere. Similarly, his undertaking to take precautions to keep "the submissives" sexually healthy does not rely on his medical qualification or experience. The third example, however states:

[7] Dr Appanna's Brief of Evidence

> You know that I have the knowledge of the skills, safety and first aid measures necessary to put me through painfully ecstatic and euphoric edgeplay that are within your limits.

[126] Dr Appanna's enquiries about Ms Y's pain are not of themselves the acts of a doctor. However, his display of knowledge takes it further. In the text exchange where he explained to her that Buscopan is an antispasmodic, he also says, "Ok I presume you've tried gabapentin for pain relief too baby?" It was later that day that they spent time together and he gave her a Midazolam. There was a blurring of his professional and personal boundaries.

[127] Particular 2 is established.

Particular 3 – engaging in sexual activity with Ms Y at his medical practice

[128] There is no dispute that Dr Appanna and Ms Y engaged in sexual activity at his clinic. With the exception of the first occasion this was largely in the office rather than the examination room. It is the sexual activity in that clinical setting which the Tribunal finds was a blurring of boundaries in this instance. Particular 3 is established.

Particular 4 – sending a video to Ms Y

[129] The conduct in particular 4 is the sending of a video and/or photo of a patient in Australia to Ms Y, and that in doing so, he breached the patient's privacy and/or breached his professional obligations.

[130] It was accepted that on or around 21 June 2019, Dr Appanna sent Ms Y a photograph of an unknown female patient in an operating theatre. No copy of the video was available for viewing and so it is not clear that the unknown female patient was visible in the video. That part of the charge is therefore not established.

[131] The sending of the photograph was not found to be a clear case of a breach of the privacy of the female patient, as the Tribunal was not satisfied that she is easily identifiable.

[132] However, there was no reason for him to send this photo to anyone and there was no reason for her to receive it. The Tribunal found it implausible that a patient who had just delivered a baby via emergency forceps would have consented to a photograph being sent to a friend of the obstetrician but, in any event, even if there had been consent, this was unprofessional. Dr Appanna had no control of the photograph once it was sent and indeed, Ms Y did forward it to her friend. The

Tribunal finds that Dr Appanna breached his professional obligations in sending a photograph of an unknown female patient to Ms Y. Particular 4 is therefore established.

Particular 5 – refusal to delete video

[133] The conduct in particular 5, is that on or about 12 July 2019, in a text declining to delete video footage of sexual activity with Ms Y, at the same time Dr Appanna said that he had her notes or referral if she still wanted to. The test from Dr Appanna read, "But I'm not deleting videos hon, have your notes for referral if you still want me to?" It was alleged that this was another blurring of boundaries between his personal life and his professional practice by using his position as a medical practitioner in connection with his personal sexual practices.

[134] The Tribunal found that the reference to Ms Y's notes in this text regarding a video of sexual activity was an example of blurring of boundaries. Had he not been a medical practitioner, he would not have had her notes or been in any position to refer to her medical records. Particular 5 is established.

Particular 6 – disclosure of personal and health information to Mr Shand

[135] Mr Shand had been reluctant to provide the information sought and ordered to produce. As outlined in an earlier decision on the PCC's application to produce the document, this was based on the claim that the conversations with Dr Appanna were confidential. The publisher relied on sections 68 and 69 of the Evidence Act 2006. It was perhaps a defence of principle, rather than a specific objection to disclosure in the circumstances of this case. He was summoned to appear. He presented as impartial.

[136] On the basis of the evidence of Ms Y and Mr Shand, the Tribunal found that between 12 July 2019 and 8 August 2020 Dr Appanna disclosed personal and health information about Ms Y to Mr Shand, a reporter, without her consent and that this was during a time when a complaint relating to him by her was under investigation.

[137] Particular 6 was therefore established.

Professional misconduct

[138] The Tribunal's grounds for discipline of a health practitioner are found in section 100 of the Act, which provides:

> **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

[139] Determining professional misconduct is approached in a two-step test:[8]

(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 requires the Tribunal to be satisfied that the health practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

[140] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct",[9] and as:

> *1. Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer … 2. Gen. A criminal or illegal action: wrong doing, misconduct."* [10]

[141] A finding of negligence requires the Tribunal to determine:[11]

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[8] *F v Medical Practitioners Disciplinary Tribunal* [2005] 3NZLR 774, subsequently confirmed in the High Court on appeal from the Health Practitioners Disciplinary Tribunal, see for example *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [16].

[9] *Collins English Dictionary* 2nd Edition. Definition accepted in many cases, including *Leach* 389/Nur11/179P and *Rodrigues* 384/Ost11/173P.

[10] *New Shorter Oxford English Dictionary* (1993 edition) See paragraph 34 of *Jackson* (Decision No. 35/Nur35/20P

[11] *Cole v Professional Conduct Committee* [2017] NZHC at [41]

> Whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal.

[142] 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:[12]

> … 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.

