NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	**1283/Med19/458P**
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 pursuant to section 71 of the Health Practitioners Assurance Act 2003. **Applicant**
AND	**DR JUDITH GILL** of Auckland, registered Medical practitioner. **Practitioner**

HEARING held at Auckland on 13 to 15 June 2022 and
Penalty Hearing held on papers 29 June 2022.

TRIBUNAL	Ms M Dew KC, Chair Dr B Bond, Dr K Good, Dr V Beavis, Ms A Kinzett
Counsel for PCC	Mr H Wilson and Ms A Retter
Practitioner	Dr Gill (not in attendance)
Technical Adviser to the Tribunal	Mr M Regan
Executive Officer	Ms K Davies

DECISION OF THE TRIBUNAL

ON LIABILITY AND PENALTY

CONTENTS

Introduction

[1] Dr Gill graduated with a medical degree from the University of Auckland in 1983 and then obtained a general scope of practice with the Medical Council of New Zealand (the Council) on 12 December 1983.

[2] Dr Gill became vocationally registered as a General Practitioner in November 1989 and obtained membership with the Royal New Zealand College of Graduate Practitioners (the College).

[3] From 2000 to 2011, Dr Gill owned and operated as a doctor at Queen Street Healthcare (Auckland Metro Doctors) Limited and The Travel Clinics (Travel Care) New Zealand Limited (together AMDT). Dr Gill has not held a practising certificate since March 2017 and has stated she has no intention to return to medical practice.

[4] The Charge against the practitioner relates to patient funding claims to ProCare of some $420,652, made by Dr Gill through her medical practices between 2003 and 2011, which it is alleged she was not entitled to make.

[5] Dr Gills conduct as alleged, was the subject of criminal charges laid by Police arising from a complaint by the Ministry of Health in 2015. The charges were later withdrawn on the basis of a confidential settlement between the Ministry of Health and Dr Gill. No criminal charges were ever pursued.

[6] On 13 August 2019, the Professional Conduct Committee ("PCC") appointed by the Medical Council of New Zealand, laid a disciplinary charge against the Dr Judith Gill ("the practitioner") under s80(3)(b) of the Health Practitioners Competence Assurance Act 2003 ("the Act").

[7] This disciplinary proceeding has taken an unusual course since the Notice of Charge alleging professional misconduct by Dr Judith Gill was first filed in August 2019.

[8] Since that time the proceeding has been delayed on multiple occasions, and for reasons including COVID 19, but most particularly because the Tribunal made significant efforts to seek to accommodate the practitioner, given her indication that she wanted to defend the Notice of Charge.

[9] Ultimately, Dr Gill did not attend the hearing to defend the charge. The liability hearing proceeded, over three days, from 13 to 15 June 2022, without Dr Gill's attendance.

[10] On 15 June 2022, the Tribunal issued a Minute confirming its decision that the charge of professional misconduct had been established.[1] The Tribunal set down a timetable for penalty submissions to be provided by the PCC and Dr Gill, prior to a penalty hearing on the papers on 29 June 2022. This decision now records the full reasons for the liability and penalty decisions.

[11] Given the unusual and lengthy history to this Charge being heard, the Tribunal sets out the steps taken to set this proceeding down.

[12] A three-week hearing was initially set down for May 2020[2]. At the time this was the time the parties counsel both considered would be required for a defended hearing. By memorandum dated 31 January 2020, counsel for the practitioner at the time, Mr Waalkens KC, sought to vacate the hearing and requested a hearing for November 2020. The PCC did not oppose vacating the May 2020 hearing.

[13] The hearing was set down for three weeks to commence 3 August 2020 to 21 August 2022 with timetable directions for filing evidence.[3]

[14] In May 2020, the practitioner, through counsel, filed an application for an adjournment of the August 2020 hearing, on grounds including risks to Dr Gill's health, lack of urgency given the alleged fraudulent conduct dating between 2003 and 2011 and that Dr Gill was no longer practising. The PCC opposed the application

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1 Minute of the Tribunal dated 15 June 2022. This was emailed to Dr Gill on 16 June 2022.
2 Tribunal Directions Conference Minute dated 19 November 2019.
3 Tribunal Directions Conference Minute dated 13 February 2020.

for an adjournment. The Tribunal granted the adjournment on the grounds set out in its Minute dated 28 May 2020. The hearing was adjourned to a three-week hearing commencing 15 February through until 5 March 2021.

[15] In November 2020, the Tribunal ordered, by consent, that the February 2021 hearing could be reduced to two weeks as confirmed by the Tribunal's Minute dated 23 November 2020.

[16] On 4 December 2020, counsel for the practitioner advised the Tribunal that he sought leave to withdraw as counsel for Dr Gill. Counsel for Dr Gill, Mr Waalkens QC advised the Tribunal that he could no longer act for Dr Gill. At that date, Dr Gill had not sought an adjournment and the hearing dates remained in place as noted in the Tribunal's Minute dated 21 December 2020. Dr Gill had not instructed any new lawyer.

[17] By Minute dated 22 January 2021, the Tribunal confirmed the appointment of a technical advisor to the Tribunal, Mr Michael Regan, solicitor. This was done to ensure that if Dr Gill did not engage new counsel, that the Tribunal was able to call on legal advice to assist in ensuring a fair hearing.

[18] The practitioner filed and served an application dated 20 January 2021 seeking the Notice of Charge be withdrawn on grounds related to her health, the health of her child, the alleged delay in laying the Charge and that Dr Gill had retired from medical practice in 2017. The Tribunal dismissed this application on the grounds that it did not have jurisdiction to order the withdrawal of a Notice of Charge as set out in the Tribunal's Minute dated 22 January 2021.

[19] On 14 February 2021, due to a community outbreak of Covid-19 the Tribunal adjourned the start of the hearing to Wednesday 17 February 2021. This was further adjourned due to Covid-19 and a teleconference was scheduled to take place on 18 February 2021. The Tribunal indicated the view that the hearing would take place on 23 February 2021.

[20] Dr Gill filed a draft affidavit on 17 February 2021 which was subsequently sworn and filed on 18 February 2021, in which she made an application for permanent name suppression and requested an adjournment of the hearing set to commence on 23 February 2021.

[21] Dr Gill's affidavit raised concerns as to her health and the health of her child. The practitioner confirmed that she did wish to attend the hearing to defend the Charge and that she was willing to attend a hearing after her child was 12 months old. Her child was only a few months old at the time of this application.

[22] The PCC opposed the adjournment maintaining that Dr Gill had failed to take proper steps in the proceeding to that date. The Tribunal granted the adjournment in a Minute dated 22 February 2021 on the grounds set out in Dr Gill's affidavit, noting that costs would be an issue to be reserved for a final hearing for the matter given the late filing of the application for adjournment.

[23] Hearing dates in November 2021 were set down by the Tribunal in a Minute dated 25 February 2021, however, those dates were vacated because of ongoing Covid-19 restrictions in Auckland and the Tribunal considered the hearing needing to take place in person, given the detailed documentary and witness evidence filed. The hearing was then set down for June 2022[4].

