NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

Level 24, AON Building,
1 Willis Street, Wellington 6011
PO Box 10509, The Terrace,
Wellington 6143, New Zealand
Telephone: +64 4 381 6816
Website: www.hpdt.org.nz

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	**1518/Med24/617D**
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	**DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994 **Applicant**
AND	**DR DIGVIJAY GOEL** registered medical practitioner of Invercargill **Practitioner**

HEARING held at Invercargill on 29 to 30 April 2025

TRIBUNAL:	Ms T Baker (Chair) Dr B Howcroft, Dr A Humphrey, Dr P Jacobs, Dr B McCulloch (Members) Ms C Pope, Executive Officer Ms K O'Brien, Stenographer
REPRESENTATION:	Ms J O'Sullivan and Ms K Corbett for the Director of Proceedings Mr A Holloway for the Practitioner

---

TRIBUNAL DECISION DATED 30 OCTOBER 2025

Contents

Introduction

[1] A panel of the Health Practitioners Disciplinary Tribunal (**the Tribunal**) convened in Invercargill on 29 April 2025 to 30 April 2025 to hear a charge of professional misconduct laid by the Director of Proceedings appointed under the Health and Disability Commissioner Act 1994 (**the Director**) against the practitioner, Dr Digvijay Goel (**the practitioner**).

[2] The charge comprises five particulars arising from Dr Goel's interactions with three patients between 2014 and 2019. It is alleged that his communication with and about the patients was unprofessional, and/or inappropriate, and/or disrespectful, and in one case potentially dangerous.

[3] A full copy of the charge is attached as Appendix A and the allegations are also set out within this decision.

Summary of findings and orders

[4] For the reasons outlined below, the Tribunal finds the charge of professional misconduct is established.

[5] Dr Goel is censured under section 101(1)(d), and a fine of $3,000 is imposed under section 101(1)(e).

[6] Under section 101(1)(f), Dr Goel is ordered to contribute $34,563.42, being 40% of the costs of the Director of Proceedings and the Tribunal.

[7] Under section 95(2) of the Act, there are orders for non-publication of the following names and identifying details:

(a) [Mr E]

(b) [Ms S]

(c) [Mr N].

[8] There are further orders for non-publication of the following details:

(a) The cause of death for [Mr E].

(b) Reference to [Ms S]' health conditions, including the [procedure] and the diagnosis [health condition].

[9] Dr Goel's application for permanent name suppression was declined but interim name suppression continues until this final written decision is issued.

Evidence

[10] The Director filed briefs of evidence from five witnesses:

(a) [Ms U], the mother of patient, [Mr E]. Dr Goel's clinical notes and correspondence concerning [Mr E] are the subject of particular 1 of the charge.

(b) [Ms S], a patient. Her encounter with Dr Goel on 7 October 2016 and Dr Goel's clinical notes and correspondence regarding [Ms S] are the subject of particulars 2 and 3 of the charge.

(c) [Mrs O], the mother of patient, [Mr N]. Their meeting with Dr Goel and Dr Goel's notes and correspondence regarding [Mr N] are the subject of particulars 4 and 5 of the charge.

(d) Mark Treleaven, Complex Resolution and Investigations Manager at the office of the Health and Disability Commissioner.

(e) Dr Rosemary Edwards, a consultant psychiatrist who provided expert opinion on the relevant standards expected of psychiatrists in relation to interactions with patients and appropriate clinical records and correspondence. The Tribunal also received a supplementary brief of evidence in reply to Dr Goel's evidence.

[11] The practitioner accepted this evidence and so it was not read at the hearing.

[12] No issue was taken with Dr Edwards' expertise or suitability to provide an expert opinion. In summary, Dr Edwards has been a consultant psychiatrist since February 2002 and sub-specialised in Forensic Psychiatry. In her private practice, she specialises in working with

adults who have Attention Deficit Hyperactivity Disorder. She is also a Consultant Forensic Psychiatrist at Ratonga Rua O Porirua, within the Regional Forensic and General Mental Health Rehabilitation Service and held the role of Clinical Leader for General Adult and Transcultural (Māori Mental Health and Pacifica Health) Services at Capital & Coast District Health Board (**CCDHB**) in Wellington from 2008 to 2015.

[13] Dr Edwards has several years' experience as a Consultant Forensic Psychiatrist with the Regional Forensic Service at CCDHB in Wellington. This is on top of experience as a Consultant Forensic Psychiatrist at Justice Health for the New South Wales Community Forensic Mental Health Service in Sydney, Australia and private work in Sydney.

[14] Since 2009, Dr Edwards has been involved with the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) in various committee roles and as Chair of the NZ Committee from 2011 to 2016. She continues to be a member of the RANZCP ADHD Committee.

[15] The Tribunal considered documents in an Agreed Bundle of documents, including relevant clinical records and correspondence regarding the three patients, and relevant guidelines and standards, and listened to an audio recording of a consultation and viewed a video of part of a consultation.

[16] The practitioner filed two statements of accepted facts. The practitioner accepted most of the allegations in the charge and that cumulatively, his conduct amounted to professional misconduct.

[17] Despite the Dr Goel's admissions, the onus of proof remains with the Director. The standard of proof is on the balance of probabilities.

[18] The Director must prove not only the facts, but also that the conduct may be properly characterised as alleged in the charge and that the established conduct amounts to professional misconduct under section 100(1)(a) and/or (b) of the Health Practitioners Competence Assurance Act 2003 (**the Act**). That is negligence or malpractice and/or conduct that brings or is likely to bring discredit to the medical profession.

[19] Although Dr Goel accepted that his conduct amounts to professional misconduct, this decision sets out the details of his conduct and excerpts of the relevant expert opinion. This is for two reasons.

[20] Unlike the criminal law which defines offences and crimes in a series of statutes, a charge of professional misconduct can cover a range of acts or omissions. Whether the test is met depends on the facts and degree of departure from expected practice. The Tribunal's priorities in discipline are maintaining and setting standards for the profession. Members of the public and the profession should be able to understand the extent of Dr Goel's inappropriate verbal and written communication and why the Tribunal found it needs discipline.

[21] Secondly, there were patients who were affected by Dr Goel's behaviour. The impact on them should not be minimised and so some detail of the nature of Dr Goel's conduct and the Tribunal's consideration of it is warranted.

Background

[22] The following summary is taken from the uncontested evidence presented by both parties.

[23] Dr Goel has been a psychiatrist for nearly 60 years, including over 30 years in the Armed Forces Medical Services in India and three years in an advisory role with the World Health Organisation. Since October 2005, Dr Goel has been a consultant psychiatrist at Southland Hospital. He has authored or co-authored a number of chapters and articles in peer-reviewed books and journals. He trained the first nurse practitioner in the Invercargill hospital, has supervised a number of newly appointed physicians and medical officers as well as consultants new to New Zealand.

The charge

[24] The particulars of the charge contain a mixture of allegations which require the Tribunal to make findings of fact: Did Dr Goel make the relevant statements in the clinical notes or correspondence? Before moving to the test for professional misconduct, the charge also requires the Tribunal to make evaluative judgments: Was the language or behaviour

unprofessional, inappropriate, disrespectful, or potentially dangerous? We must also decide whether Dr Goel failed to uphold professional and ethical standards.

[25] There is some overlap in the exercise of deciding whether the allegations in the charge are established and finding whether those established matters reach the definition of professional misconduct, which may be negligence, malpractice[1] or conduct that brings or is likely to bring discredit to the profession.[2] The overlap is particularly pronounced in the case of negligence, which in this jurisdiction means a failure to meet the standards expected of a practitioner in the circumstances.

[26] In most respects, the statements made by Dr Goel are self-evidently inappropriate and disrespectful. The Tribunal is nonetheless greatly assisted by Dr Edwards' articulation of why that is so, why his language and behaviour do not meet the standards expected of a psychiatrist and how such conduct impacts the therapeutic relationship.

[27] From the relevant professional guidelines, which were also before the Tribunal, Dr Edwards helpfully distilled the following expectations that psychiatrists:

(a) treat patients as individuals and respect their dignity by treating them with respect;[3]

(b) work in partnership with patients by listening to them and responding to their concerns and preferences;[4]

(c) give patients the information they want or need in a way they can understand and to ensure that they understand it;[5]

(d) provide a good standard of clinical care when assessing, diagnosing, and treating patients. This includes: adequately assessing the patient's condition, taking

1 Section 100(1)(a).
2 Section 100(1)(b).
3 MCNZ *Good Medical Practice* (2013 and 2016), "Professionalism", page 6, and "Respecting Patients", page 12 at [15].
4 "Professionalism," Page 6, and "Working in partnership with patients and colleagues", page 17.
5 "Professionalism," Page 6, and "Working in partnership with patients and colleagues", page 17.

account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate;[6]

(e) develop a professional partnership with patients based on mutual trust and treat patients to the best of their ability;[7]

(f) aim to establish and maintain trust with patients;[8]

(g) be mindful of respect for patient autonomy;[9]

(h) be courteous, respectful and reasonable;[10]

(i) not let personal beliefs, including political, religious, and moral beliefs affect advice or treatment;[11]

(j) not express personal beliefs to patients in ways that exploit their vulnerability or that are likely to cause them distress;[12]

(k) be aware that a doctor's culture and belief systems may influence his or her interactions with patients;[13]

(l) ensure that the patient has received all the information that a reasonable patient, in that patient's circumstances, would expect to receive about their condition and treatment options;[14] and

---

6 "Caring for Patients", page 9 at [2].

7 RANZCP Code of Ethics (2010), "Principle Three: Psychiatrists shall provide the best attainable (psychiatric) care for their patients", page 5 at [3.1]; (2018), page 9 at [3.1].