[143] The second step in assessing professional misconduct requires the Tribunal to be satisfied that the practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the practitioner. In *B v Medical Council*[13] the Court of Appeal expressed it this way:

> 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.

[144] This was further discussed in *Martin v Director of Proceedings* where the High Court said:[14]

> … 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 the relatively low-level misconduct to misconduct of a 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 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.

[145] More recently the position has been summarised in *Williams*,[15] where the following conclusion was reached at [36]:

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12 *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28]
13 *B v Medical Council* [2005] 3 NZLR 810
14 *Martin v Director of Proceedings* [2010] NZAR 333 at [32]
15 Williams v PCC of Medical Council [2018] NZHC 2471

> …The Tribunal must assess whether the departure from acceptable standards has been significant enough to warrant a finding of professional misconduct against the practitioner. It should bear in mind that a finding of professional misconduct carries considerable stigma. It sends a very strong message about the practitioner's failure to properly discharge his or her professional responsibilities. An adverse finding will likely be keenly felt by the practitioner, and it will inevitably be noted by his or her peers. A finding of professional misconduct is a significant matter, which is reserved only for serious conduct. [16]

PCC Submissions

[146] For the PCC, Dr Coates referred the Tribunal to:

(a) *Good Medical Practice* 2016 which contains the standards "which the public and profession expect a competent doctor to meet"

(b) *Sexual boundaries in the doctor patient relationship* (November 2018)

(c) *Statement on providing care to yourself and those close to you* (November 2016)

(d) *Good prescribing practice* (November 2016)

(e) *Professional boundaries in the doctor-patient relationship* (November 2018)

(f) *Health Information Privacy Code*

[147] The PCC referred to a number of cases where the Tribunal has considered the violation of professional boundaries with current/former patients and found it amounted to malpractice or negligence and that it will, or is likely to, bring discredit to the profession.

[148] The PCC highlighted the following passages from Dr McDowell's evidence:

(a) Although Ms Y did not appear to have been a patient of Dr Appanna's in the strict sense, some of his behaviour and communication were more in keeping with a doctor-patient relationship.

[16] Footnotes included in the original: Collie v Nursing Council of New Zealand; Martin v Director of Proceedings [2010] NZAR 333 (HC) at [30]–[31]. Vatsyayann v Professional Conduct Committee HC Wellington CIV-2009-485-259, 14 August 2009 at [8]; and *Johns v Director of Proceedings*, above n 21, at [84]. *Cole v Professional Conduct Committee of the Nursing Council of New Zealand*, above n 22, at [45]

(b) The lines between professional boundaries and personal boundaries became very blurred.

(c) An STI screening is "an invasive clinical examination" and it was inappropriate to offer and complete that screening.

(d) Suggesting that Ms Y could have the screening elsewhere does not justify or excuse him then proceeding to complete the screening.

(e) In Dr McDowell's opinion, the completion of the STI screening at Dr Appanna's practice changed the nature of the relationship, moving the interaction from on of a personal nature to a professional one.

(f) Dr McDowell said:

> The combination of performing a specialised medical procedure and having sexual relationships in the same interaction at a professional place of work entirely changes the landscape. This merits extreme poor judgement, boundaries are totally blurred. Dr Appanna for at least some of the time was behaving like Ms Y's doctor.

[149] The PCC submitted that in blurring his professional and personal boundaries, Dr Appanna acted contrary to his professional obligations. In particular:

(a) The medical services Dr Appanna provided were directly linked to the initiation of a sexual encounter. He provided the STI test so that he could start a sexual relationship with Ms Y and proceeded to finger her. He provided her with midazolam when she told him she was too sore to "do anything sexual".

(b) Dr Appanna used his position as a doctor to get Ms Y to do what he wanted. She felt that he would hold the pain clinic referral over her so she would agree to doing "sexual stuff" with him. She had joined Seeking Arrangement to make extra money, but apart from $100 for food and stuff, Dr Appanna did not pay her.

(c) Dr Appanna used his position as a doctor to maintain and further his relationship with Ms Y.

(d) Dr Appanna did not act in accordance with his role as a fiduciary; his relationship with Ms Y became one of trust and confidence in which she was entitled to rely on him as a doctor.

(e) Ms Y was vulnerable as a result of that relationship as well as her longstanding serious health concerns of which Dr Appanna was well aware.

(f) Dr Appanna did not put Ms Y's needs first. He carried out her STI screening for the sole purpose of determining whether he would commence an arrangement with her, inevitably an arrangement of a sexual nature (evidenced by the initial communication and contract sent only one day after the STI screening).

(g) Dr Appanna commenced and continued a sexual relationship with Ms Y despite there being a significant power imbalance between the two; she was reliant on him for conveyance of medical results, advice on what to do regarding a possible cervical abnormality and referral to a chronic pain service.

(h) Dr Appanna acknowledged that his judgement was impaired by the impending personal relationship with Ms Y.