The Charge

[24] The Charge itself consists of four particulars of alleged professional misconduct namely that:

> "Pursuant to sections 81(2) and 91 of the Act, the Committee charges Dr Gill as follows:
>
> 1 Between 2003 and 2011, while the sole director and shareholder of Queen Street Healthcare (Auckland Metro Doctors) Limited and The Travel Clinics (Travelcare) New Zealand Ltd (collectively **AMDT**), Dr Gill submitted age/sex registers of patients (the **Registers**) to ProCare (an Auckland Primary Health Organisation (**PHO**)) in circumstances where:

[4] The dates were confirmed with the parties by email on 11 November 2021.

a) AMDT received funding from ProCare on the basis of the number of patients included on the Registers and submitted quarterly to ProCare;

b) the submitted Registers contained details of 2618 patients who were not eligible for and / or entitled to capitation based funding, as set out in **Appendix A (attached to the Charge)**

c) as a result of submitting the Registers, which included ineligible and/or non-entitled patients set out in Appendix A, to ProCare, Dr Gill and/or AMDT received an additional $420,652.31 of funding.

2 Dr Gill knew or ought to have known:

a) that the patients set out in Appendix A were ineligible or not entitled to capitation-based funding; and / or

b) that her actions particularised above would result in Dr Gill and / or AMDT obtaining funding it was not entitled to.

3 Dr Gill's conduct, as alleged in paragraphs 1 and 2 above, was contrary to;

a) the Council's statement *Good Medical Practice* (January 2002, November 2003, October 2004, and June 2008); and/or

b) accepted standards of medical practice.

4 The conduct alleged in 1 – 3 above amounts to professional misconduct in that, either separately or cumulatively, it:

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

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

The hearing

[25] The hearing took place in Auckland on 13 June 2022 to 15 June 2022. There were appearances by the PCC and counsel assisting the Tribunal. Dr Gill did not participate in the hearing. The hearing was completed in three days rather than the two weeks initially set down, as the Charge was not defended.

[26] However, the Tribunal records that Dr Gill did not admit any professional misconduct as alleged. This was plain from Dr Gill's limited interaction with the Tribunal and her written statements provided to the Tribunal prior to the hearing,

including her various memoranda to the Tribunal, her sworn and unsworn affidavits in support of her non-publication applications, all filed during 2020 and 2021.

[27] There was one substantive "Memorandum of Judith Gill to be read before the Tribunal" dated 9 February 2021, which set out the essence of her defence of the Charge.

[28] At the eventual June 2022 hearing, the Tribunal heard evidence from the four PCC witnesses:

(a) Dr Robin Bowman, Convenor of the Professional Conduct Committee appointed to investigate Dr Gill's conduct;

(b) Ms Hsu, former receptionist and clinical assistant at Dr Gill's practice in 2003 and 2004;

(c) Ms Judith Keys, former Senior Manager, Risk and Compliance at ProCare Health Limited. She worked at ProCare Health in various roles during the relevant period; and

(d) Mr Christopher Unsted, Manager for Audit and Compliance at the Ministry of Health (MOH), who was involved in the MOH investigation of Dr Gill's practice.

[29] The Tribunal was also presented with four volumes of documents filed in evidence by the PCC, in support of the Notice of Charge.

[30] Following the hearing, by Minute dated 15 June 2022,[5] the Tribunal held that it was satisfied, based on all the evidence presented, that liability as set out in the Notice of Charge had been established. The Minute also set out a timetable for the filing of evidence and submissions in relation to penalty.

[5] Minute of the Tribunal dated 15 June 2022.

[31] The PCC filed submissions on penalty, costs and name suppression on 17 June 2022. Dr Gill did not file submissions but emailed the Tribunal on 29 June 2022. The PCC filed a response to Dr Gill's email on 29 June 2022. The Tribunal has proceeded to determine penalty, name suppression and costs on the basis of the PCC's submissions filed 17 June 2022 and Ms Gill's email, so far as it can be given weight.

The practitioner's non-attendance

[32] Mr Regan, as counsel assisting the Tribunal usefully canvassed the legal principles relevant to determining whether and how to proceed with a substantive hearing of a disciplinary charge in a practitioner's absence.

[33] Mr Regan referred the Tribunal to *Hart v Auckland Standards Committee 1 of New Zealand Law Society* [2013] NZHC 83, [2013] 3 NZLR 103 and the principles laid out for such cases. In summary, it is paramount that the Tribunal ensures:

(a) The practitioner who is absent retains the benefit of a fair hearing of the charge against them, the right to a fair process is absolute and this must be kept at the forefront of the Tribunal's mind;

(b) The Tribunal must do more than simply conduct a formal proof exercise; and

(c) In exercising its quasi-inquisitorial function, it does not become partisan.

[34] Prior to the hearing in June 2022, Dr Gill was offered multiple opportunities to participate. The hearing was postponed times, twice in relation to Covid-19, but on three other occasions in response to Dr Gill's requests for additional time to prepare her defence.

[35] The Tribunal is satisfied that by June 2022, it was reasonable to proceed in Dr Gill's absence given the efforts made to accommodate her and in conducting the hearing and coming to its decision, that it has satisfied the principles set out above.

Summary of the evidence

[36] In 2021, the PCC and Dr Gill had attempted to file an Agreed Summary of Facts. This was never completed. However, the practitioner did sign her own version of a Summary of Facts dated 12 February 2021 that she presented to the PCC and was ultimately presented in evidence. [6]

[37] The Summary of Facts signed by Dr Gill accepts, in general terms the manner in which the Procare patient funding worked, that she was responsible for ensuring that patients were first eligible to enrol before registration for funding, that her patients were registered to ProCare and that she received patient funding. Dr Gill confirms in her memorandum of 9 February 2021, that she repaid patient funding, investigation and legal costs to the Ministry of Health including her own costs of some $1.5 million dollars.

[38] However, Dr Gill does not accept the element of the Charge that alleges her actions carried a fraudulent intent or were negligent in any way, that would amount to a finding of professional misconduct. Dr Gill maintains that the Ministry of Health eligibility criteria were equivocal and that she always acted in good faith and in a manner that she regarded as advocating for the rights of patients to claim funding for healthcare.

[39] Dr Gill's medical practice, AMDT, received funding from ProCare for patients. AMDT (and other primary healthcare providers in the ProCare network) would provide registers listing all the eligible and entitled patients at the practice. ProCare would then provide the registers to the Ministry of Health, who would pay the Auckland District Health Board (ADHB). The ADHB would then distribute public funding for entitled and eligible patients to ProCare. This arrangement was formalised between the ADHB and ProCare in a contract and subsequent variations, and between ProCare and Dr Gill in a separate contract.

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[6] Summary of Facts amended by Dr Gill dated 12 February 2021.

[40] The more patients included on the registers submitted to ProCare, the more funding AMDT would receive. However, to be validly included on the register patients must be both eligible and entitled to be enrolled.

[41] The contract between ProCare and the ADHB defines an 'eligible person' as 'a person who is eligible for publicly funded health services in accordance with the current Health and Disability Services Eligibility Direction published in the New Zealand Gazette'.

[42] Over the period covered by the Charge, there were two Health and Disability Services Eligibility Directions in force. The first was the 2003 Direction and the second was the 2011 Direction. Both Directions define eligibility as:

> The right to be considered for receipt of publicly funded services but does not equate to an entitlement to receive those services, and eligibility is assessed at the time services are sought

[43] To be eligible under either Direction, a patient may fall into any category set out in the Direction. For the purposes of this proceeding, the relevant categories are:

(a) New Zealand citizens;

(b) Those who are ordinarily resident in New Zealand;

(c) Residents of Australia who is temporarily in New Zealand, subject to criteria specified in the Health Benefits (Reciprocity with Australia) Act 1999; and

(d) Citizens of the United Kingdom who is temporarily in New Zealand, subject to certain criteria specified in the Health Benefits (Reciprocity with the United Kingdom) Act 1982.