8 MCNZ Good Medical Practice (2013 and 2016), "Professionalism", page 6; "Respecting patients", page 12.

9 RANZCP Code of Ethics (2010), "Principle One: Psychiatrists shall respect the essential humanity and dignity of every patient", page 4 at [1.3]; (2018), page 7 at [1.3].

10 MCNZ Good Medical Practice (2013 and 2016), "Respecting patients", page 12 at [16].

11 "Respecting patients", page 13 at [20].

12 "Respecting patients", page 13 at [21].

13 "Respecting patients", page 13.

14 "Working in partnership with patients and colleagues", page 18 at [32].

(m) contribute to the promotion of a professional environment with an ethos characterised by mutual respect, free from discrimination, bullying, and sexual harassment. [15]

[28] Dr Edwards emphasised that communication skills are the cornerstone of practising medicine and even more crucial for a psychiatrist. A psychiatrist spends a lot of time listening to patients in a non-judgemental way, often supporting the patient when they have communication difficulties. It is important to have patience and understanding along with the ability to listen effectively and to communicate with patients in a way that is clear, effective and understandable. Without this it is not possible to build a productive and supportive relationship.

[29] Dr Edwards said that if the person with mental illness pushes the psychiatrist away, it is important the response is gentle, to express concern and let the patient know that you are there to support them.

[30] Dr Edwards said it is best to avoid being confrontational or using judgemental language as this can exacerbate patient distress. Inappropriate personal comments and judgements, name-calling and negative personal descriptions of patients can, apart from being unkind and unprofessional, have serious negative impacts on patients and increase their emotional distress. Inappropriate personal comments and judgements can impact the patient-doctor relationship, for example, reducing trust and reducing the information likely to be shared by the patient. This can result in escalating poor behaviour not only with the doctor but with others and can harm the trust the patient has not only in that individual doctor but other doctors and the system.

[31] It is important for a psychiatrist to be able to manage uncertainty as humans are complex beings with unique patterns of experience and behaviour and mental illness can evolve with diagnoses changing as more information comes to light. People with the same diagnosis will often require different plans to support them, for example, people with

[15] RANZCP *Code of Ethics* (2018), "Principle Ten: Psychiatrists should uphold the integrity of the medical profession", page 19 at [10.5].

schizophrenia may have a very different cluster of symptoms. People also respond differently to treatment - some people respond fully, and some don't respond at all. Patients do not fit neatly into boxes and this can be challenging and sometimes frustrating for doctors.

[32] Dr Edwards acknowledged that dealing with difficult emotions can be challenging for a psychiatrist due to the patient's behaviour and the stories that they tell the psychiatrist. This can impact the way the psychiatrist communicates or empathises with them. If the patient is aggressive or hostile it is important not take the response personally as a patient may be angry about a range of issues that are completely unrelated to the psychiatrist. This is a skill that is developed over a career lifetime. Dr Edwards said that the key is to become calmer as the patient gets angrier as this can help to defuse the situation. This requires a lot of practice. A good psychiatrist remains calm, unruffled, especially in a crisis and is mature, behaves predictably and is not rude or abrasive.

[33] Dr Edwards emphasised that it is important to understand the disease, the person with the disease, and the way the two interact. A psychiatrist should have good boundaries, good self-care skills, curiosity, open-mindedness and a humility/willingness to be wrong. A good psychiatrist is not rude or abrasive and gets the job done in an assertive manner without being angry with the patient or family members. A good psychiatrist must be able to consider the ethical implications of treatment and clinical management regimes using the principles of fairness, respect, equality, dignity and autonomy as fundamental to good, ethical psychiatric practice.

[34] Dr Edwards confirmed that practitioners are required to ensure that entries they make in the patient's clinical notes are accurate and respectful. There is the potential for significant detrimental impact on patients, and on patient care, if clinical notes are not accurate and respectful. Clinical notes are a permanent and formal record and can impact the way that other staff perceive and treat a patient, as well as the trust that a patient has in his/her/their doctor or treating professional. It is inappropriate to include personal judgements and opinions, rather than professional ones, in a clinical record which should focus on that which is clinically relevant to the patient and their treatment.

Particular 1: Clinical notes and written communication concerning [Mr E]

[35] The first particular concerns Dr Goel's written statements concerning [Mr E].

[36] [Mr E] had longstanding schizoaffective disorder (a mental health disorder which involves symptoms of both schizophrenia and a mood disorder), cannabis dependence and severe chronic obstructive pulmonary disease (**COPD**). [Mr E] died in August 2018 of [cause of death].

[37] On 14 October 2014, [Mr E] was admitted to the SDHB inpatient Mental Health Unit, his fourth such admission in 2014. He was admitted because he had experienced a psychotic and manic relapse. This allegedly occurred because he had stopped taking his medications[16] shortly after he had been discharged from the unit in September 2014.

[38] At the time of his admission to the inpatient Mental Health Unit, [Mr E] was under a compulsory treatment order, [17] pursuant to section 30 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (**Mental Health Act**).

[39] Consultant psychiatrist Dr Chen was responsible for [Mr E]'s care at admission, but on 12 November 2014 Dr Goel took over as [Mr E]'s responsible psychiatrist.

[40] [Mr E] experienced auditory hallucinations, paranoid delusions about his family and grandiose delusions that his communication had resulted in the dismissal of teachers at school. He could spend money excessively. He could present as irritable and elevated in mood.

[41] [Mr E]'s risk of aggression was closely associated with his mental illness with most episodes occurring during periods of relapse, especially when also disinhibited with alcohol or drugs.

[42] [Mr E] remained an inpatient at the Mental Health Unit for nearly a year, before being discharged on 5 October 2015 to supported accommodation in Invercargill known as PACT. [Mr E] remained under a compulsory treatment order having his treatment provided in the community rather than as an inpatient.

---

[16] Clozapine (a medication used to treat schizophrenia) and lithium (a medication used to stabilise mood).

[17] Compulsory treatment orders are made under the Mental Health Act.

[43] Dr Goel took over as [Mr E]'s responsible clinician[18] in November 2014 while [Mr E] was an inpatient under a Compulsory Treatment Order, and he continued to be his psychiatrist following [Mr E]'s discharge from impatient care in the Mental Health Unit. After [Mr E] became an outpatient, Dr Goel continued to be his responsible psychiatrist and managed his care following his discharge.

[44] On 12 February 2018, [Mr E] wrote to Ms Coupe, Team Leader of the Invercargill Community Mental Health Team, requesting a change of psychiatrist. On 14 May 2018, [Mr E]'s request was approved[19] and he had one appointment with Dr Romann, a locum consultant psychiatrist.

[45] Particular 1 alleges that between November 2014 and February 2018, Dr Goel failed to uphold professional and ethical standards when, in the clinical notes and/or in the written communications to third parties regarding [Mr E], he used language that was unprofessional, and/or inappropriate, and/or disrespectful to [Mr E]. The particular instances referred to in the Appendix of the charge are:

(a) An email dated 14 November 2014.

(b) Clinical notes on 17 November 2014, 7 July 2016 and 15 November 2017.

(c) Three letters, 18 May 2017, 16 November 2017 and 13 February 2018.

(d) An application to extend the Compulsory Treatment Order on 20 April 2015.

[46] Dr Goel accepted that he did this.

[47] In an email dated 14 November 2014 sent to 12 mental health service staff in the context of a treatment team change, Dr Goel recorded the following statements:

[18] Responsible clinician means clinician in charge of the treatment of that patient. See Section 2 Mental Health Act.

[19] Bundle, Section B, Tab 4, p. 57.

(a) "…[Mr E] has become used to routinely breaching boundaries and getting away with grossly offensive and often abusive/assaultive behaviour by using intimidation as a tool, an art which he has practised to perfection."

(b) "…In my first meeting with him earlier this week, he tried the same stunt but when firmly told to cut this crap out, he shut up, but not before making a final attempt at physical intimidation by suddenly moving towards me and sitting down on the chair next to mine. However, when this tactic was treated with the contempt it deserved, his bravado instantly deflated. At no point did I feel physically threatened."

(c) "…Responding to such pathetic antics only serves to give him a sense of power and reinforces this pattern of behaviour…"

(d) "…While dealing with him, any expression of fear will embolden him further and probably result in actual physical assault. This formulation is not only based on my experience, as a military psychiatrist, in dealing with captured Sikh and Islamist terrorists during 1988-1999, but also on a large body of published research on victimology…"

(e) "…Since we cannot allow him to commit chronic latent suicide, no leave (which he will use to consume alcohol and/or illicit substances) or smoking breaks will be allowed."

[48] In Dr Edwards' opinion, Dr Goel's comments telling [Mr E] to "cut this crap out" and describing [Mr E]'s response as "he shut up" is not language that is expected or appropriate from a psychiatrist when writing about their patients and breaches a number of the standards of acceptable practice referred to above.

[49] Dr Edwards was also concerned that these comments illustrate a lack of awareness that Dr Goel's belief system influenced his interactions with [Mr E] and staff. This was a vulnerable patient in supported accommodation with schizoaffective disorder, not obviously or necessarily similar to a captured terrorist. Dr Edwards said it was not appropriate to apply his experience in that dissimilar circumstance to the treatment of [Mr E] and encourage other

staff to not show fear, but rather to respond as he did. There is training provided to health professionals on de-escalation, such as taking patients to areas where they can calm down with less stimulation and providing medication. It was not appropriate to write to other staff comparing [Mr E] to "captured Sikh and Islamist terrorists."

[50] Dr Edwards said that Dr Goel's noting that he treated [Mr E]'s "tactic" of intimidation with "contempt," referring to [Mr E]'s "bravado" and "pathetic antics" is an example of Dr Goel describing his personal beliefs regarding [Mr E]'s character, rather than clear clinically appropriate communication. By communicating in this way, Dr Goel did not show compassion or respect for [Mr E]'s dignity or his mental state. Dr Goel's language is not respectful or courteous; it was adversarial and was unlikely to promote a trusting relationship with [Mr E] and other staff working with him.