[150] On the blurring of boundaries found in particulars 1, 2 and 3, the PCC submitted that Dr Appanna had breached his professional obligations found in Good Medical Practice to ensure the care of patients was his first concern and not to provide medical care to anyone with whom he had a close personal relationship. And he had not maintained sexual boundaries in the doctor-patient relationship.

[151] Although the charge invited the Tribunal to find that the particulars in the charge either separately or cumulatively amounted to professional misconduct, no submissions were made on the test for professional misconduct for any of the particulars individually. The submissions concluded that Dr Appanna's conduct was immoral, unethical and completely devoid of consideration for his professional obligations. It was a significant departure from accepted standards of practice, suffice to amount to negligence or malpractice under section 100(1)(a) of the Act, and at the

very least his actions are likely to bring discredit to the profession. A disciplinary sanction is warranted for the protection of the public, maintaining professional standards and as a deterrence.

Practitioner Submissions

[152] For the practitioner, Mr Waalkens emphasised the following passage from *Dr G v Director of Proceedings*[17] where Duffy J said at [55]:

> …Whilst there are those in the community who would consider a married man engaging in sexual relations with a married woman who was not his wife was shabby, if not immoral conduct, it is clear to me that the professional standards and ethical standards to be applied do not go so far as to regard extra marital affairs per se by doctors as amounting to professional misconduct. Nor do those requirements identify a doctor who engages in an extra marital affair with a married employee as demonstrating professional misconduct. It is those aspects of Dr G's conduct that are likely to attract the greater moral condemnation.

[153] On the second stage of the test for professional misconduct, Mr Waalkens referred to the following from *Martin v Director of Proceedings*[18] and he added the emphasis:

> However, it cannot be that every departure from accepted professional standards or every unwise or immoral act by a health professional in his or her personal life should amount to professional misconduct for the purpose of s 100(1). The principal purpose of the Act is to protect the health and safety of members of the public. That purpose does not require a disciplinary response to the minor human errors that inevitably occur in professional practice **nor the human transgressions that health professionals might commit in their personal lives**. The need for a threshold to distinguish between this type of conduct and conduct that warrants a disciplinary response therefore exists under the current scheme as much as it did under the previous schemes.

[154] And in *Director of Proceedings v MPDT* [2003] NZAR 250, the High Court said:

> There can be no principle that every case of a sexual relationship between a doctor and patient must result in a disciplinary finding, each case must be judged on its facts.

[155] Referring to the *Medical Council Statement on Providing Care to Yourself* and Those Close to You, Mr Waalkens submitted that the statement is not expressed in

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[17] CIV-2009-404-000951 HC Auckland, 13 October 2009

[18] Above, note 14 at [23]

mandatory terms. The final sentence of the opening paragraph of that statement reads:

> The Medical Council (Council) expects that you will not provide care to yourself or those close to you in the vast majority of clinical situations.

[156] Mr Waalkens submitted that the reasons for not treating those close to you, as set out in the Statement are not relevant to the present case.

Discussion

[157] There are aspects to the factual context of the charge that many would find distasteful. The Tribunal has focused on whether the established conduct as particularised in the charge amounts to professional misconduct.

[158] Particulars 1, 2 and 3 relate to the overlap of a sexual and personal relationship. The Tribunal did not find that Ms Y was Dr Appanna's patient. The findings of professional misconduct have been reached on the basis of the charge as framed: that there was a blurring of boundaries. The Tribunal did not consider that this is a true case of a breach of a fiduciary relationship. This was not a case of a sexual relationship arising out of a doctor-patient relationship.

[159] In the Medical Council Statement on *Providing Care to Yourself and Those Close to You* (**the Council Statement**), "those close to you" includes family members and:

> Any other individuals who have a personal or close relationship with you, whether familial or not, where the relationship is of such a nature that it could reasonably be expected to affect your professional and objective judgement. Council recognises that those close you will vary for each doctor.

[160] The Tribunal finds that Dr Appanna has provided medical care to someone with whom he had a close personal relationship. The first provision of health care was the STI test which was performed with the intention of engaging in sexual activity, and in fact that sexual activity in the form of fingering overlapped with the provision of care.

[161] As noted above, particulars 1(a), (b) and (c) set out some of the factual foundation for the charge. Dr Appanna met Ms Y after connecting on "Seeking Arrangement" arranged to engage in sexual activity and asked her to undergo an STI test before doing so.

[162] However, the performance of an STI test is a different matter. Dr Appanna took Ms Y to his medical practice and performed an STI test, commented on an abnormality

on her cervix, and told her he could arrange to remove the abnormality (Particulars 1(d), (e) and (f)). They had agreed that they were going to have sex.

[163] The Tribunal finds that the provision of an STI test was contrary to the standards expected of a reasonable medical practitioner of the Council Statement. The Tribunal accepts Dr McDowell's opinion that this is an invasive clinical procedure.[19] This was not a matter of emergency. The Tribunal would expect that Dr Appanna's peers and the Medical Council would not approve of Dr Appanna performing such a test on any of his family members. Performing invasive procedures is one of the treatments that is listed in the Council Statement as one which, "You **must not**" provide.