[44] Following an investigation into Dr Gill's practice, the Ministry of Health identified 2,618 patients included on her registers who were not eligible for and/or

not entitled to public funding for the health services provided. These patients fell into one of five categories:

(a) Unconsented: this category of patients did not sign the enrolment form and therefore did not consent to be enrolled with the practice. There are 194 patients in this category, amounting to $23,024.97 of funding.

(b) Australian: this category of patients is comprised of 264 patients who were from Australia and ineligible for enrolment. Under the Health Benefits (Reciprocity with Australia) Act 1999, Australian residents are entitled to subsidised healthcare if it is 'immediately necessary'. The services Dr Gill provided as a general practitioner were all alleged to be not 'immediately necessary'. The funding for this category amounted to $44,572.90.

(c) United Kingdom A: these 1221 patients saw Dr Gill for medical services not covered by the Health Benefits (Reciprocity with the United Kingdom) Act 1982. Dr Gill was paid $231,340.49 in respect of these patients.

(d) United Kingdom B: there were 551 patients in this category, amounting to $83,191.70 in funding. These patients received treatment that may have been covered by the Health Benefits (Reciprocity with the United Kingdom) Act 1982. However, they were not entitled to be enrolled because of the short period of time that they spent in New Zealand. As a result, they could not use Dr Gill as a provider for ongoing medical care, such that they would qualify for capitation-based funding.

(e) Other countries: There were 428 patients amounting to $38,552.25 of funding in this category. These were patients who were not from

New Zealand, Australia or the United Kingdom who had no eligibility or entitlement to be enrolled with the PHO.

[45] In total, the categories amount to $420,652.31 of funding claimed through the submission of the registers by Dr Gill.

[46] Dr Robin Bowman's evidence to the Tribunal included Dr Gill's statement to the PCC dated 3 April 2019. In that statement, Dr Gill admitted that between 2003 and 2011, she had received more capitation-based funding than she was entitled to, and that overpayment had been made to her medical practices. Dr Gill has not disclosed the exact amount repaid to the Ministry of Health.

[47] The evidence shows that Dr Gill was aware of which patients were on the registers because she was responsible for generating them and deciding which patients were included. Ms Hsu, Mrs Keys and Mr Unsted all gave evidence on this point:

(a) Ms Hsu was the former receptionist and clinical assistant at Dr Gills practice from July 2003 to 22 May 2004. Her evidence was that the only person who created and submitted the patient registers to Procare was Dr Gill;

(b) Mrs Keys was a senior manager at Procare in various roles between 2003 and 2011. She states she frequently dealt with Dr Gill in the process of her submitting registers and that Dr Gill often queried why patients were not being funded and communicated frequently with Mrs Keys; and

(c) Mr Unsted, a senior investigator with the Ministry of Health Audit Unit during the relevant period, gave evidence regarding Dr Gill's access to the enrolment screen and therefore knowledge of patients' enrolment.

[48] In relation as to whether Dr Gill knew the eligibility and enrolment criteria that were applicable before patients could be enrolled for capitation-based funding based, the Tribunal heard the following evidence:

(a) Mrs Keys' evidence is that Dr Gill was well aware of the eligibility criteria, given that she attended a number of ProCare funding trainings, received several ProCare guidance documents, and would be in constant communication regarding funding for patients who had been rejected.

(b) The extensive information on enrolment requirements provided to Dr Gill. In addition to background material that Dr Gill was provided with, ProCare would often give presentations on the funding scheme and Procare records show that Dr Gill attended these.

(c) Mrs Keys' evidence was that ProCare was continually updating information about enrolment requirements and what was required before a patient was enrolled and that doctors were proactively directed to information as it was released. She was also of the view, based on her conversations with Dr Gill about which patients were being funded, that Dr Gill 'knew more [about enrolment rules] than the average general practitioner because she wanted to know who would be eligible and who wouldn't be.'

(d) Dr Gill's patient funding claims were rejected at a higher rate, than the average New Zealand general practitioner. The Tribunal notes that given the number of times that Dr Gill's applications for funding got rejected, she would have had the requirements explained to her many times.

(e) The Ministry of Health, during its investigation, found several documents at Dr Gill's practice which set out eligibility criteria which had been highlighted, with ballpoint pen and vivid marker and with

handwritten comments, all of which indicated that Dr Gill kept up to date with eligibility and entitlement criteria.

Dr Gill's Memorandum dated 9th February 2021

[49] Dr Gill provided an unsworn statement to the Tribunal on 9 February 2021. In summary, she stated that she was confused about eligibility and entitlement requirements for funding and that the requirements were unclear. Dr Gill states that at all times she was acting in good faith in relation to the application of healthcare funding for United Kingdom and Australian patients and for patients with visas that entitled them to live or work in New Zealand for two years or more and in the earlier phases of the PHO to study in New Zealand for two years or more. She said the Ministry of Health was equivocal and failed to clarify its position regarding the eligibility of Australian and United Kingdom nationals for funding. She stated her actions would not be considered actions of someone intent upon fraud or medical malpractice.

[50] Dr Gill also argued the proceedings were redundant because she is retired, the matters had already been subject to civil and criminal proceedings in 2015 and that she has paid back the funding she received but was not entitled to.

[51] Dr Gill did not provide any documentation to support her memorandum dated 9 February 2021. While this was an unsworn statement and Dr Gill did not appear before the Tribunal to be questioned about this statement, it has been admitted as evidence, but cannot be given full weight as it cannot be challenged by questioning or cross examination. This approach is consistent with the approach adopted by the Tribunal in *Ms Y*.[7]

Liability

Onus and Standard of Proof

[52] The onus is on the PCC to establish the Charge and provide evidence that satisfies the Tribunal, irrespective of whether the practitioner attends the hearing to

[7] *Ms Y* (742/Mid15/326D) at [74].

defend the Charge or not. The Tribunal has been mindful to ensure that it thoroughly reviews the evidence to determine whether the evidence supports the Charge.

[53] The applicable standard of proof is the civil standard, that is, proof to the satisfaction of the Tribunal on the balance of probabilities. The degree of satisfaction varies according to the gravity of the allegations.[8]

Test for Professional Misconduct

[54] The Tribunal must first be satisfied that the facts related to patient funding alleged in the Charge and Appendix A are made out on the evidence. Having reviewed the documents produced and the witness evidence for the PCC, that explained:

(a) the Procare funding process and payment,

(b) the age/sex registers for patients of Dr Gill; and

(c) the patient eligibility and entitlement criteria provided by the Ministry of Health;

The Tribunal was left in no doubt that the Ministry of Health audit established that the $420,652.31 of funding was received by Dr Gill's medical practices for the 2618 patients over the period 2003 to 2011. The Tribunal is also satisfied that these same 2618 patients were not eligible and/or entitled to the funding claimed by Dr Gill.

[55] It is next for the Tribunal to determine if this conduct meets the test for professional misconduct under s100(1)(a) and / or s100(1)(b) of the HPCA Act is made out. This first requires an objective analysis of whether the practitioner's acts or omissions can be reasonably regarded as constituting:[9]

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[8] See *Z v Complaints Assessment Committee* [2009] 1 NZLR 1.