[51] Dr Edwards gave examples of appropriate alternative wording for many of Dr Goel's statements. For the statement at [47] (a) above, she suggested:

> [Mr E] has difficulty maintaining boundaries and can become angry and express this as aggression both verbally and by throwing objects. I have found this intimidating at times.

[52] Dr Edwards explained this could be supplemented with factual information as to any relevant history (if present) of physically assaulting staff or others, to alert clinicians to any need to maintain their own safety.

[53] Dr Edwards said the approach used by Dr Goel in this situation is also not accepted practice. It is important to de-escalate any aggression or to leave. People may be angry towards a psychiatrist for many different reasons, the vast majority having nothing to do with the psychiatrist themselves. Understanding the cause of the anger/aggression/fear is part of the assessment and of helping the person with these emotions. Responding to aggression with aggression is not accepted practice as this does not help establish a therapeutic relationship in which to help the patient.

[54] There is a power imbalance between a psychiatrist and an unwell mental health patient, and the psychiatrist is trained to have a broad understanding of illness and to consider not only the illness symptoms but also the social and cultural background of the person

including any life stressors they may be experiencing. The better approach, if the psychiatrist feels intimidated, is to ensure distance between them and the patient and to ensure an exit that can be taken if needed.

[55] As for the statement about cigarettes, alcohol and cannabis, Dr Edwards provided the following alternative:

> I have spoken to [Mr E] about the damage that cigarettes can do to his lungs. I have also spoken to him about the damage that alcohol and cannabis can have on his mental state and make his symptoms of illness worse. He disagrees with me and finds smoking cigarettes to be relaxing for him. He enjoys alcohol and cannabis and says that he feels more relaxed and can sleep better. He does not think these substances have a negative effect on his mental illness. He lacks insight and he does not agree that he needs medication or to give up cannabis. The protocols regarding cigarettes, alcohol and substances will be followed when he is on the ward. Any leave that [Mr E] has off the ward will depend on his mental state and ability to remain safe and not to harm himself or others.

[56] Dr Edwards explained that the alternative example is still a strong directive that may be most relevant in a situation where a person has just been admitted as an inpatient to a hospital due to mental illness symptoms, for the safety of the patient and the public. To smoke cigarettes is a decision for the patient to make. The Mental Health Act does not apply to medical conditions. Education regarding alcohol and illicit substances is common. Dr Goel's approach of refusing leave to a patient on the basis they may smoke cigarettes, was not appropriate, was controlling, and lacked empathy for the patient.

[57] In a Court Application for extension of the Compulsory Treatment Order on 20 April 2015, Dr Goel said:

> …Over the past decade, [Mr E] has become used to routinely breaching boundaries and getting away with grossly offensive and often abusive/assaultive behaviour by using threats/intimidation as a tool, an art which he has practised to perfection…

[58] Dr Edwards said that for the same reasons set out above, this language does not meet standard of acceptable practice. Dr Goel has provided his personal, rather than professional judgement, and he was not courteous, respectful and reasonable. Dr Goel's language is adversarial and was unlikely to promote a trusting relationship with [Mr E] for other staff working with him.

[59] The application also included the following:

> Going by the past pattern, he is likely to discontinue medication, relapse, and probably die within months, given his severe COPD and heavy smoking...

[60] Dr Goel repeated some of these statements and other with a similar tone in other documents. The following examples are taken from [Mr E]'s discharge summary of 5 October 2015:

(a) … has become used to routinely breaching boundaries and getting away with grossly offensive and often abusive/assaultive behaviour by using intimidation as a tool, an art which he has practiced to perfection.

(b) He tried the same stunt, but when firmly told to cut this crap out, he shut up, but not before making a final attempt at physical intimidation ... however when this tactic was treated with the contempt which it deserved, his bravado instantly deflated…"

(c) "… Responding to such pathetic antics …"

(d) "While dealing with him … [t]here will be no negotiation, no accommodation, no compromise…

(e) No dilution of this strategy is permissible…

(f) … he will die within the next one year … we cannot allow him to commit chronic latent suicide no leave or smoking breaks will be allowed…"

[61] In Dr Edward's opinion, this language does not meet standards of acceptable practice for the following reasons:

(a) Dr Goel has given personal rather than professional judgement which was not courteous, respectful or reasonable.

(b) The language is derogatory and unlikely to promote a trusting relationship with [Mr E] for other staff working with him.

(c) Dr Goel used strong, dominant language as an authority figure in a situation where there is a significant power imbalance in relation to the patient. Dr Goel's choice of language most likely had a bullying or overwhelming effect on the patient rather than encouraging two-way respectful communication.

(d) The comments made by Dr Goel go as far as inappropriately directing other staff, which was likely to negatively impact the communication the patient was able to have even with other staff treating him:

[62] In a letter dated 18 May 2017, to [Mr E]'s GP, Dr Goel described [Mr E] as: "excitable, accusative and even more unpleasant than he usually is".

[63] Dr Edwards describes this as not being courteous, respectful and reasonable. Instead, the approach taken was, in short, very unkind. The use of this discourteous language by Dr Goel risks exacerbating the patient's distress.

[64] In another letter dated 16 November 2017, Dr Goel said:

> … he remains in denial, contemptuous and dismissive of medication, becoming really unpleasant and obnoxious …
>
> … conveniently forgets he has not needed to be hospitalised since…
>
> … I have little more to offer, even as [Mr E] continues down the path of self-destruction.

[65] Dr Edwards said this was again an expression Dr Goel's personal view rather than a relevant professional judgement. Stating this was inappropriate and fell significantly below the standards expected of Dr Goel as a psychiatrist. The language used was again adversarial and unlikely to promote a trusting relationship with [Mr E] for other staff working with him. The phrase "*conveniently forgets*" was sarcastic and was not appropriate language to use in these notes.

[66] Dr Goel's letter on 13 February 2018 to [Mr E]'s GP included:

> … [Mr E] was even more hostile, combative and accusative than is his wont.

… in this rather regressive narrative …"

[67] Dr Edwards said that calling a patient "*even more hostile, combative and accusative than is his wont"* falls significantly short of the acceptable standards and practice. Dr Goel has given personal, rather than professional judgement, and it was not courteous, respectful or reasonable. To the contrary, the language Dr Goel used is adversarial and was again, unlikely to promote a trusting relationship with [Mr E] for other staff working with him.

[68] Dr Edwards added that the context in which [Mr E]'s "*regressive narrative*" was made related to [Mr E]'s concerns and fears of not being attractive, particularly as he had been gaining weight on the medication he was prescribed. She said that Dr Goel appears dismissive and not seeing the patient's concerns as important and instead belittling them. It is reasonable for patients to be concerned about their weight, appearance and ability to forge connections with others.

[69] The charge against Dr Goel also refers to his statements in [Mr E]'s clinical notes on three occasions, where his notes included the following:

(a) On 17 November 2014:

- … tendency of using threats/abuse/intimidation to repeatedly sabotage his treatment …
- … there will be zero tolerance for misbehaviours/abuse/threats …
- … any such episode will carry a price tag …

(b) On 7 July 2016

- … [[Mr E]] unwilling to engage, trying to behave like a spoilt child throwing a tantrum …

(c) 15 November 2017

- ... behaviour remains as contemptuous, dismissive and obnoxious as ever …"
- … continues on the path of self-destruction …"

[70] In Dr Edwards' view, these excerpts demonstrate a continuation of the theme of belittling and using bullying language with a vulnerable patient. She considers use of the term "zero tolerance" extreme and would have impacted on other staff. Dr Goel describing a patient as "*trying to behave like a spoilt child*" is putting them down and is unkind and unproductive in approach. The use of the phrase a "*price tag*" was threatening and inappropriate. A more appropriate approach would be to refer instead to consequences, which is therapeutic, rather than a "*price tag*" which suggests a punishment.

[71] The Tribunal has no hesitation in finding that the comments were inappropriate and disrespectful to [Mr E].

[72] For the reasons outlined by Dr Edwards, the Tribunal also finds that they were unprofessional and that Dr Goel failed to uphold professional and ethical standards when he acted in this way. As outlined in submissions on behalf of the Director of Proceedings, Dr Goel's conduct was contrary to the following Good Medical Practice standards:

(a) *Professionalism*: Dr Goel failed to treat [Mr E] with respect, work in partnership with [Mr E] and give information to [Mr E] in a way that he could understand. The written information was not what a reasonable consumer, in that consumer's circumstances, would expect to receive. It was possible to convey clinically relevant information while remaining respectful and compassionate. Instead, Dr Goel's language was inflammatory, derogatory, and disrespectful.

(b) *Caring for Patients* and *Respecting Patients*: Dr Goel allowed his personal views and beliefs to affect his relationship with [Mr E] and expressed his views in a way likely to cause distress. Dr Goel's language was inappropriate and not intended to establish or maintain trust with [Mr E]. Instead, it was belittling and disrespectful.

(c) *Working in Partnership with Patients and Colleagues*: In these documents Dr Goel failed give [Mr E] information he needed in a way that he could understand, nor was it appropriate as shared with other professionals. Instead, the information was inflammatory and included Dr Goel's personal judgements.

[73] Particular 1 is established.

Particular 2: Clinical notes and written communication concerning [Ms S]

[74] Particulars 2 and 3 concern [Ms S], who was a patient of the Southern District Health Board. She has been diagnosed with [health condition][20] complicated by [suppressed by order of the Tribunal].

[75] Dr Edwards explained that [health conditions] are characterised by [Suppressed by order of the Tribunal].

[76] According to the RANZCP Guide on [health condition] (2007). individuals with [health condition] [Suppressed by order of the Tribunal]and are characterised by [Suppressed by order of the Tribunal] and resulting in transference[21] and counter transference.[22] Counter transference can interfere with the therapist's ability to remain detached and objective. It is important that the clinician removes such impediments by analysis or, recognises that they do not work well with this particular type of patient and refer them to a colleague.