[164] The Tribunal finds that together, particulars 1(d), (e) and (f) amount to negligence.

[165] While performing the STI test 'fingered' her in a sexual manner and immediately engaged in sexual activity. The Tribunal finds that this conduct as particularised in particulars 1(g) and (h) amounts to malpractice and conduct likely to bring discredit to the profession, noting that the seamless transition from the performance of an STI test to sexual conduct while Ms Y was still on an examination bed is a serious matter. The totality of the conduct in particular 1 is sufficiently serious to warrant a disciplinary sanction and amounts to professional misconduct.

[166] Particular 2 concerns the overlap of Dr Appanna's roles as a medical practitioner and the sexual partner of Ms Y over the period from 15 May until 12 July 2019.

[167] The Tribunal finds that Ms Y was vulnerable in this respect: she had a chronic pain condition as a result of her caesarean and subsequent surgeries. This had a significant impact on her life. He is a gynaecologist and should have recognised how appealing that would be to someone in her position. The offers of help, prescriptions and advice were not appropriate. This includes the offer to refer her to a specialist pain clinic.

[168] The Tribunal found that the provision of midazolam, a Class C controlled drug in circumstances where no record was made of it and he did not monitor her was negligent. It was not an emergency. Neither was his offer to obtain her medical

[19] Although this finding is not consistent with Duffy J's statement in *G v Director of Proceedings* that a cervical smear is not invasive, the Tribunal has had the advantage of an expert opinion in the present case on this matter, which is not a question of law.

records. The combination of the conduct outlined in particular 2 was negligent, malpractice and conduct that brings discredit to the profession. It is sufficiently serious to warrant a disciplinary sanction and amounts to professional misconduct.

[169] The conduct in particular 3, which is the engaging of sexual activity at his medical practice, was a blurring of boundaries. When a patient attends a gynaecologist's practice and consents to an intimate examination, it is a clinical, not a sexual interaction. She does not expect that the room where this occurs is also one where the doctor engages in sexual activity. The Tribunal finds this is conduct likely to bring discredit to the profession. On its own the Tribunal did not find that it amounts to professional misconduct.

[170] Particular 4 concerned the sending of a photograph of a patient. As noted above, the Tribunal found that this was not breach of that patient's privacy, but was unprofessional. It was negligent but not of a sufficient seriousness to warrant a disciplinary finding. On its own it does not amount to professional misconduct.

[171] Particular 5 was Dr Appanna's refusal to delete the video, while in the same message letting Ms Y know that he has her clinical notes and asking if she wanted him to make a referral. Ms Y felt that the offer of help was being "dangled" in front of her and that she was being blackmailed. Ms Y did not seek payment for her services because she was hoping to have her pain addressed. The text communications do not fully support that conclusion. The Tribunal is being asked to draw an inference. However, Dr Appanna is not charged with inducement to engage in sexual conduct in exchange for medical services, and so the Tribunal has not made a finding as to that aspect.

[172] Particular 5 has been dealt with as another example of blurring of boundaries, as outlined in paragraph 153 above. On its own this blurring of boundaries does not amount to professional misconduct but when viewed with particulars 1, 2 and 3 which also relate to blurring of boundaries, the combination amounts to professional misconduct.

[173] The Tribunal found that Dr Appanna's disclosure of Ms Y's personal and health information to a journalist was a very clear breach of Ms Y's privacy. Although there may have been some health information contained in previous publicity relating to Dr Appanna's appeal against his interim suspension, Dr Appanna provided the link

between that information and Ms Y. Without his role in that, Mr Shand would not have known the name and contact details of the woman referred to in previous publicity. The Tribunal also found that even if Ms Y's name had been in the public domain, because Dr Appanna had provided health services to her, Dr Appanna had assumed the role of a health service provider. He was, therefore, under the obligations of a medical practitioner not to divulge her health information. His responsibilities as a medical practitioner to keep her health information confidential, including not divulging or confirming health services he provided, subsists no matter what information is in the public arena.

[174] The Tribunal considers that this particular amounts to negligence, malpractice and conduct that brings discredit to the profession and is sufficiently serious to warrant a disciplinary sanction.

[175] In summary, particulars 1, 2 and 6 were found individually to amount to professional misconduct. Particulars 1, 2, 3, 4 and 5 cumulatively amount to professional misconduct.

Penalty

Penalty Principles

[176] Section 101(1) of the Act provides:

> **101 Penalties**
>
> (1) In any case to which section 100 applies, the Tribunal may—
>
> (a) order that the registration of the health practitioner be cancelled:
>
> (b) order that the registration of the health practitioner be suspended for a period not exceeding 3 years:
>
> (c) order that the health practitioner may, after commencing practice following the date of the order, for a period not exceeding 3 years, practise his or her profession only in accordance with any conditions as to employment, supervision, or otherwise that are specified in the order:
>
> (d) order that the health practitioner be censured:
>
> (e) subject to subsections (2) and (3), order that the health practitioner pay a fine not exceeding $30,000:

[177] In *Roberts v Professional Conduct Committee,*[20] His Honour Justice Collins discussed eight relevant factors in determining an appropriate penalty in this jurisdiction. These factors have more 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".