[9] See *Nuttall* (8/Med04/03P); *Aladdin* (12/Den05/04D and 13/Den04/02D); and *Dale* (20/Nur05/09D).

(a) Malpractice;

(b) Negligence; or

(c) Otherwise meets the standard of having brought, or was likely to bring, discredit to the practitioner's profession.

[56] The second step in this process, is to consider whether there has been a sufficiently serious departure from those accepted standards as to warrant a finding of professional misconduct and disciplinary sanction to protect the public and/or maintain professional standards and/or to punish the practitioner.

[57] Gendall J in *Collie v Nursing Counsel of New Zealand* HC, Wellington Registry, AP300/99, 5 September 2000, [2001] NZAR 74 Gendall J noted at [21]:

> Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be the standards applicable by competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.

[58] Malpractice is defined in the Collins English dictionary as meaning:[10]

> The immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct.

[59] Gendall J in *Collie* described the term "to bring discredit to the nursing profession" in the following way at [28]:

> To bring discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard with the question to be asked by the Council being whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standard of the nursing profession was lowered by the behaviour of the nurse concerned.

Applicable professional standards

[60] In determining whether the charge of professional misconduct against Dr Gill is made out, Dr Gill's conduct is to be assessed against the standards and professional obligations of the medical profession which applied at the time the conduct occurred.

[61] The professional and ethical obligations to have regard to are those set by the Medical Council of New Zealand in accordance with its statutory functions under the Act. The Medical Council fulfils this function, in part, by publishing guides for doctors, including *Good Medical Practice*. *Good Medical Practice* outlines the standards that the public and the profession can expect of a competent medical practitioner. The standards as set in the text are not exhaustive.[11]

[62] The June 2008 iteration of *Good Medical Practice* provides that doctors must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. It also states that doctors should be honest, trustworthy and act with integrity. Acting with integrity includes *"never abusing...the public's trust of the profession."* As a registered doctor, Dr Gill was required to comply with these standards. The Tribunal accepts these standards provide a relevant measurement of the conduct expected of Dr Gill.

Submissions made by the PCC

[63] The PCC submit that Dr Gill's conduct was a serious breach of her professional obligations and was likely to bring discredit to the medical profession. In summary, the PCC submit:

(a) Medical practitioners must act in a way that justifies public trust in the profession. Dr Gill's submission of the registers breached her professional obligations relating to honesty and trustworthiness in

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[10] 2nd Edition.

[11] *Wright* (624/Med13/263P).

financial and commercial matters and were likely to jeopardise public trust in the medical profession.

(b) Public funding schemes for medical care rely on the honesty of health practitioners.[12] The PCC submits that capitation-based funding similarly relies on the honesty of medical practitioners when submitting patients for public funding and practitioners need to be aware of eligibility and entitlement requirements and only submit patients that meet those criteria.

(c) On the evidence, Dr Gill did not misunderstand her obligations in relation to claiming capitation. The period covered by the Charge spans over 8 years and the PCC submit that it is not plausible that innocent misunderstandings as to entitlements could persist for that length of time, particularly as the issue of overpayments on her PHO register had previously been raised with Dr Gill in 2004. At that time, Dr Gill had been required to repay the overpayments.

(d) Even if it is accepted that Dr Gill's actions were not deliberate, they fall well below the standard expected of a medical practitioner and therefore amount to professional misconduct on the basis that they were negligent. Dr Gill was required to be aware of her obligations in claiming capitation-based funding and to adhere to those obligations.

(e) Failing to adhere to eligibility and entitlement requirements or failing to understand these basic requirements when claiming for public funding, falls well below what is expected of a medical professional who is in a privileged and trusted position when accessing public funds for services that they provide.

[12] The Tribunal has made comments along these lines in previous cases. See for example *Howells* (980/Med18/416P), *Henderson* (451/Med11/200P), *Tovaranonte* (870/Med16/344P), *Evans* (1039/Phys18/433P), and *Nonoa* 1013/Phys18/427P).

(f) A responsible medical practitioner in similar circumstances would conclude that either deliberately claiming $420,652.31 in capitation funding that they were not entitled to, or failing to be educated and understand funding requirements, to the extent that the practitioner incorrectly claimed this amount must amount to professional misconduct.

(g) Although not all cases of overclaiming would warrant disciplinary sanction, this is clearly a case where the conduct is serious enough to warrant a finding of professional misconduct.

[64] The PCC referred the Tribunal to previous cases that demonstrate the Tribunal's approach to conduct in similar cases of misuse or overclaiming on public health funds.

[65] In *Howells*, [13] the Tribunal was critical of Dr Howells' ignorance of the requirements of capitation-based funding and found that it was negligence amounting to professional misconduct. The Tribunal commented that while individual patients' safety was not compromised, the public funding system of patient care "*depends heavily*" on a doctor's compliance with capitation funding requirements.

[66] In the case of *Evans*, [14] the practitioner was found to have deliberately claimed ACC payments he was not entitled to. The Tribunal found that this amounted to malpractice, negligence and conduct likely to bring discredit to the profession and therefore amounted to professional misconduct.

[67] In *Henderson*, [15] the Tribunal found that regardless of whether Dr Henderson was naïve or deliberately circumventing the funding rules to claim extra funding, his actions amounted to malpractice and negligence.

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[13] *Howells* (980/Med18/416P) at [32].
[14] *Evans* (1039/Phys18/433P).
[15] *Henderson* (451/Med11/200P).

[68] In *Nonoa*[16], the practitioner inappropriately claimed funds by double billing and claiming treatment under another physiotherapist's registration number. This conduct which made up only part of the Charge was considered by the Tribunal to constitute malpractice, negligence and conduct that was likely to bring discredit to the profession amounting to professional misconduct.

[69] The Tribunal in these cases found that Dr Howells, Mr Evans, and Mr Nonoa all brought their respective health professions into disrepute for claiming funds (either through capitation-based funding, maternity care funding, or ACC funding) that they were not entitled to. It is notable that in these cases, the practitioners all improperly claimed funds that were materially smaller than in the present case.

Finding on liability

[70] The Tribunal finds the Notice of Charge is established.

[71] The Tribunal is satisfied on the balance of probabilities that Dr Gill submitted patient registers which contained 2,618 ineligible and/or unentitled patients and obtained funding of $420,652.31 for those patients when she ought to have known, that they were ineligible and/or unentitled and that it would result in her obtaining funding that she was not entitled to.

[72] The Tribunal confirms that each of the Particulars 1 to 4 are established. Dr Gill's conduct as alleged amounts to professional misconduct that separately and cumulatively amounts to malpractice under s100(1)(a) of the Act and that it separately and cumulatively amounts to conduct that has brought or is likely to bring discredit to the medical profession under s100(1)(b) of the Act.

[73] Although the circumstances of each case will differ, the improper use of public funds which medical practitioners have unique access to reflects a serious breach of a health practitioner's obligations. The public has a reasonable expectation that medical practitioners will not abuse this position of trust.

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[16] *Nonoa* (1013/Phys18/427P).

[74] Dr Gill's actions while not established as deliberate fell well below the standard expected of a medical practitioner. Her actions therefore amount to professional misconduct on the basis that they were grossly negligent and in circumstances where she ought to have known that she was not entitled to the funding of these patients.