[77] Dr Edwards told the Tribunal that [health condition] is considered one of the most painful medical illnesses, since individuals are constantly trying to cope with [Suppressed by order of the Tribunal]. It may look to others that they are manipulative or overly-dramatic, but it is usually an effort to obtain relief from almost constant pain.

[78] People with [health condition] experience [Suppressed by order of the Tribunal].

[79] [Health condition] is a treatable condition and, positive long-term outcomes are possible. Evidence-based treatments such as cognitive behaviour therapy and dialectical behaviour therapy can help people experience fewer symptoms.

[80] Particular 2 alleges that between October 2016 and March 2019, Dr Goel failed to uphold professional and ethical standards when, in the clinical notes and/or in the written communications to third parties regarding [Ms S], he used language that was unprofessional, and/or inappropriate, and/or disrespectful to [Ms S].

---

[20] This diagnosis is disputed by [Ms S].
[21] Transference refers to feelings the patient has for and against the therapist.
[22] The feelings the therapist has towards the patient.

[81] There are two clinical records 7 October 2016 and 15 March 2019 and one letter dated 18 March 2019.

[82] The first clinical record concerns a consultation that is also the subject of Particular 3. It includes the following:

> The lady came in and sat down, avoided eye contact. When requested to look at me while talking to me, as is expected in civilised discourse, she burst into rather melodramatic tears and walked out...

[83] Dr Edwards considered Dr Goel's written documentation, in particular stating that [Ms S] burst into "*rather melodramatic tears"*, fails to meet the accepted standards. Describing [Ms S]' tears as "*rather melodramatic*" was unnecessary, lacked empathy and did not show compassion. She said that as an alternative, Dr Goel could have recorded the situation in a more factual manner:

> "[Ms S] entered the room and sat down. I noted she was unable to make eye contact. Soon after she became upset, began crying, and precipitously left the room."

[84] The second clinical record is from 15 March 2019 when Dr Goel assessed [Ms S]. Also present in the consultation were RN McPherson and RN Driver. The extensive written record includes the following:

> "… She began narrating her usual story, which has been documented extensively in the past and which I had heard innumerable times…over the years from a number of psychiatrists, nurses, key workers who had been involved in her 'care' over the years, and had had to be changed as she burnt them out with her frequent [behaviour]/threats, refusal to [action], [the procedure] and, more recent approach to the news media …"

[85] Dr Edwards observed that this language lacks empathy and does not reflect an understanding of mental illness being a treatable condition of the brain and mind, not the person's fault, and not something they caused. It is treatable and with treatment most people can recover. There is a lack of compassion and respect for [Ms S]' dignity, and it is not courteous or reasonable.

[86] In particular, Dr Edwards said that the comment relating to staff burn out, is irrelevant to a discussion in an acute assessment with a patient and unnecessary for [Ms S]' care and

treatment. Staff burnout is a possible experience for staff working with patients with the diagnosis of [health condition]. This is discussed and managed within the clinician team and is not relevant to a discussion with the patient at any time.

[87] Dr Edwards also gave her opinion on Dr Goel's statements to [Ms S] and why those statements were inappropriate. The focus of this particular of the charge is the appropriateness of what Dr Goel wrote in the notes, rather than how he behaved in the consultation. In fact, much of this entry seemed to be Dr Goel expressing his opinions and frustrations, rather than recording relevant statements made by [Ms S] or showing any sort of useful assessment for another practitioner. Examples include:

> … [[Ms S]] complied with the request to switch off the cell phone and place it on the table. Cautioned that any recording, audio or video of the consultation proceedings, will be unlawful and constitute[s] a culpable offence which will be reported to the law enforcement agencies …
>
> … It was pointed out to her that [substance] did not grow on trees, nor was it a pharmaceutical product provided in a factory. [Suppressed by order of the Tribunal] …
>
> … [Suppressed by order of the Tribunal] …
>
> … I shared my view that such conduct constituted antisocial behaviour …"

[88] Further excerpts from the same clinical note are:

> … composed, euthymic, smiling at times as if enjoying being able to manipulate everyone at will …
>
> … It will be in her interests, and in the interest of the mental health staff who have been badly singed by her exploitative, manipulative and highly traumatising behaviour …

[89] Dr Edwards observed that Dr Goel documented that [Ms S] seemed to be enjoying her situation and exerting control over the health professionals. Dr Edwards said it is important that all health professionals understand the process of [health condition] and the high likelihood of countertransference. Dr Goel has expressed his personal beliefs in a way that was likely to cause the patient distress and in a manner that does not assist them to understand the treatment or advice.

[90] In Dr Edwards' opinion, documenting that mental health service staff have been "badly singed" by [Ms S]' behaviour is not relevant to an acute assessment. It is not relevant to the patient's clinical notes to record any possible effect of their mental illness on staff. It can be very distressing working with such patients, and this is already well known. The clinical notes suggest that this is a patient who is deliberately causing issues, essentially blaming the patient rather than recognising that they are mentally unwell and not doing it on purpose. It was not therapeutic or expressed in a form, language or manner that enabled [Ms S] to understand or benefit. He did not show compassion and was not courteous, respectful or reasonable.

[91] The final document concerning [Ms S] is a letter dated 18 March 2019 to her GP and copied to her. Relevant excerpts are:

> … [Ms S] had been demanding to be admitted to the Inpatient Mental Health Unit … She had 'upped the ante' by contacting the news media and other entities sometime yesterday, a distasteful move which, sans the mental health context, could be arguably termed as an attempt at blackmail/extortion …
>
> … [Ms S] came in with a sense of entitlement and an aura of victimhood …
>
> … she violated the agreement literally within hours by [Suppressed by order of the Tribunal] and [the procedure] while on leave from the ward. This charade went on for months …"
>
> … [Ms S] apparently felt painted into a corner and stalked out of the room …"
>
> … During this entire interaction, I did not see any current evidence of a mental health disorder, nor any [behaviours]. What I saw was manipulative behaviour, reinforced by attainment of secondary gain in the form of escalating investment of mental health resources in her care…"

[92] Dr Edwards considered Dr Goel expressed his personal beliefs in a way likely to cause distress. His language is very strong and indicates a poor understanding of [health condition] as a mental illness that can be treated and is not the patient's fault. The goal of an acute assessment is not for the patient to feel 'painted into a corner,' but rather to feel their heightened emotion is more controlled so they are at a reduced risk of [behaviour] such as [the procedure]. He did not show compassion and was not courteous, respectful or reasonable.

[93] The Tribunal agrees and finds that the communication was unprofessional, and/or inappropriate, and/or disrespectful to [Ms S], as charged by the Director of Proceedings.

[94] The Tribunal must also find that Dr Goel failed to uphold professional and ethical standards. By expressing himself in this way, he showed no respect for his patient. This is a departure from the standards contained in Good Medical Practice regarding respect.[23] It is a breach of Right 1 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

[95] The Tribunal finds that Particular 2 is established.

Particular 3: Consultation with [Ms S]

[96] Particular 3 is also about [Ms S], but concerns Dr Goel's interactions with her during a consultation on or around 7 October 2016. It is alleged that Dr Goel failed to uphold professional and ethical standards when he acted in a manner that was unprofessional, and/or inappropriate, and/or disrespectful to [Ms S].

[97] On 7 October 2016 at 3.25pm, Dr Goel saw [Ms S] with two other members of staff, clinical psychologist Mr Musese and RN Steele. The interview was recorded and was available to the Tribunal. The focus of the interview concentrated on why [Ms S]' usual psychiatrist was not available to conduct the assessment.

[98] Dr Goel asked for [Ms S] to make eye contact with him which [Ms S] struggled to do. [Ms S] then started crying and asked to leave the room. Dr Goel responded saying that if [Ms S] was going to cry, she should leave.

[99] Following the assessment with Dr Goel, [Ms S] was seen by an RN who documented that [Ms S] had experienced a panic attack immediately after leaving the assessment. Mr Musese and [Ms S]' mother both made complaints about Dr Goel. On 28 February 2017, [Ms S] received an apology for discussing organisational issues in front of her. The apology did

[23] As outlined above. MCNZ *Good Medical Practice* (2013 and 2016), "Professionalism", page 6, and "Respecting Patients", page 12 at [15].

not address the other comments about [Ms S] crying, insisting that she look at him, or telling her to leave the room if she was going to cry.

[100] Dr Edwards advised that when dealing with individuals with [health condition], the relationship between the patient and the clinician is an important part of the treatment. The clinician listens, guides and pays attention to the patient's emotions and accepts that their experiences and feelings are real.

[101] Dr Edwards said that Dr Goel did not listen and pay attention to [Ms S]' emotions. He was impatient and did not listen effectively. He interrupted the answers from both [Ms S] and Mr Musese. His conduct did not create a safe environment where [Ms S] felt able to speak about her emotions. When Dr Goel asked questions, he was abrupt and his tone was unlikely to establish a good relationship.

[102] Dr Edwards observed that Dr Goel spent the assessment expressing his personal beliefs about the availability of [Ms S]' usual psychiatrist in a way that was likely to cause distress. There was a lack of discussion with [Ms S] about her presenting issues. Instead, Dr Goel spent the majority of the assessment putting Mr Musese down, which is irrelevant to the patient and unnecessary. The purpose of an acute assessment is to assess the presenting issue and focus on reducing the distressing emotion and problem solving with the patient to increase their sense of control and ability to manage. Discussing the availability of another doctor with a patient shows a lack of respect for the profession and does not best serve the interests of the patient.

[103] Dr Edwards also noted that Dr Goel appeared intolerant of behaviour such as lack of eye contact from others. Whether a patient makes eye contact or not is irrelevant to the doctor–patient interaction during an acute assessment. The quality of eye contact will be commented on in the clinical record as part of an observed mental state of the patient and will contribute to the opinion of the assessor at the time.