[178] There are a number of High Court decisions[21] from which the principles relating to cancellation may be derived:

(a) An order for cancellation or suspension is not to punish, but to protect the public because the person is not a fit and proper person to remain registered as a professional person.

(b) Cancellation is more punitive than suspension (albeit the purpose of neither is to punish).

(c) The choice between the two turns on proportionality, and therefore the decision to suspend implies that cancellation would have been disproportionate.

(d) Suspension is more appropriate where there is a "condition affecting a practitioner's fitness to practice that may or may not be amenable to a cure".

(e) Suspension should not be imposed simply to punish.

Discussion

[20] [2012] NZHC 3354 at [44] to [51]

[21] *PCC v Martin* High Court Wellington (CIV2006-485-1461), 27 February 2007, Gendall J; *A v PCC* HC Auckland [2008] NZHC 1387 [81]

[179] As both parties acknowledged, each case before the Tribunal is unique. It is therefore difficult to find guidance from the Tribunal's other decisions. Both parties referred to several cases where cancellation[22] or suspension[23] had been imposed for professional misconduct arising from sexual relationships with patients or former patients. Because the Tribunal has found that Dr Appanna's sexual relationship did not arise out of a pre-existing doctor/patient relationship, we have not found those decisions so helpful for the decision we have to make.

[180] The parties were asked for other cases where a practitioner had treated someone they were close to, and advised of *Dr N* 1089/Med 19/454P. In that case, over a 12-year period, a doctor had repeatedly prescribed himself a number of drugs, including codeine phosphate and oxycodone hydrochloride, which were accepted to be drugs of dependence and/or abuse. He had also over that period prescribed various close family members oxycodone hydrochloride; tramadol hydrochloride; codeine phosphate; morphine sulphate; and alprazolam (Xanax). He was also found to have kept no records, not disclosed his acknowledged addiction to Medical Council, and had misled the PCC and Council. The Tribunal censured the doctor, fined him $2,000, imposed conditions on his practice, including supervision and restrictions on prescribing, and ordered him to pay costs of $35,000.

[181] There are various other cases where medical practitioners have written prescriptions for themselves and/or other family members where the practitioner is an addict.[24] In those cases it is usually accepted or at least suspected that the drugs prescribed for others were actually for the use of the practitioner.

[182] In an older case, *Dr E* 136/Med07/76D, a general practitioner diagnosed his de facto partner of some years with depression, prescribed her an antidepressant on about 30 occasions, failed to keep any records of consultations or treatments and prescribed her other medications. These four particulars were each found to amount to professional misconduct. On appeal, the finding of professional misconduct on the fourth particular (prescription of paradex for pain relief on about 13 occasions; trisequens (hormone replacement) on or about 9 occasions; and Losec (a treatment for

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[22] *Bennett* Med20/488P, *Bennett v PCC* [2022] NZHC 876; *Dr N* Med09/120P, *N v Professional Conduct Committee*, HC Wellington CIV-2009-485-2347; *Mete* Nur08/104D, 26 November 2008; *O* Psy07/58D; Chand Nur06/49P; *Gulliver* Nur06/35P; *Nuttall* Med04/03P

[23] *Dr L* Med20/489P

[24] 994/Med18/417P; 855/Med16/353P; 844/Med16/348P; 812/Med15/335P; 636/Med14/272P

peptic ulcers) on or about 2 occasions. The High Court said that the Tribunal's conclusions that Paradex and Trisequens should not have been prescribed for over three years should expressly have been put to the appellant for a response. Without that added factor of risk of harm, the prescribing on its own would not have given rise to a charge or a finding of professional misconduct.

[183] In that case the penalty was a censure, recommendation that the Medical Council of New Zealand undertake a competence review of the appellant's practice with particular focus on women's mental health and record keeping; a fine of $7,500, which was reduced to $5,000 on appeal and an order for costs.

[184] In the case of *Gwyn* 390/Nur10/167P boundaries were blurred by a nurse who was also the neighbour of a patient. The charge in that case focussed on the quality of care provided in his role as a support worker and his entering into a contract with the patient, giving him sole real estate agency rights over the sale of her property for a period of two years. The nurse was censured, fined $15,000 and had conditions imposed on his practice. He had to pay $25,000 in costs, representing 30% of the total.

[185] A physiotherapist treated family members over a period of some years in *Nonoa* 1013/Phys18/427P. The charge of professional misconduct concerned his invoicing to ACC for this treatment which was not an emergency or in exceptional circumstances, the claims were not independently verified by a third party, and the records were in adequate. Unlike the present case, the charge was not one of inappropriate blurring of boundaries between his professional and personal life.