[75] The Tribunal acknowledges the points made in Dr Gill's unsworn witness statement dated 9 February 2021. The Tribunal finds that Dr Gill's purported confusion about eligibility and her claim she was acting in good faith all carry limited weight in comparison to the sworn evidence of the PCC witnesses and the documents the PCC witnesses produced.

[76] The Tribunal is in no doubt that the practitioner's actions were such a significant departure from accepted standards that a disciplinary sanction must be imposed for the purposes of maintaining professional standards and protecting the public by marking out the unacceptable conduct of a former medical practitioner.

Penalty

[77] Having determined that the Charge is established, the Tribunal must go on to consider the question of penalty under the Act.

[78] The penalties may include:

(a) Cancellation of the practitioner's registration as a health practitioner;

(b) Suspension of the practitioner's registration for a period for up to 3 years;

(c) An order that the practitioner may only practise in accordance with any conditions as to employment, supervision or otherwise, such conditions not to be imposed for more than 3 years;

(d) An order that the practitioner is censured;

(e) An order that the health practitioner pay a fine not exceeding $30,000; and

(f) An order that the practitioner pay part or all of the costs of the Tribunal and/or the PCC.

[79] The appropriate sentencing principles are set out in *Roberts v Professional Conduct Committee*,[17] where Collins J identified the following eight factors as relevant whenever this Tribunal is determining an appropriate penalty. In particular, the Tribunal is bound to consider what penalty:

(a) most appropriately protects the public and deters others;

(b) facilitates the Tribunal's important role in setting professional standards;

(c) punishes the practitioner;

(d) allows for the rehabilitation of the health practitioner;

(e) promotes consistency with penalties in similar cases;

(f) reflects the seriousness of the misconduct;

(g) is the least restrictive penalty appropriate in the circumstances; and

(h) looked at overall, is the penalty which is "*fair, reasonable and proportionate in the circumstances*".

[80] The objective when determining penalty is described in *Young v Professional Conduct Committee*:[18]

> The protection and maintenance of professional standards is an important part of the protection of the public. It is through the maintenance of high professional standards that the public is protected. Deterrence is in the same category. This is intended to discourage others from acting the same way reflected in the severity of the punishment imposed.

[81] The imposition of a penalty by the Tribunal is not a "*formulaic exercise*".[19] Each case must be addressed according to its own facts and circumstances. The

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[17] *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 3354 at [44] – [51].

[18] *Young v Professional Conduct Committee* HC Wellington CIV 2006-485-1002 1 June 2007 at [30].

[19] *Park* (566/Nur13/239P) at [75].

Tribunal must endeavour to impose a penalty that is the least restrictive that can be imposed.[20] This approach recognises the importance of rehabilitation where relevant, as articulated in *Roberts*:[21]

> …health professionals and society as a whole make considerable investments in the training and development of health practitioners. Where appropriate, the Tribunal should endeavour to ensure these investments are not permanently lost, provided of course the practitioner is truly capable of being rehabilitated and reintegrated into the profession.

[82] The Tribunal must determine the appropriate penalty considering the nature of the conduct and the purposes of the Act including to protect the public and the integrity of the profession.

[83] Dr Gill was given the opportunity to file and serve any submissions on penalty, costs or name suppression and provide any affidavit evidence as to her financial position by 27 June 2022. Dr Gill did not do so but emailed the Tribunal on 29 June 2022.

[84] In her 29 June 2022 email, Dr Gill stated she was presently overseas and that she was suffering from Covid-19. She did not make submissions as to penalty but stated that she had previously requested her name be removed from the medical register as she had retired and will not be returning to medicine, and she referred to her affidavit of 18 February 2021.

[85] The Tribunal met to consider the matter of penalty, costs and name suppression on the papers on 29 June 2022.

Submissions on penalty

[86] The PCC seeks a penalty against Dr Gill of censure, cancellation of her registration and costs.

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[20] *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 3354 at [50].

[21] At [47].

[87] In oral submissions, the PCC sought conditions be imposed should Dr Gill return to practice. In written submissions, the PCC reflected that this issue would be best addressed by the Registrar of the Medical Council in response to any application Dr Gill might make. The PCC therefore did not seek further conditions if the Tribunal cancels the practitioner's registration.

The PCC otherwise sought conditions, in the event the Tribunal was instead considering suspending Dr Gill, rather than cancelling her registration. The conditions sought include completing an education program, to work under supervision, not operating in sole practice for three years after recommencing practice and, undertaking a cognitive assessment by a health professional to assess fitness to practise.

Aggravating and mitigating factors

[88] The PCC submits that in determining the appropriate penalty, the following aggravating features are particularly relevant:

(a) *Length of time over which the conduct occurred*: the period covered by the Charge runs from 2003 to 2011.

(b) *The amount of capitation-based funding claimed*: Dr Gill claimed a significant amount of money ($420,652.31) for patients who were not entitled and/or not eligible for that capitation-based funding. This is significantly more than previous disciplinary cases concerning claims for public funding or monies practitioners were not entitled to.

(c) *Deliberateness*: Dr Gill was aware of her obligations related to capitation-based funding and was responsible for patient enrolments at her practice.

(d) *Repeated pattern of behaviour*: In 2004, Dr Gill was investigated by the Ministry of Health for irregularities in her PHO registers. On that

occasion 342 patients were identified as being ineligible for enrolment and Dr Gill paid back $9,958.53 in funding that she had been overpaid. Despite this previous investigation, Dr Gill continued to make claims for capitation-based funding she was not entitled to.

(e) *Level of experience*: By the time her offending began, Dr Gill had been practising for 20 years. She was a senior member of the medical profession and worked extensively with overseas patient travellers.

(f) *Lack of insight into conduct*: It is evident from Dr Gill's statements to the Tribunal that she remains of the view that her conduct was not detrimental to the public interest and has not accepted responsibility for receiving funds that she has in the past acknowledged that she was not entitled to.

(g) *Lack of cooperation*: Dr Gill been uncooperative from the time that the Charge was filed. She did not properly engage with the PCC on an Agreed Statement of Facts, made no admissions, caused multiple delays, failed to appear at teleconferences, and did not appear before the Tribunal at the hearing.

(h) *Position of responsibility at the time of the offending*: Dr Gill was the sole director and shareholder of AMDT and the sole general practitioner. In this role, she should be expected to set professional standards for others at the practice.

[89] The PCC acknowledges that the following mitigating factors are relevant:

(a) *No previous history of professional discipline*: Despite being the subject of a Ministry of Health audit, no disciplinary charges have previously been laid against Dr Gill.

(b) *Repayment of funds*: Dr Gill has repaid the wrongly claimed public health funds. While it is remains unclear how much she has repaid, it

was sufficient to satisfy the Ministry of Health and for the criminal charges to be withdrawn.

[90] The PCC also acknowledges that there is no evidence that Dr Gill's conduct directly caused harm to the public and no issues have been raised about her clinical competence. Nevertheless, the PCC submit that Dr Gill's conduct indirectly harmed the public by reducing public funds available for public healthcare.

[91] Overall, the PCC submit that censure and cancellation are the appropriate penalty in order to reflect the duration and extent of misconduct in claiming $420,652.31 of capitation-based funding for patients. The PCC say that suspension would be an inadequate penalty, from a public safety perspective and when setting professional standards for the profession given the level of offending.