[104] Dr Edwards said that people do not make eye contact for a wide variety of reasons, and it is not required for an assessment. A person might be socially anxious, psychotic, or depressed. Even without mental illness, there are lots of reasons why people may not wish to

make eye contact. The lack of eye contact might be observed and recorded, but it is not clinically necessary.

[105] Dr Edwards said Dr Goel was aware of [Ms S]' diagnosis and did not make her care, at that time, his first concern or establish a good relationship. [Ms S]' freedom of choice was not respected, she became more distressed and experienced a panic attack immediately following this assessment and received care from another clinician to manage her heightened emotion.

[106] The Tribunal finds that in asking [Ms S] to make eye contact with him and saying that if [Ms S] was going to cry, she should leave, Dr Goel's conduct was unprofessional, inappropriate and disrespectful. For the same reasons as our findings in particulars 1 and 2, the Tribunal finds that Dr Goel's conduct was a breach of professional and ethical standards.

Particular 4: Clinical notes and written communication [Mr N]

[107] Particulars 4 and 5 concern [Mr N]. [Mr N] was assessed on 31 January 2019 by the Southland Emergency Department expressing persecutory ideas and thoughts of self-harm. He was reviewed by another psychiatrist who did not consider admission was necessary. He was given medication and a referral to Alcohol and Other Drug (**AOD**) Services. [Mr N]'s mother was reported as saying there were no safety concerns at that time.

[108] From 1 February to 11 February 2019, [Mr N] was admitted to the Mental Health Service. He was diagnosed as having a cannabis-induced psychotic disorder following an overdose of quetiapine prescribed the previous day. In the Emergency Department he said that he wanted to sleep due to psychotic symptoms and denied wanting to die. His mental state settled rapidly under the antipsychotic, olanzapine. He was admitted under the Mental Health Act and discharged as a voluntary patient. He was seen in follow-up on 28 February 2019 and was well and agreed to ongoing medication.

[109] [Mr N] was discharged from the mental health service with a three-month script of olanzapine and referred to AOD services and his GP.

[110] On 27 March 2019, [Mr N] was seen by an AOD counsellor, having taken an overdose the previous day. He complained of poor sleep and vivid dreams that scared him. The AOD counsellor organised psychiatry follow-up. It was that appointment on 27 March 2019 that is the subject of particulars 4 and 5 of the charge.

[111] Particular 4 alleges that in March 2019, Dr Goel failed to uphold professional and ethical standards when, in the clinical notes and/or in the written communications to third parties regarding [Mr N], he used language that was unprofessional and/or inappropriate and/or disrespectful to [Mr N].

[112] There are two records: 27 March and 28 March 2019. The entry for 27 March 2019 includes the following:

> [[Mr N]] continues to take cannabis and then takes "overdose" of drugs which, according to his mother, he "steals." She is unable to explain why she doesn't keep the drugs locked…
>
> There is no evidence of a mental health disorder, nor any psychotic features. He is aware of what he is doing and his "suicidal" attempts are a consciously motivated attempt at emotional blackmail…
>
> It was pointed out that such suicidal stunts sometimes succeed by accident and result in a fatal outcome…
>
> Unfortunately his mother did not seem to like the [mirror] being shown and became abusive, using 4-letter words liberally, threatening to go to the media. Then stalked out screaming, with the patient (who did not seem frightfully keen to get mental health help and had apparently been dragged here by his mother) in tow…

[113] Dr Edwards' opinion is that in the context of an acute assessment with recent serious overdoses, the above language is aggressive and unlikely to promote engagement or rapport to discuss the reason for the assessment to focus on a positive outcome.

[114] Dr Edwards said it is concerning that Dr Goel referred to [Mr N]'s overdosing as "suicidal stunts." Even when there are no symptoms of depression or psychosis, it should be recognised that overdose behaviour is not normal and indicates significant distress. This distress could be explored, acknowledged and a way forward supported.

[115] Dr Edwards referred to Dr Goel's use of the term 'emotional blackmail' which implies extortion or emotional intimidation and that the patient is behaving wilfully in a way to get secondary gain. Dr Edwards considered [Mr N] was distressed and likely overwhelmed, and his behaviour reflected this. She said the clinical team needs to have space to feel empathy and understanding rather than to engage in, or be encouraged to engage in, veiled hostility or blame toward the patient in distress.

[116] Dr Edwards described Dr Goel's language as not in a form, language or manner that enabled [Mr N] or his mother to understand or benefit. Dr Goel did not show compassion and was not courteous, respectful or reasonable.

[117] In Dr Edward's opinion the above examples fail to meet the principles for accepted practice. This departure is moderately-severe, to severe.

[118] The Tribunal finds that for the same reasons as the other particulars, Dr Goel failed to uphold professional and ethical standards when, in the clinical notes and/or in the written communications to third parties regarding [Mr N], he used language that was unprofessional, inappropriate and disrespectful to [Mr N].

[119] Particular 4 is established.

Particular 5: Consultation with [Mr N]

[120] Particular 5 also concerns a consultation. It is alleged that on or around 27 March 2019, during an appointment with [Mr N] and his mother, Dr Goel failed to uphold professional and ethical standards when he acted in a manner that was unprofessional, and/or inappropriate, and/or potentially dangerous to [Mr N].

[121] The evidence of this is in a video recording of the 27 March 2019 assessment provided by [Mrs O]. Dr Goel's communication on the video recording included '*your only problem is cannabis',* and when asked by [Mrs O] if he was going to send [Mr N] home to die, Dr Goel stated, '*well that's up to him, I can't help him. Because he takes cannabis … so that means he is not trying to help himself at all. Why don't you keep the medication yourself* (to [Mrs O]), and *'so keep it under lock and key.'*

[122] Dr Edwards advised that when on call a psychiatrist can be asked to see people for a wide range of reasons. The purpose of an acute assessment is to assess the presenting issue and focus on reducing the distressing emotion and provide problem solving with the patient to increase their sense of control and ability to manage.

[123] In Dr Edwards' opinion, Dr Goel appeared dispassionate and disinterested in the video recording. She noticed the lack of emotion (body language and tone) from Dr Goel, and for the duration of the video recording a lack of enquiry or productive discussion with [Mr N] and [Mrs O].

[124] Dr Edwards said there was no attempt by Dr Goel to discuss or explain [Mr N]'s serious overdose presentations and suicidal ideation. [Mrs O] was clearly distressed and exited the consultation in a highly emotional state. Dr Goel's conduct ignored [Mrs O]'s emotional state and did not respect the doctor–patient or the patient's family relationship.

[125] Dr Edwards said that Dr Goel should have recognised that his personal beliefs and cultural perspective on cannabis may have influenced the patient-doctor relationship. During the acute assessment, [Mr N] urgently needed emotional support, not reprimand. By focussing primarily on [Mr N]'s cannabis use and neglecting to consider his broader needs, Dr Goel's approach was clinically unhelpful and caused significant distress. Dr Goel had other clinical options available for his consideration, but the approach he chose did not effectively address [Mr N]'s and [Mrs O]'s immediate emotional concerns.

[126] Dr Edwards expressed concern that Dr Goel seemed to place blame on [Mrs O] for not adequately locking away [Mr N]'s medication, implying that [Mrs O] was partly responsible for the patient's continued overdoses. This approach is both disrespectful and unprofessional. She considered that the incidents described failed to meet the principles for accepted practice. This departure is moderately-severe, to severe.

[127] The Director also charged that this conduct potentially dangerous. Dr Goel knew that [Mr N] had taken an overdose the night before but said there was nothing he could do and that it was "*up to him*". It was submitted that his attitude towards [Mr N]'s distress may have

contributed to [Mr N]'s intentional overdose after the appointment, when he presented to Southland ED after taking an overdose.

[128] Mr Holloway submitted that the evidence did not establish this aspect of the charge.

[129] The Tribunal finds that such comments are highly unprofessional and inappropriate. This language is a significant departure from the standard expected of a psychiatrist. These comments may well have adversely affected [Mr N's] mental health. Indeed, Dr Goel's communication with, and about, all three patients would likely have made them feel worse, but the Tribunal does not think it is fair to categorise this language as "potentially dangerous" in any of the instances. Therefore, Particular 5 is established to the extent that it was unprofessional and inappropriate.

Professional misconduct

[130] The Tribunal must decide whether individually or cumulatively the established conduct as particularised in the charge amounts to professional misconduct. 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

[131] Determining professional misconduct is approached in a two-step test:[24]

[24] *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].

(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.

[132] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct",[25] 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.*[26]

[133] A finding of negligence requires the Tribunal to determine:[27]

> 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.

[134] Negligence or malpractice must be established as behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error or oversight or even carelessness.[28]

[135] 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:[29]

---

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

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

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

[28] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [21].

[29] Above at [28].

> … 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.

[136] The High Court has also observed that:

> The legislature has entrusted the Tribunal, comprising in large part health practitioners, with bringing their collective judgment to bear on individual fact situations, and in determining whether or not conduct by a health practitioner is likely to bring discredit on the medical profession. The decision in this regard essentially calls for a value judgment. The Tribunal acts in a representative capacity, formulating standards which of themselves are representative. **It is an expert body, well placed to assess and evaluate the seriousness of a practitioner's conduct. Deference is appropriate in respect of the Tribunal's judgment on such matters.** [Emphasis added]

[137] As to the second step of the test for professional misconduct, the High Court has endorsed the earlier statement of Elias J in *B v Medical Council* [2005] 3 NZLR 810 that "the threshold is inevitably one of degree". This was further discussed in *Martin, HRE v Director of Proceedings* where the High Court said:[30]

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

[138] This two-step test has been adopted by this Tribunal since its first decision, *Nuttall* 8/Med04/03P issued in 2005 and endorsed by the High Court in many decisions.[31] The second step is a "threshold" rather than a "substantive hurdle".[32]

---

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

[31] *Martin v Director of Proceedings,* above note 25, *Johns v Director of Proceedings* [2017] NZHC 2843 [85]; *H v Director of Proceedings* [2018] NZHC 2175.