[186] The blurring of boundaries in this case is not sufficiently serious to warrant a penalty of cancellation. However, the Tribunal finds the circumstances of this case somewhat more serious than *Dr E* for the following reasons:

(a) The performance of the STI swab was an invasive procedure.
(b) There was a provision of a health service (taking an STI swab) which overlapped with the sexual conduct.
(c) The purpose of that STI test was for Dr Appanna's benefit.

(d) Another health service was the provision of a controlled drug which is used for sedation, not pain relief, with no monitoring and no clinical record of that.[25] This was not an emergency at all.

(e) Dr Appanna breached Ms Y's confidentiality.

(f) Dr Appanna sent Ms Y a photograph of a woman in the lithotomy position.

[187] There were aggravating features of this case:

(a) Dr Appanna used his position as a gynaecologist to obtain Ms Y's health records. That position enabled him to have Waikato District Health Board forward them to him without requiring her signature.

(b) Although there was no explicit discussion of a provision of health services in exchange for sex, Dr Appanna should have realised that his position as a doctor who could assist Ms Y with her health issues would have been very attractive to her. This made her vulnerable.

(c) Dr Appanna is a senior practitioner and should not have needed reminding of his fundamental professional obligations.

(d) Dr Appanna lied to the PCC when he said that he had not given the Stuff reporter Ms Y's contact details.

(e) Dr Appanna conveyed no evidence of remorse or insight into his actions.

[188] With those factors in mind, the Tribunal reached the conclusion that a period of suspension of up to 12 months is warranted to make it clear to Dr Appanna and the profession that behaviour such as his will not be tolerated.

[189] The Tribunal has taken into account that it is now some three years since the events. He provided the Tribunal with some favourable references from patients and colleagues. This hearing was adjourned twice. In the meantime, Dr Appanna has been practising with a chaperone. With that in mind, the Tribunal orders that Dr Appanna is suspended from practice for three months under section 101(1)(b). In order to allow him to make arrangements with his practice, that suspension will commence 14 days from the date of this written decision.

[190] In considering what safety measures should be in place on his return to practice, Dr Appanna's decision not to pursue name suppression is a relevant factor. This gives

[25] Ms Y had not complained of sleep deprivation. She gave no evidence that she needed a good night's sleep.

women some information upon which to base their choice of gynaecologist. The Tribunal has decided not to impose a condition on his practice that there must be a chaperone present for all intimate examinations, but in doing so, we would expect that Dr Appanna will continue to offer a chaperone.

[191] The Tribunal does consider that Dr Appanna requires some supervision, and therefore orders under section 101(1)(c) upon his return to practice, he is to undergo supervision for a period of one year with a supervisor approved by the Medical Council. Such supervision will be at Dr Appanna's own expense and will include:

(a) A review of Dr Appanna's prescribing and provision of medications including controlled drugs;

(b) His understanding of boundaries and his position of power as a medical practitioner.

[192] It is a further condition that for a period of three years following his return to practice, Dr Appanna must inform any employer, practice partner or health care provider to whom he contracts his medical services of the Tribunal's decision. That includes Te Whatu Ora or any other publicly-funded health service.

Costs

[193] Under section 101(1)(f), 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) any investigation made by the Health and Disability Commissioner under the Health and Disability Commissioner Act 1994 in relation to the subject matter of the charge:
>
> (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 the Director of Proceedings or a professional conduct committee, as the case may be:
>
> (iv) the hearing by the Tribunal.

[194] The starting point for costs should be 50%.[26] Where there has been a guilty plea and co-operation with a disciplinary prosecution, some reduction is usually made.

[195] The PCC submitted a schedule of costs totalling $162,022.47. It was acknowledged that there should be some reduction for the costs of applying unsuccessfully for revocation of interim name suppression. Following the hearing the matter of name suppression was set down for further hearing. Dr Appanna then withdrew his application for permanent name suppression. The PCC sought further costs, noting that they had incurred a further $9,635 in preparation for that hearing.

[196] At the hearing, Mr Waalkens objected to the quantum of costs, submitting that the PCC costs of $162,000 for a three-day hearing is "grossly excessive".

[197] On the matter of the Tribunal costs, which were estimated to total $67,603.61, Mr Waalkens noted that Dr Appanna should not be required to contribute to cancellation costs resulting from adjournments that were no fault of Dr Appanna's. He submitted that the combined costs of approximately $229,000 for a three-day hearing were massive.

[198] As for the further costs incurred by the PCC for the preparation for the name suppression hearing, the practitioner, Mr Waalkens submitted that Dr Appanna's counsel had been willing and available to deal with the matter of name suppression at the close of the hearing on 25 August 2022. The application was made orally and in accordance with convention across professional disciplinary jurisdictions, at that point of the hearing. It must have been expected by the PCC that the application by Dr Appanna for permanent name suppression was to be advanced at the conclusion of the hearing (as routinely happens), and further that it would have been based on the previous applications filed and the grounds and evidence previously provided in support.