Comparative cases on penalty

[92] The Tribunal must have regard to other decisions to ensure an element of consistency, though it is well accepted that the Tribunal "*should apply an element of discretion when imposing penalty because each case will depend on and be peculiar to its own particular facts and circumstances.*" [22]

(a) The PCC referred to the following key cases as relevant authorities in determining penalty:*Howells* [23] – Dr Howells was found guilty of altering the records of 12 patients and as a result Dr Howells obtained capitation funding which he was not entitled to. His practice received financial benefits totalling $3,929. The Tribunal found this was this conduct was not intentional. Dr Howell's was censured and was subjected to conditions for a period of three years.

(b) *Healey* [24] – Ms Healey periodically made fraudulent ACC claims between 1992 and 2002, amounting to over $200,000. The Tribunal

[22] *Re Chiew* (180/Phar08/95P) at [102].
[23] *Howells (980/Med18/416P).*
[24] *Healey* (123/Nur07/70P).

considered that her offending involved a gross breach of trust over a long period of time and noted that a substantial sum of money was involved. The Tribunal ordered cancellation based on the seriousness of the offending. The Tribunal determined the planned, pre-meditated and deliberate conduct reinforced the inevitable conclusion that she was not a fit and proper person to be on the register.

(c) *Evans* [25] – Mr Evans was charged with improperly invoicing ACC over three years and providing ACC funded treatment to family members. He repaid $75,000 to ACC after its audit had established this amount as due. The Tribunal found it was not plausible that he did not understand there was a risk he was overcharging. The Tribunal also considered the mitigation being practitioner's cooperation, his repayment of the claim, his long service and his competency. Mr Evans was censured, suspended for 2 months, subject to conditions and made to pay a $5,000 fine.

(d) *Tovaranonte* [26] – A charge of negligence and malpractice was made out in circumstances where the practitioner had claimed monies from ACC that he was not entitled to, amounting to $3,553.44. His actions were intentional and dishonest. The Tribunal considered that Dr Tovaranonte had engaged in sustained conduct, planned his offending, and personally benefitted financially. There was also a significant breach of trust, misuse of confidential patient information, the potential for patient care to be compromised, and repeated attempts by the doctor to minimise his behaviour. Mitigating factors were that he repaid ACC, his professional competence was not in question, he acknowledged the facts, and assisted the Tribunal by completing an Agreed Summary of Facts. The practitioner was suspended for three months, censured, had conditions imposed on his return to practice, fined $5,000.

[25] *Evans* 1039/Phys18/433P
[26] *Tovaranonte* 870/Med16/344P.

(e) *Satya* [27] – Mr Satya was charged based on a conviction for dishonest use of a document. The charge related to the making of twice monthly claims for government subsidies in respect of repeat prescriptions dispensed at the pharmacy. Mr Satya's management of medication meant he received government subsidies for the medication that he was not entitled to. Mr Satya was suspended from practice for six months, was subject to conditions and censured.

(f) *Sathe*[28] – Mr Sathe was a dentist who submit claim summary forms which included inflated claims for funding of $49,274.41. The offending took place over four years, and he had continued to offend after repaying a portion. Mitigating factors included family health issues, co-operation and repayment. Mr Sathe was suspended for 12 months, the Tribunal imposed conditions on his practice and censured him.

(g) *Baker* [29] – Mr Baker was a pharmacist who made false claims for subsidies for prescription medicines. The false claims amounted to $95,814.290. Aggravating factors were the number of charges and events, the different ways the offending occurred, the gravity of the offences and the fact it was deliberate and planned. Mitigating factors included character references, cooperation, acceptance of charge and reparation paid. He was suspended for nine months, censured and had conditions imposed on resumption of practice.

[93] The PCC submit that cancellation was ordered in the cases referred to for the following amounts of funds claimed: $95,000,[30] over $200,000,[31] $219,366.66,[32] and

[27] *Satya* (365/Phar10/169P).
[28] *Sathe* (568/Den13/246P).
[29] *Baker* (472/Phar12/206P).
[30] *Murdoch* (76/Phys06/45P).
[31] *Healey* (123/Nur07/70P).
[32] *Pellowe* (137/Phar07/74P).

$15,529.26.19.[33] Dr Gill's conduct resulting in $420,652.31 of wrongly claimed capitation-based funding for patients is at the highest end of the cases.

Tribunal's consideration of penalty

[94] The Tribunal has considered the relevant sentencing principles and assessed the aggravating and mitigating factors, identified by counsel for the PCC.

[95] The Tribunal has determined that it is necessary and appropriate to both censure Dr Gill and cancel her registration as a medical professional, to mark the Tribunal's disapproval of this serious professional misconduct. The length, extent and continued recklessness that Dr Gill displayed over 8 years in claiming public funding when she ought to have known this was not correct, makes this conduct at the serious end of offending. The wrongly claimed funds is one of the most serious this Tribunal has had to deal with, given the sums involved.

[96] As the Tribunal observed in *Tovaranonte*:[34]

> It will be seen that there is a range between cancellation of registration and suspension periods. Relevant to these are the amounts involved with the larger sums almost inevitable attracting cancellation.

[97] The Tribunal reiterates the point it made in *Henderson* about the seriousness attached to misuse of public health funds by health professionals.[35] Public funding is a limited resource. Every dollar improperly paid out means that other patients or hospitals have compromised resources or have missed out.

[98] The seriousness of the conduct is then compounded by her lack of any meaningful acceptance of her wrongdoing and her lack of co-operation through this disciplinary process. There is no ability for the Tribunal to consider any lesser penalty that might be more rehabilitative, as Dr Gill has not shown any willingness to

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[33] Hawes (185/Nur08/94P).
[34] *Tovaranonte (*870/Med16/344P) at [135].
[35] See *Henderson* (451/Med11/200P) at [74] – [76].

engage in any sustained way with this Tribunal or the Medical Council, that would enable this assessment.

[99] In these circumstances, the Tribunal determines that censure and cancellation is the most appropriate and proportionate penalty.

Costs

[100] The Tribunal has the power to award costs and expenses related to the Tribunal and the PCC prosecution of the case and including the PCC inquiry or investigation under section 101(1)(f) of the Act.

[101] The costs of both the Tribunal and the PCC are substantial in this case. This is because of the COVID delays, practitioner related adjournments and the attempts to engage with Dr Gill between when the Charge was first laid in August 2019 through to the final hearing dates in June 2022.

[102] The Tribunal's costs and disbursements incurred up to and including the date of the hearing are $134,035.12. The PCC costs and disbursements claimed amount to $155,694.04.

[103] In relation to costs, the Tribunal records that it has used as a starting point the expectation that a health practitioner will contribute 50% of the actual and reasonable costs of the Tribunal and PCC.[36]

[104] Before considering the percentage of the costs to be awarded against Dr Gill, the PCC has properly conceded that COVID related adjournment costs in 2021 were estimated to be in the region of some $20,000 of the PCC's costs. The Tribunal also acknowledges that some of its own costs will be related to the two adjournments that were caused by COVID, and should not be borne by the practitioner.

[105] The Tribunal considers it is appropriate to apply a 20% reduction to both the Tribunal and PCC costs as a result of the Covid-19 delays and various delays they

[36] *Cooray v Preliminary Proceedings Committee*, HC Wellington, AP 23/94, 14 September 1995.

were either by consent or due to the PCC request to defer filing evidence in the earlier stages of the process in 2020.