[32] *PCC v R* [2018] NZHC 2531.

[139] There is no room for subjective considerations of the practitioner's circumstances when it comes to the second step. As Venning J said in *McKenzie v Medical Practitioners Disciplinary Tribunal*:[33]

> In summary, the test for whether a disciplinary finding is merited is a two stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in a **consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular practitioner**. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner. (Emphasis added)

Director submissions

[140] For the Director, Ms O'Sullivan submitted that Dr Goel's conduct, particularly viewed as a whole, amounts to malpractice, because of the particular aggravating features including the extent of the conduct, its persistence over time, the continuance after the complaints made in 2016, and the impact that the conduct risked having, and did have, on the effectiveness and access of psychiatric care to consumers. After the 2016 complaint, Dr Goel was on notice that this was not the type of conduct that was appropriate, however it continued.

[141] Ms O'Sullivan outlined the impact of Dr Goel's conduct on each of the patients, including the following:

(a) Dr Goel's written notes and correspondence included each of these behaviours and impacted his relationship with [Mr E] and his parents. His conduct was likely to have negatively influenced the way others thought of [Mr E] and fell well short of the standard expected. [Mr E] asked to be transferred to another psychiatrist.

(b) Dr Goel's strong and unsubstantiated claims undermined [Ms S]' negative experiences with mental health services and obscured that she was struggling with [action] and was desperate for help. The language was inappropriate and

[33] *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC) at [71].

reflected a personal judgement unnecessary to include in a clinical letter to her GP. Describing [Ms S] as having an "*aura of victimhood*" minimised her mental health struggles. It was belittling language and implied that her emotional state was exaggerated or self-constructed, rather than rooted in her [health condition] and [suppressed by order of the Tribunal] diagnoses.

(c) [Mr N] left an urgent consultation with his mother feeling like Dr Goel did not want to help. This was dangerous in a situation where [Mr N] had persistent thoughts of killing himself and indeed locked himself in a room and overdosed on his prescribed medication leading him to be admitted into critical care.

[142] It was submitted that although the Director's case is not about the diagnoses received by patients, or the medication prescribed, the efficacy of psychiatric treatment depends, in large part, on good communication skills. The variance between acceptable practice and what the consumers were exposed to in this case, is significant.

[143] This is not a once-off lapse of judgment or restraint. Instead, the conduct represents repeated conduct of a theme, over a five-year period involving three separate consumers. The conduct is also aggravated by the fact that Dr Goel repeated the conduct in relation to all three consumers after and despite receiving [Ms S]' complaint in 2017 and making an apology to her.

Practitioner submissions

[144] For the practitioner, Mr Holloway submitted that Dr Goel's admitted conduct is negligence, not malpractice. While Dr Goel has responsibly conceded the relevant communications were not good enough, he never intended to cause harm. The conduct at issue was not 'immoral' (such as in cases of malpractice, where the practitioner has been dishonest, or deliberately taken advantage of a patient).

[145] It was further submitted that the Tribunal should find that they cumulatively amount to professional misconduct under the Act rather than each particular qualifying as professional misconduct separately.

Discussion

[146] The Tribunal acknowledges that any practitioner may experience a lapse in judgment or patience and depart from their own usual standards of treating patients with respect. The challenges of daily life, either professional or personal, can unsettle a practitioner's equilibrium, meaning that they do not find their usual professional responses within reach. One rude or impatient response, while not ideal, would be unlikely to lead to a disciplinary charge. The profession does not expect perfection 100% of the time.

[147] However, by his own admission, Dr Goel's conduct fell well short of the standards expected of a psychiatrist in his communications to, and about, his three patients.

[148] In deciding that the Dr Goel did not meet professional standards, the Tribunal has already found Dr Goel guilty of negligence. One rude or thoughtless comment might be termed an inadvertent slip, but in each case, Dr Goel's comments were extensive.

[149] The Tribunal also finds that reasonable members of the public, on hearing of the way in which Dr Goel spoke about his patients in clinical records and professional correspondence is likely to bring discredit to the profession. The same applies to the way in which he spoke to [Ms S] and [Mr N] in a consultation. Many people would be appalled at the way in which Dr Goel expressed himself. Such a manner clearly undermines confidence in the medical profession, particularly psychiatry.

[150] The Tribunal found that the volume of instances in relation to [Mr E] meant that particular 1 is on its own sufficiently serious to warrant a disciplinary sanction and amounts to professional misconduct. Cumulatively, particulars 1 to 5 reach that threshold.

Penalty

[151] Having found the charge under section 100(1) established, the Tribunal may consider whether the conduct requires a disciplinary sanction for the purposes of protecting the public and maintaining professional standards. Section 101 provides for the following penalties:

(a) Cancellation of registration.

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

(c) Conditions imposed on practising certificate.

(d) Censure.

(e) A fine up to a maximum of $30,000.

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

Penalty principles

[152] In *Roberts v Professional Conduct Committee,*[34] His Honour Justice Collins discussed eight relevant factors in determining an appropriate penalty in this jurisdiction. These factors have been summarised in the decision of *Katamat v Professional Conduct Committee*:[35]

(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 a penalty which is "fair, reasonable and proportionate in the circumstances".

[153] The following guidance was also given in *Katamat:*[36]

> In summary, the case law reveals that several factors will be relevant to assessing what penalty is appropriate in the circumstances. Some factors, such as the need to protect the public and to maintain professional standards, are more intuitive in their application. Others, such as the seriousness of the offending and consistency with past cases, are more concrete and capable of precise evaluation. Of all the factors discussed, the primary factor will be what penalty is required to protect the public and deter similar conduct. The need to punish the practitioner can be considered, but is of secondary importance. The objective seriousness of the misconduct, the need for consistency with past cases, the likelihood of rehabilitation and the need to impose the least restrictive penalty that is

[34] [2012] NZHC 3354 at [44] to [51].

[35] [2012] NZHC 1633 Williams J.

[36] Above, at [53].

> appropriate will all be relevant to the inquiry. It bears repeating however, that the overall decision is ultimately one involving an exercise of discretion.

[154] On the question of cancellation, the High Court has stated[37] that four points could expressly be derived from the authorities (and implicitly a fifth):

> First, the primary purpose of cancelling or suspending registration is to protect the public, but that 'inevitably imports some punitive element'. Secondly, to cancel is more punitive than to suspend and the choice between the two turns on what is proportionate. Thirdly, to suspend implies the conclusion that cancellation would have been disproportionate. Fourthly, suspension is most apt where there is 'some condition affecting the practitioner's fitness to practise which may or may not be amendable to cure'. Fifthly, and perhaps only implicitly, suspension ought not to be imposed simply to punish.

[155] The Tribunal must consider the alternatives available to it short of removal from the register and explain why lesser options have not been adopted in the circumstances of the case.[38]

[156] The parties were not far apart on the proposed suitable penalty. The Director sought a penalty of a censure and fine. Dr Goel accepted that censure alone was appropriate, but acknowledged that it could be augmented with a fine.

Dr Goel's evidence

[157] Dr Goel gave evidence. He provided a detailed history of his career.

[158] Dr Goel apologised to his former patients and their families and acknowledged that his communications were not appropriate.

[159] Dr Goel set out the process of the Health and Disability Commissioner's investigation into his conduct, which arose out of three separate complaints, the first of which was made in January 2019. The Commissioner's final opinion was issued on 2 December 2021 and included recommendations that Dr Goel apologise, provide a reflective statement and complete further training. He has complied with all the recommendations.

---

[37] from *A v Professional Conduct Committee* HC Auckland CIV 2008-404-2927, 5 September 2008 at [81].
[38] *Patel v Dentists Disciplinary Tribunal* HC Auckland AP77/02, 8 October 2002.

[160] On 2 December 2021, the Medical Council was notified of the outcome of the HDC investigation and Dr Goel was then required to undergo a Performance Assessment Committee process which included 'Multi Source Feedback' conducted by an independent agency over a 22-day period (15 September to 6 October 2021) involving a confidential survey of 29 patients and 32 colleagues representing the whole spectrum of mental health professionals. There was also a site visit and an educational programme followed. Dr Goel completed all requirements at his own expense.

[161] The educational programmed included:

(a) Clinical supervision with the Medical Director, Dr Evan Mason.

(b) Review of medical records and consultations.

(c) Monthly meetings with the supervisor.

(d) A communication training programme with 'Connect Communications' in Auckland.

(e) Cultural awareness (including Treaty of Waitangi) training and observed consultations with consumer advisors.

[162] This was all completed by the end of November 2023. The Director's charge was then brought some time later, on 27 June 2024.

[163] Dr Goel said that these complaints were regretful and rare incidents in nearly 60 years of an otherwise unblemished professional life. He has taken what occurred very seriously, and has spent hours reflecting on these lapses, while also engaging with the HDC and Medical Council.

[164] Throughout this period, Dr Goel has continued to work full time as a consultant psychiatrist in Invercargill, providing mental healthcare services to the community. Apart from routine clinical duties, including dealing with crisis situations, his duties involve training, teaching and supervision responsibilities. In addition to training the first nurse practitioner in Southland Hospital who passed her finals with distinction, Dr Goel has supervised a number

of newly appointed psychiatrists and medical officers, as required by the Medical Council for their registration within the vocational scope of practice. At the time of the hearing, Dr Goel was supervising a consultant psychiatrist who had recently come from Canada, and a young GP who was working as the senior house officer in the inpatient unit. Dr Goel had also been designated as the supervisor for two other consultants who were arriving from overseas on temporary assignments.