[199] Mr Waalkens submitted that although the PCC had indicated it from October 2021 that it had wanted to hear from Dr Mark Taylor, Dr Appanna never agreed that Dr Taylor should or would be made available for questioning (this being apparent from counsel's response dated 20 October 2021). The PCC had not applied to have a witnesses summons issued in respect of Dr Taylor. It is unorthodox to call medical

[26] *Cooray v Preliminary Proceedings Committee* (unreported, AP 23/94, Wellington Registry, 14 September 1995)

practitioners who have provided reports in support of name suppression as witnesses. Rather, it is for the Tribunal to determine how much weight to give such a report (a point that has been made by the PCC in both oral and written submissions). This is not something that that Dr Appanna took issue with.

[200] Aside from Dr Appanna's medical records, the PCC has not had to consider any new information in opposing the application for name suppression and should have been prepared to deal with name suppression at the hearing, and counsel had already filed a comprehensive memorandum on the issue on 23 December 2021.

Discussion

[201] Stuff Ltd had asked to be heard on the question of name suppression. When Dr Appanna withdrew his application for permanent name suppression, Stuff filed a memorandum, reserving its position to costs. Because there is no provision in the Act to order the practitioner to pay costs other than as outlined in section 101(1)(f), the Tribunal has made no directions to hear further from Stuff.

[202] Dealing first with the additional costs for name suppression, the Tribunal appreciates why the PCC wished to have Dr Taylor available for cross-examination. His evidence had been the foundation for the Tribunal's decision to grant interim suppression. It might not be the usual course of action, but it was not unreasonable in the absence of a recent, comprehensive report from a relevant specialist. It would have been premature for a summons to have been issued for Dr Taylor to attend at the end of the hearing in anticipation of the Tribunal's findings of fact and professional misconduct.

[203] However, the Tribunal accepts that a further $9,635 was not warranted in preparation for the proposed hearing. Instead, a sum of $2,000 may be added to the PCC's costs. That brings them to a total of $164,022.47.

[204] Returning to the quantum of costs for the preparation and attendance to the substantive hearing and the interlocutory applications, the Tribunal appreciates that there have been some matters in this case that have increased costs. In particular, because of Covid restrictions, there have been two adjournments, which can lead to some duplication of preparation time, and the applications for production of documents from Stuff added to the expense of this case. The Tribunal considers that the applications for production of Stuff documents and summons of Mr Shand were

necessary. They would not have been required if Dr Appanna had admitted that he had provided personal and health information about Ms Y to the reporter. However, the Tribunal agrees that overall the legal costs are significant.

[205] In *Beer* 1025/Den18/428P, the Tribunal considered an objection to the quantum claimed for the PCC costs. Other cases were cited for comparisons:

(a) *Devi* 943/Nur17/399P $44,000 for a four-day hearing

(b) *Napier* 971/Nur17/395P $73,000 for a four-day hearing

(c) *Mendel* 996/Med17/394P) $72,773 for a five-day hearing

(d) *Cooper* 1022/Phar18/425P $155,000 for a four-day hearing reduced by the Tribunal to $60,000.

[206] After receiving detailed breakdown of costs, the Tribunal reduced the total PCC costs in *Beer* from $140,169.00 to $90,000.

[207] In the present case there may have been some duplication of preparation occasioned by adjournments related to restrictions imposed under the Covid pandemic. It is not reasonable that expenses incurred through those circumstances should fall at Dr Appanna's feet. Overall, the Tribunal agrees with Mr Waalkens that the PCC costs are very high for a four-day hearing. The Tribunal considers in the circumstances of this case, $100,000 is a reasonable total for a four-day hearing.

[208] Taking into account the costs for cancellations because of adjournments, the Tribunal's reasonable costs are reduced to $65,103.61.

[209] All particulars of the charge were upheld. There were some alternative factual matters within the particulars that were not established. The Tribunal did not find that Dr Appanna had administered a cervical smear, that he had referred Ms Y to a pain clinic or that he had breached another patient's privacy. The cervical smear allegation was the focus of some of the cross-examination.

[210] The Tribunal finds that a 45% contribution to costs is appropriate. The Tribunal orders Dr Appanna to pay $45,000 under section 101(1)(f) towards the PCC's costs and $ 29,296.62 towards the Tribunal's costs.

Suppression of Name

[211] Dr Appanna withdrew his application for final name suppression, but sought non-publication of his personal health information. The PCC did not oppose this.

[212] Stuff Ltd had also asked to be heard on the question of name suppression. They did not oppose suppression of Dr Appanna's personal health information.

[213] Dr Appanna's interim name suppression therefore lapses 14 days from the date of this decision.

[214] Balancing Dr Appanna's personal interests against the public interest the Tribunal considers it is desirable to prohibit publication of Dr Appanna's personal health information under section 95(2).

[215] There is a permanent order for non-publication of the name and identifying details of [Ms Y] under section 95(2).

Results and Orders

[216] The charge of professional misconduct is upheld.

[217] Under section 101(1)(b) the practitioner's registration is suspended for three months commencing 14 days after the date of this decision.