[106] The costs of the Tribunal and PCC discounted by 20% will be the starting point to determine the costs to be paid by the practitioner. i.e. for the purposes of determining costs in this case, the Tribunal's total costs will be taken as $107,228.10 and the PCC's total costs will be $124,555.23.

[107] Aside from the Covid-19 discount, counsel for the PCC submit that there should be an uplift from the usual 50% payment by the practitioner, to 75% because Dr Gill has failed to cooperate with the Tribunal's process and has been the cause of the majority of the adjournments, including the lastminute adjournment in February 2021, which caused increased costs.

[108] The PCC acknowledge that an award of costs above 50 percent is rare, but that where it occurs it is often because the practitioner has not cooperated with Tribunal proceedings or failed to take part.[37] The PCC also note that Dr Gill rejected offers by the PCC to resolve the proceedings without the need for a defended hearing, which would have avoided costs.

[109] The Tribunal is in no doubt that Dr Gill's lack of cooperation with the Tribunal and PCC included failing to meet multiple deadlines for filing evidence, failing to attend teleconferences and Dr Gill's applications for adjournment and for the Notice of Charge to be withdrawn, have all added significantly to costs incurred.

[110] In February 2021, Dr Gill indicated by email to the Tribunal that she does not have the money to pay for these proceedings. However, Dr Gill has not provided any evidence of her financial position. In her email to the Tribunal of 29 June 2022, the practitioner states that she and her young son live on her National Superannuation and another government subsidy from WINZ. The Tribunal has considered these statements by Dr Gill but without sworn evidence and documents to support these

[37] See *Vatsyayann* (374/Med1010/52P) at [43]; *Laverty* (661/MLS14/275P), *Feller* (1045/Med19/442P), and *Fernando* 860/Med16/352P.

statements, the Tribunal is only able to give them limited weight. The Tribunal was also made aware by Dr Gill that over the time of this disciplinary proceeding, she was able to fund travel overseas on at least two occasions.

[111] Overall, the Tribunal considers the proper contribution to costs ordered to be paid by the practitioner in this case should be 75% of the total costs of both the Tribunal and PCC, after the deduction of 20% to the Tribunal's and PCC costs attributed to Covid-19 delays. The Tribunal considers this uplift in costs ordered to be paid by the practitioner, is appropriate in the circumstances where Dr Gill has continuously failed to cooperate with the PCC and Tribunal causing substantial delay and cost to this proceeding, that should not be borne by the medical profession.

Name suppression

[112] The practitioner has had interim name suppression granted by the Tribunal in this proceeding to date.

[113] On 18 February 2021, Dr Gill filed an application for name suppression. She filed an affidavit in support dated 18 February 2021 which included a letter from her clinical psychologist. This was the basis on which the Tribunal has continued the grant of interim name suppression.

[114] In an email to the PCC on 29 June 2022, Dr Gill stated that she wished for her February 2021 application for name suppression to stand as her application for permanent name suppression.

[115] Dr Gill's 18 February 2021 affidavit referred to the ongoing mental health issues the proceedings have caused her, including anxiety and reoccurrence of PTSD symptoms. She stated that publication of her name will cause her mental health to relapse and will cause harm to her infant son, who is still preschool age.

[116] Dr Gill also states that the threat of publication of her name means that she is unable to present psychological reports as evidence as she did not wish for these

reports to "fall into the hands" of a government agency that she has had interactions with that she considers have been harmful to her and her child.

[117] The clinical psychologist's report dated 2 December 2019, describes the stress Dr Gill has reported caused by this disciplinary charge. The report states that publication of her name would increase the risk of psychological and physical harm to Dr Gill.

[118] The practitioner's affidavit was filed 16 months before the hearing finally occurred in June 2022. The medical report was written some 18 months before this hearing. There is no more recent evidence about Dr Gill's current health or the effect publication will have on her, despite the Tribunal's penalty hearing timetable which provided the opportunity for Dr Gill to submit such evidence.

[119] The PCC oppose the practitioner's application for name suppression on the basis that the Tribunal has found Dr Gill guilty of a serious charge and that there is now an overriding public interest in the transparency and accountability of publishing this decision and the practitioner's name.

Legal Principles

[120] Under s95 of the Act, the Tribunal must consider whether it is "desirable" to prohibit publication of the name of the applicant after considering the interest of any person and the public interest. The Tribunal must balance the presumption of openness in judicial proceedings with the private interests of the individuals effected.[38]

[121] In *Beer v A Professional Conduct Committee* the Court stated, "*the balancing exercise is case specific, and little assistance in weighing each factor may be gained from other decisions*."[39]

[38] *Lal* (1129/Nur20/478P) at [63].
[39] *Beer v A Professional Conduct Committee* [2020] NZHC 2828 at [30].

[122] The onus is on the practitioner to satisfy the Tribunal that the presumption of open justice should be departed from, particularly where the practitioner has been found guilty of professional misconduct.[40]

[123] Public interest factors identified by the Tribunal and Court include:[41]

(a) The transparency and accountability of disciplinary proceedings;[42]

(b) Protection of the public;

(c) Maintenance of professional standards;

(d) Public interest in knowing the identity of a health practitioner charged with and/or found guilty of a disciplinary offence; and

(e) The risk of unfairly impugning other practitioners.

[124] The public factors are to be balanced against the private interests of the practitioner including:

(a) The health of the practitioner;

(b) Matters that may affect their family and wellbeing; and

(c) Rehabilitation.

[125] The deterrence effect is also relevant to the Tribunal. It is desirable that it is clear to health professionals that when offending occurs, name suppression is unlikely unless there are overriding private interest considerations. [43]

[126] The PCC referred the Tribunal to a number of cases to assist. In *T v Director of Proceedings* Pankhurst J observed: [44]

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40 *Ben-Dom v Professional Conduct Committee* [2020] NZHC 3094 at [141].

41 *Dr H* HPDT (1105/Med19/448P) at [218].

42 In *Davey v Professional Conduct Committee of the Nursing Council* [2012] NZHC 765 at [9] Justice Simon France held that publishing a practitioner's name is an essential part of ensuring transparency in the disciplinary process.

43 *Makaea* (102/Nur07/53P).

> "following an adverse disciplinary finding more weighty factors are necessary before permanent suppression will be desirable. This, I think, follows from the protective nature of the jurisdiction. Once an adverse finding has been made, the probability must be that public interest considerations will require the name of the practitioners be published in the preponderance of cases. Thus, the statutory test of what is desirable is necessarily flexible

[127] In *Professional Conduct Committee v Gwynn*, the Tribunal considered the submission regarding the likely damage to Mr and Mrs Gwynn's reputation from publication. The Tribunal decided against making suppression orders and stated:[45]

> It is well established that distress and embarrassment for family members inevitably falls upon the family members of persons convicted of a crime or professional misconduct. But something more is required.