[165] Dr Goel had continued to work during periods of extreme resource constraint and had over 17 weeks of accumulated leave. This is despite his age and a serious injury he suffered in December 2023 when assaulted by an unwell patient. After four months recovering, he returned to work in April 2024.

[166] Dr Goel has many achievements to show for his long career, including a 'Certificate of Achievement on the momentous occasion of completing 50 years in psychiatry' in September 2015, and the University of Otago Medical School 'Excellence Award for Long Standing Contribution to Teaching' in 2021. He values most a 2019 citation for the 'Southern Excellence Award', jointly initiated by the Clinical Leader, Combined Services Manager, several team managers, fellow consultants and a nurse practitioner.

[167] In answer to questions from the Tribunal about changes he has made to his practice since these events, Dr Goel said that he has become less challenging of patients' own beliefs and their own concept of their illness. For example, he is no longer impatient of a person continuing to use cannabis without realising that it was having an adverse impact on their psychotic illness. He has become more accommodating and is less assertive about his own values.

[168] Dr Goel also set out a response to aspects of Dr Edwards' opinion and further information about the backgrounds and treatment of his patients. The Director filed a brief of evidence in response. The Tribunal did not find this exchange relevant to our determinations. We have assessed the content of Dr Goel's communication against the expected standards, with some assistance from Dr Edwards as to the application of those standards in practice.

Director submissions

[169] For the Director, it was submitted that the following factors are of key relevance in assessing the gravity of the conduct and to determining an appropriate penalty:

(a) The nature of the communications and the extent to which these fell short of expected practice in a number of areas, including respect for patients, effective communication and empathy. The conduct is in conflict with good psychiatry at its essence.

(b) The number of unprofessional communications by Dr Goel.

(c) The length of time over which this conduct persisted over the period 2014 to 2019.

(d) The conduct negatively impacted three consumers and their whānau. The conduct not only caused actual harm to the consumers by failing to address their acute emotional distress on presentation, but also negatively impacted their experiences of the mental health services such that the conduct risked having, and did have, a negative impact on the effectiveness and access to ongoing care. The Director has already referred, in the liability submissions filed, to evidence of the consumers and their whānau as to the impact of the conduct on them.

(e) The conduct involved both written and acute consultation person-to-person formats.

(f) Dr Goel repeated this type of conduct, even after the complaint was made relating to his treatment of [Ms S] in 2016, and his apology in 2017. This aggravates his culpability and the assessment of his intent.

(g) That Dr Goel repeated unkind remarks in various forms, which means that in saying those words he had no compunction about repeating them to various audiences, despite the opportunity in creating a new document, to do better.

(h) Some of the conduct related to a patient who was the subject of a Compulsory Treatment Order (CTO) and was vulnerable in the light of that and his relationship

to Dr Goel who was his treating psychiatrist who he was required to engage with (until he had a change in psychiatrist).

(i) Instances of the particularised conduct occurred in acute and risk settings and where the patients were in clear distress with suicidal ideation.

(j) After [Ms S] and [Mr N] left the consultations they had with Dr Goel in distress, he appears to have taken no immediate steps to ensure their wellbeing.

(k) Dr Goel's conduct as a senior practitioner modelled inappropriate conduct for others in the mental health team, and was likely to have had a negative impact on his colleagues. Mr Musese, a clinical psychologist, found the approach by Dr Goel shocking in a modern context. Other health professionals had to pick up the pieces after [Ms S]' encounter with Dr Goel. Registered Nurse Driver was so taken aback by Dr Goel's "clinically unhelpful" approach with [Ms S] that he spoke with his manager after the 15 March 2019 consultation regarding his concerns.

[170] In relation to Dr Goel's conduct and comments since the events, Ms O'Sullivan noted the following:

(a) Although Dr Goel admitted negligence and discredit, this was not until after the Director had filed her evidence.

(b) Dr Goel admitted key facts in that he authored the documents, went to the meetings, and that the records of those meetings were accurate. No agreed summary of facts was able to be reached. Dr Goel therefore only admitted to the core aspects of his conduct, rather than the relevant context. However, Dr Goel later accepted the Director's evidence could be taken as read and was not in dispute.

(c) While Dr Goel has apologised at various times, he still lacks key insight into the issues with his conduct and appears to consider that the ends of his proposed treatment justified the means. It seems he does not recognise the importance of

respecting and listening to patients and their families: not only as an ethical requirement, but as part of good psychiatric practice.

(d) In his brief of evidence, Dr Goel framed his behaviour as "lapses". Ms O'Sullivan submitted that Dr Goel's behaviours were not mere lapses of judgement, but reflected his personal beliefs and biases, resulting in repeated instances of insensitive conduct fuelled by his own "moral outrage" forced on vulnerable and unwell patients.

(e) Despite his apologies, Dr Goel appears to lack insight and empathy.

[171] It was acknowledged that:

(a) Dr Goel engaged with the HDC and Medical Council (having undergone a Performance Assessment Committee (**PAC**) educational programme), and voluntarily implemented recommendations made by the HDC.

(b) Dr Goel apologised to the consumers.

(c) Dr Goel has not been the subject of any discipline before.

(d) Dr Goel has contributed to the profession in various ways and has provided character references to the Tribunal.

Practitioner submissions

[172] For the practitioner, Mr Holloway addressed the penalty principles articulated above.

[173] It was submitted that public protection is not a significant factor in the present case. Dr Goel has acknowledged the relevant conduct (some of it having occurred over 11 years ago) was inappropriate and reflected on it extensively. The public is not at risk from him. This is clear from the remedial actions Dr Goel has successfully undertaken and a six year track record of a trouble-free practice.

[174] Mr Holloway submitted that there is no evidence of any shortcomings beyond the conduct identified in the charge. To the contrary, the references provided by his colleagues, both nurses and medical practitioners included the following comments:

> [Dr Goel] has demonstrated a commitment to excellence in patient care and has made significant contributions to the field of psychiatry …
>
> He is an honourable, well-liked man, who works hard, is thoughtful, caring and is a natural leader.
>
> Dr Goel has a sound character and is a person of high moral fibre and integrity … his reliance and discipline can be admired by most and is inspirational.

[175] Dr Goel has provided evidence of proactive steps he has taken to ensure similar lapses in communication with his patients will not occur again, including being open to colleagues providing feedback on his clinical interactions.

[176] On the question of setting professional standards, Mr Holloway acknowledged that general deterrence is also a purpose of discipline, and that the disciplinary finding against Dr Goel will serve as a warning to the profession of the consequences of breaching relevant professional standards, including the Code of Health and Disability Services Consumers' Rights. The fact of an adverse disciplinary finding and censure would be an expression of strong disapproval of Dr Goel's conduct. There is no suggestion of a need for any greater general deterrence in this case.

[177] Mr Holloway submitted that to the extent punishment is a relevant objective, this matter has already had a significant impact on Dr Goel. He has spent thousands of dollars and committed significant time to remedial actions. The process has also lasted more than six years (so far) over the twilight of an admirable career. It has engendered significant shame and learning for Dr Goel. He is aware the conduct identified in the charge let himself and his profession down. To punish Dr Goel further would be neither appropriate nor necessary in the circumstances.

[178] It was submitted that a penalty that allows for rehabilitation is appropriate. Dr Goel has accepted liability. Dr Goel's long-standing commitment to mental health services in Southland is significant. He has been employed as a loyal and valuable consultant psychiatrist

at Southland Hospital for 20 years. He is capable of rehabilitation and seeks the opportunity to work the final months of his career and fulfil the supervisory obligations he has to the Medical Council and an international medical graduate within his service.

[179] Dr Goel has learned from what happened and it would not occur again. He has insight to his conduct. Dr Goel is confident he will be able to maintain appropriate communication in the future.

[180] Mr Holloway referred to some cases which involved inappropriate communication and clinical entries, but like Ms O'Sullivan, acknowledged that it was difficult to find a case that is similar to the present one.

[181] It was submitted that there is no ongoing risk to the public in Dr Goel's case. He is a competent and caring doctor. Imposing cancellation in this case would be out of step with precedent and the failure to adopt lesser alternatives could not be justified.

[182] Dr Goel has clearly reflected, including via the remedial actions undertaken. A suspension is no longer necessary to allow for this. It would also deprive the community of a psychiatrist who is able to provide competent and safe care.

[183] Mr Holloway submitted that while this might have been a case suitable for conditions, none are necessary given the time that has passed since the relevant events, the remedial actions already undertaken and Dr Goel's subsequent track-record of exemplary practice.

[184] Dr Goel accepted censure is appropriate, and censure has been recognised as a significant penalty in and of itself.[39]

[185] It was submitted that the imposition of a fine is typically punitive. Cases where fines are imposed often involve a practitioner behaving dishonestly or unlawfully.[40] It was

---

[39] See for example, *Auckland Standards Committee 2 v Halse* [2021] NZLCDT 7 at [23]: "*A censure is a permanent mark on a practitioner's record. It is a significant penalty component, not something to be treated as a mere matter of course*." See also *New Zealand Law Society v B* [2013] NZCA 156 at [39].

[40] See for example, *PCC v Twentyman* Auckland 717/Med14/280P (19 August 2025) where a fine of $7,000 was ordered for altering clinical records to make the practitioner come across more favourably in the PCC investigation. Also see *PCC v Hanne* 1375/Med20/499P (20 March 2024) where a fine of $12,000 was ordered for the practitioner's flagrant breaches of his undertaking.

submitted that a fine in this case is unnecessary. That said, if something more than censure is necessary to appropriately set professional standards, then a modest fine could perhaps be imposed.

[186] It was submitted that the following are mitigating factors:

(a) Dr Goel's contribution to his service has otherwise been exemplary.

(b) His conduct was not motivated by ill-will — he wanted to provide good care but accepts he went about it in the wrong way. Dr Goel's treatment of [Mr E] did turn around a history of frequent admissions and keep him supported in the community.