[218] Under section 101(1)(c) upon his return to practice, the following conditions are imposed on the practitioner's practice:

(a) For a period of one year, he is to undergo supervision with a supervisor approved by the Medical Council. Such supervision will be at Dr Appanna's own expense and will include:

    (i) A review of Dr Appanna's prescribing and provision of medications including controlled drugs;

    (ii) His understanding of boundaries and his position of power as a medical practitioner.

(b) For a period of three years the practitioner must inform any employer, practice partner or health care provider to whom he contracts his medical services of the Tribunal's decision. That includes Te Whatu Ora or any other publicly-funded health service.

[219] Under section 101(1)(f)(ii) and (iii) the practitioner is to pay $45,000 towards the costs and expenses of the PCC inquiry and prosecution of the charge and under section 101(1)(f)(iv) $29,296.62 towards the costs and expenses of the hearing by the Tribunal.

[220] Under section 95(2) there is an order prohibiting publication of the name or identifying details of Ms Y.

[221] The interim order suppressing the practitioner's name will lapse 14 days from the date of this decision.

[222] Pursuant to section 157 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 Medical Council of New Zealand 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 21st day of November 2022

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T Baker
Chair
Health Practitioners Disciplinary Tribunal

APPENDIX A: The Charge

PARTICULARS OF CHARGE

Pursuant to sections 81(2) and 91 of the Act, the PCC charges that between on or around 15 May 2019 and 8 August 2020 Dr Nalendra Appanna acted in breach of his professional and/or ethical obligations in the following ways:

1. On or around 15 May 2019, Dr Appanna inappropriately blurred the boundaries between his personal life and his professional practice, by using his position and expertise as a medical practitioner, specialising in gynaecology, in connection with his personal sexual practices, in that he provided health services to, and had sexual contact with, Ms Y, in the following circumstances:

   (a) Dr Appanna and Ms Y met after connecting on an App called "SeekingArrangement";

   (b) Dr Appanna and Ms Y agreed to engage in sexual activity;

   (c) Dr Appanna told Ms Y that prior to engaging in sexual activity he wanted her to undergo an STI test; and/or

   (d) Dr Appanna took Ms Y to his medical practice and performed an STI test and/or a smear test on her; and/or

   (e) while performing the STI test and/or smear test on Ms Y, Dr Appanna commented on an abnormality on Ms Y's cervix; and/or

   (f) Dr Appanna asked Ms Y questions about an abnormality on her cervix and/or told Ms Y that he could arrange to remove the abnormality; and/or

   (g) while performing the STI test and/or smear test on Ms Y, Dr Appanna 'fingered' Ms Y in a sexual manner; and/or

   (h) after completing the STI test and/or smear test on Ms Y, Dr Appanna engaged in sexual activity and/or sexual contact with Ms Y; and/or

2. Between on or around 15 May 2019 and 12 July 2019, Dr Appanna inappropriately blurred the boundaries between his personal life and his professional practice, by using his position and expertise as a medical practitioner, specialising in gynaecology, in connection with his sexual relationship with Ms Y, in that he provided health services and/or offered to provide health services to Ms Y. In particular, Dr Appanna:

(a) told Ms Y that he could help her with medical matters; and/or

(b) told Ms Y that he could prescribe her anything she wanted; and/or

(c) provided Ms Y with test results; and/or

(d) provided Ms Y with medical advice; and/or

(e) gave Ms Y a Class C controlled drug, namely midazolam; and/or

(f) told Ms Y that he would refer and/or had referred her to a specialist pain clinic; and/or

(g) asked Ms Y for permission to obtain her clinical records to enable a referral to a pain clinic; and/or

3. Between on or around 15 May 2019 and 12 July 2019, Dr Appanna inappropriately blurred the boundaries between his personal life and his professional practice by engaging in sexual activity with Ms Y at his medical practice; and/or

4. On or around 21 June 2019, Dr Appanna sent Ms Y a video and/or photograph of an unknown female patient in an operating theatre, and by doing so he breached the patient's privacy and/or breached his professional obligations; and/or

5. On or around 12 July 2019, Dr Appanna inappropriately blurred the boundaries between his personal life and his professional practice by using his position as a medical practitioner in connection with his personal sexual practices, in that when he refused to delete all available video footage of sexual activity with Ms Y, at her request, he made reference to a referral to a pain clinic by telling Ms Y: "*But I'm not deleting videos hon, have your notes for referral if you still want me to?*"; and/or

6. Between on or around 12 July 2019 and 8 August 2020, Dr Appanna disclosed personal information and/or health information about Ms Y to a reporter from Stuff Limited, without Ms Y's consent and/or at a time when a complaint relating to Ms Y was under consideration by a Professional Conduct Committee.

The conduct alleged above amounts to professional misconduct in that, either separately or cumulatively, it amounts to malpractice or negligence in relation to his scope of practice pursuant to section 100(1)(a) of the Act and/or has brought or is likely to bring discredit to the profession, pursuant to section 100(1)(b) of the Act.