[128] Where there is a current and material risk to a practitioner's health and safety, name suppression may be granted, however, a Tribunal will be reluctant to hold that health issues override the public interest in publication unless there is clear and current evidence of the risk of harm.[46]

[129] In *Schubert,*[47] the practitioner provided evidence that she had a "fragile mental state" and that there was risk that "*publication of her name could exacerbate her condition*".[48] The Tribunal nevertheless commented that publication would have an adverse impact. However, as the Tribunal had not been presented with a current independent medical or psychological report stating there was a current material risk to the practitioner's health and safety, there was insufficient evidence of any private interest factor that outweighed the public interest.[49]

[130] In *McNair,*[50] the Tribunal refused to grant permanent name suppression despite the practitioner's reliance on a psychologist report produced in support of the interim non-publication application. The Tribunal held the practitioner had been

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44 *Tonga v Director of Proceedings* HC Christchurch, CIV-2005-409-2244, 21 February 2006, at [42].
45 *Gwynn* (390/Nur10/167P) at [212.3].
46 *Schubert* (705/Psy14/288P) at [50] and [58].
47 *Schubert* (705/Psy14/288P) at [50]
48 *Schubert* (705/Psy14/288P) at [50].
49 *Schubert* (705/Psy14/288P) at [58].
50 *McNair* (680/Mrt14/289P) at [106].

unable to point to any factors that were out of the ordinary if his name was published. The health concerns were described as typical concerns of a practitioner facing disciplinary proceedings.

[131] The PCC identified the following public interest factors that they submit weigh strongly in favour of publication of Dr Gill's name:

(a) Consideration and publication of Dr Gill's name will ensure that she is held accountable for her actions;

(b) The publication of Dr Gill's name will deter other practitioners in respect of similar conduct as they will be aware name suppression is not lightly granted. It is therefore important for the protection of the public and maintenance of professional standards;

(c) Other doctors have a right not to be suspected of being the unnamed doctor in this case;

(d) Dr Gill's name has already been published in relation to the criminal charges laid and the details of the same conduct the subject of this proceeding, have already been published by media. It is therefore in the public interest for there to be knowledge of Dr Gill's accountability to her professional body and the public in this disciplinary process;

(e) There is no professional detriment to Dr Gill, as she is no longer practising and is not intending to return to practise.

[132] The Tribunal finds that the private interest factors identified by Dr Gill in her affidavit from February 2021 are not sufficiently current to outweigh the strong public interest factors identified by the PCC following a professional misconduct finding.

[133] The embarrassment and distress to Dr Gill are unfortunate and it may well impact her health, but we are not satisfied on the evidence available that this is anything more than the natural consequences of publication in these circumstances.

[134] The plaintiff's application for permanent name suppression is declined. However, the interim suppression order will remain in place for a further 20 working days after the date of this decision.

Results and Orders

[135] The Orders of the Tribunal are as follows:

(a) The Charge laid against the practitioner is established as professional misconduct under both s100(1)(a) and s100(1)(b) of the Act;

(b) The practitioner is censured to mark the disapproval of the Tribunal;

(c) The practitioner's registration is cancelled.

(d) The practitioner is ordered to pay 75% of the costs of the PCC and the Tribunal (with the costs of the Covid delays already deducted), to be paid as follows:

i. $80,421.08 in respect of the costs and disbursements of the Tribunal; and

ii. $93,416.42 in respect of the costs and disbursements of the PCC.

(e) The Tribunal orders publication of the practitioner's name. The application for permanent name suppression is declined. The practitioner has 20 working days after the date of this decision to appeal this decision not to grant the non-publication order sought, after which time, the practitioner's interim name suppression will be discharged.

(f) Pursuant to s 157 of the Act, the Tribunal directs the Executive Officer to publish this decision and a summary on the Tribunal's website and 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, to enable interested parties to access the decision.

DATED at Auckland this 19th day of December 2022

.....
Maria Dew KC
Chair
Health Practitioners Disciplinary Tribunal

Notice of Charge

A Professional Conduct Committee (**Committee**) appointed by the Medical Council of New Zealand (**Council**) pursuant to section 71 of the Health Practitioners Competence Assurance Act 2003 (**Act**) has determined in accordance with section 80(3)(b) of the Act that a disciplinary charge be laid against Dr Judith Gill before the Health Practitioners Disciplinary Tribunal (**the Tribunal**).

The Committee has reason to believe that grounds exist entitling the Tribunal to exercise its powers under section 100 of the Act.

Particulars

Pursuant to sections 81(2) and 91 of the Act, the Committee charges Dr Gill as follows:

1 Between 2003 and 2011, while the sole director and shareholder of Queen Street Healthcare (Auckland Metro Doctors) Limited and The Travel Clinics (Travelcare) New Zealand Ltd (collectively **AMDT**), Dr Gill submitted age/sex registers of patients (the **Registers**) to ProCare (an Auckland Primary Health Organisation (**PHO**)) in circumstances where:

a) AMDT received funding from ProCare on the basis of the number of patients included on the Registers and submitted quarterly to ProCare;

b) the submitted Registers contained details of 2618 patients who were not eligible for and / or entitled to capitation based funding, as set out in **Appendix A**;

c) as a result of submitting the Registers, which included ineligible and/or non-entitled patients set out in Appendix A, to ProCare, Dr Gill and/or AMDT received an additional $420,652.31 of funding.

2 Dr Gill knew or ought to have known:

a) that the patients set out in Appendix A were ineligible or not entitled to capitation-based funding; and / or

b) that her actions particularised above would result in Dr Gill and / or AMDT obtaining funding it was not entitled to.

3 Dr Gill's conduct, as alleged in paragraphs 1 and 2 above, was contrary to;

a) the Council's statement Good Medical Practice (January 2002, November 2003, October 2004, and June 2008); and/or

b) accepted standards of medical practice.

4 The conduct alleged in 1 – 3 above amounts to professional misconduct in that, either separately or cumulatively, it:

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

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

Appendix A

Patient type	Authority	Eligibility and/or entitlement	Number of patients
Australian	The Health and Disability Services Eligibility Direction 2003 (**the Direction**) refers to the Health Benefits (Reciprocity with Australia) Act 1999 which provides that Australian residents of New Zealand are entitled to subsidized health care that is 'immediately necessary'.	The type of care provided was not 'immediately necessary'. Further, most of the patients in this category did not reside in New Zealand.	264
Unconsented	Under the PHO agreement, patients must sign a registration form to indicate they consent to being enrolled with the PHO with the practice as their primary healthcare provider.	Patients did not sign the registration form, consenting to AMDT becoming their primary healthcare provider.	194
United Kingdom A	The Direction refers to the Health Benefits (Reciprocity with the United Kingdom) Act 1982 which provides that UK residents are entitled to subsidised care which, in the opinion of the medical practitioner, needed prompt attention for a condition that arose after arrival to New Zealand, or became, or without treatment would have become, acutely exacerbated after arrival.	The care provided was not of the type specified in the Health Benefits (Reciprocity with the United Kingdom) Act 1982.	1221
United Kingdom B	The Health Benefits (Reciprocity with the United Kingdom) Act 1982 provides that residents of New Zealand from the UK are entitled to subsidised care which, in the opinion of the medical practitioner, needed prompt attention for a condition that arose after arrival to New Zealand, or became, or without treatment would have become,	The care provided may or may not have been of the type specified in the Health Benefits (Reciprocity with the United Kingdom) Act 1982 but the patients were not New Zealand residents.	511

	acutely exacerbated after arrival.		
Other countries	Under the Direction, patients from 'other countries' (other than Australia, New Zealand and the UK) that had no eligibility or entitlement to be enrolled with the PHO.	Patients were from 'other countries' and were not entitled/eligible to be enrolled with the PHO.	428
		Total:	**2618**