(c) Dr Goel is genuinely remorseful. He has willingly taken steps to reflect on and address his conduct (with no further complaints arising) and substantially admitted the charge. He engaged appropriately with the HDC process and provided formal, written apologies.

Discussion

[187] Both parties referred to "aggravating features". Mr Holloway said that an aggravating factor is some feature connected with the conduct that increases its severity but is not already an element of the charge.[41] Ms O'Sullivan argued that there may be aggravating features of a case that are an element of the charge, for example where the charge is one of assault on a child, the age of the child is an element,[42] but the younger the child, the worse the offence may be, in which case it is an aggravating feature. That is relevant when the court considers the imposition of a penalty, bearing in mind that the Crimes Act 1961 and other legislation requiring the exercise of the courts' criminal jurisdiction, prescribes maximum and sometimes minimum penalties for each individual offence.

[188] In the present jurisdiction, the term "professional misconduct" covers a range of acts or omissions which are not codified in the same way as the Crimes Act 1961 and other

[41] See for example Sentencing Act 2002, section 9.

[42] Section 194 of the Crimes Act 1961 says it is an offence to assault a child under the age of 14.

legislation. It is the role of the Tribunal to decide if the conduct meets one of the definitions of professional misconduct and also whether it is sufficiently serious to warrant a disciplinary sanction. Sometimes it is the aggravating features of the conduct that bring it into the realm of discipline. The Tribunal has routinely upheld charges of professional misconduct where a medical practitioner has had a sexual relationship with their patient. When the patient is in the mental health unit with a history of psychiatric conditions, that is likely to be an aggravating feature. On the other hand, one instance of a failure to write in a patient's clinical record would probably not reach the disciplinary threshold in most cases, but several instances might make it sufficiently serious to warrant a disciplinary sanction. In that situation, it may be incorrect to repeat those factors as aggravating when considering penalty.

[189] In the present case, the Tribunal found that with the exception of particular 1, it was the cumulative effect of particulars 2 to 5 that warranted a disciplinary response. In that sense, the number of incidents is intrinsically part of the finding of professional misconduct, rather than an aggravating factor. That said, the Tribunal wants to record our strong disapproval of the following matters that may be characterised as aggravating features:

(a) Dr Goel had been made aware of the impact of his conduct toward [Ms S] and had apologised and yet continued with his disrespectful communication.

(b) [Mr E] was the subject of a Compulsory Treatment Order (CTO) and was vulnerable in the light of that and his relationship to Dr Goel who was his treating psychiatrist who he was required to engage with (until he had a change in psychiatrist).

(c) Instances of the particularised conduct occurred in acute and risk settings and where the patients were in clear distress with suicidal ideation.

(d) Dr Goel's conduct had a negative impact on his patients, and this was entirely predictable. In fact, the Tribunal considered some of his comments were entirely provocative. As noted by the Director, [Ms S] and [Mr N] left the consultations in distress, but Dr Goel appears to have taken no immediate steps to ensure their wellbeing.

(e) The communication was over a period of time. It was not just an instance of a practitioner losing his cool in difficult circumstances.

(f) Dr Goel thought it was appropriate to communicate in this way in correspondence with other health professionals and in court documents.

(g) Dr Goel is a senior practitioner and was role modelling very poor standards for those he was supervising.

[190] The Tribunal acknowledges Dr Goel's long and esteemed career, of which he is understandably very proud. We encourage him to continue to reflect on the need for empathy and respect for his patients. The steps that Dr Goel has taken since these events are highly relevant to penalty. The Tribunal agrees that any conditions that it would consider imposing are now redundant given the Performance Assessment and Educational Programme he has undergone.

[191] The Tribunal considers a fine is appropriate. A psychiatrist of his experience should have been well aware of his obligations. The way in which he spoke to and about his patients is simply unacceptable and warrants some punishment. Dr Goel is censured under section 101(1)(d), a fine of $3,000 is imposed under section 101(1)(e).

Costs

[192] Section 101(1)(f) of the Act, following a disciplinary finding, the Tribunal may order that the health practitioner pay part or all of the costs and expenses of and incidental to the PCC's investigation and prosecution of the charge and the hearing by the Tribunal.

[193] In *Vatsyayann v Professional Conduct Committee of New Zealand Medical Council* [2012] NZHC 1138 Priestley J confirmed the Tribunal's identified relevant considerations for costs:[43]

[43] At [34].

(a) professional groups should not be expected to bear all the costs of the disciplinary regime, and members who appeared on charges should make a "proper contribution" towards costs;[44]

(b) costs are not punitive;[45]

(c) the practitioner's means, if known, are to be considered;[46]

(d) a practitioner's defence should not be deterred by the risks of a costs order;[47] and

(e) in a general way 50 % of reasonable costs is a guide to an appropriate costs order subject to a discretion to adjust upwards or downwards.[48]

[194] The Director of Proceedings submitted that an order of 40 to 45% of her costs would be appropriate. The schedule totalled $46,408.56. The Tribunal's costs were estimated at $40,000.[49]

[195] Ms Corbett referred to the High Court decision of *PCC v Brown*[50] where the High Court upheld the Tribunal's order of 40% contribution to costs. La Hood J noted the more structured approach to costs which had been adopted by the Tribunal and its similarity to the approach taken in the Teachers' Disciplinary Tribunal, where an award in the region of 40% was expected in the agreed matter. His Honour noted:

> ... care also needs to be taken to avoid double accounting because the practitioner's level of cooperation will already be reflected in the quantum of costs against which the 50 per cent starting point is taken.

[196] The Director submitted that the same principles apply in the present case. Costs should not fall disproportionately upon the public where cases are brought by the Director rather than a PCC.

---

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

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

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

[47] *Vasan* above, note 44.

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

[49] This includes revised calculations for the Chair's time.

[50] *Professional Conduct Committee v Brown* [2024] NZHC 990.

[197] For the practitioner, Mr Holloway acknowledged that the Tribunal has received no statement of financial means. It was submitted that there should be the usual discount for the way in which Dr Goel has engaged in the process.

[198] Mr Holloway submitted that the Brown decision is a relatively recent High Court precedent for what is normal or accepted. It was submitted that there should be a modest reduction for the modest degree of success that Dr Goel has had in terms of the issues. It was submitted that 30 to 35% is appropriate.

[199] The Tribunal finds that a contribution of 40% is appropriate. The finding that the language in particular 5 is not "potentially dangerous" is minimal and does not affect the overall findings of the Tribunal and the decision that Dr Goel's communication was clearly unacceptable. The fact that witnesses were not required for cross-examination is reflected in the reduction of 10%. The reduction of hearing time is reflected in the overall quantum of costs. There is no reason to further reduce the practitioner's contribution to costs.

[200] Under section 101(1)(f), Dr Goel is ordered to contribute $18,563.42 to the costs of investigation and prosecution by the Health and Disability Commissioner and Director of proceedings and $16,000 to the Tribunal's costs, making a total of $34,563.42.

Name suppression

[201] The Director of Proceedings sought non-publication orders for the names and identifying details of each of the three health consumers, noting that identifying information includes the names of family members.

[202] An order was also sought for non-publication of two details concerning [Ms S], those being reference to the [health condition] [the procedure]. This is because even with name suppression, people who know her may be able to identify her from the decision and she wants those matters suppressed.

[203] On behalf of Dr Goel, there was no objection to these applications.

[204] Dr Goel also sought name suppression.

Principles

[205] Section 95(1) of the Act provides that all Tribunal hearings are to be in public.[51] Section 95(2) provides:

> (2) If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on application by any of the parties or on its own initiative) make any 1 or more of the following orders:
> …
> (d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person.

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

[207] The public interest factors have been established:[52]

(a) Openness and transparency of disciplinary proceedings;

(b) Accountability of the disciplinary process;

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

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

(e) The risk of unfairly impugning other practitioners.

[208] The disciplinary process needs to be accountable so that members of the public and profession can have confidence in its processes.[53]

[209] This is consistent with what the Supreme Court[54] has since said about open justice in a civil case between private entities:

---

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

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

[53] *Nuttall* 8Med04/03P para [26], referring to *Director of Proceedings v Nursing Council* [1999] 3NZLR 360*; Beer v A Professional Conduct Committee* [2020] NZHC 2828 at [40].

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

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

[210] The public interest in knowing the identity of a practitioner charged with a disciplinary offence includes the right to know about proceedings affecting a practitioner, but also the protection of the public and their right to make an informed choice.[55]

[211] The High Court has said the statutory test for what is desirable is flexible:[56]

> Once an adverse finding has been made, the probability must be that public interest considerations will require that the name of the practitioner be published in the preponderance of cases. Thus, the statutory test of what is "desirable" is necessarily flexible. Prior to the substantive hearing of the charges the balance in terms of what is desirable may include in favour of the private interests of the practitioner. After the hearing, by which time the evidence is out and findings have been made, what is desirable may well be different, the more so where the professional misconduct has been established.

[212] The Tribunal accepts that the stress caused by disciplinary proceedings can adversely affect a practitioner's mental wellbeing. As France J observed in *Dr X v Director of Proceedings*,[57] the "inevitable embarrassment" caused by publicity of disciplinary proceedings

---

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

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

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

does not usually overcome the imperatives behind publication. France J considered that there must be something more "sufficiently compelling" than stress or embarrassment to justify suppression of a practitioner's identity.

Practitioner's application

[213] Dr Goel's application for non-publication was on the grounds of risk of harm to:

(a) family members

(b) patients

(c) reputation

[214] Mr Holloway submitted that risk of harm to third parties is well-established as being a relevant private interest to take into account.[58] Dr Goel has raised the potential harm to his son, who shares the same uncommon surname. It was accepted this is unlikely to be determinative, but it was submitted that it is not irrelevant.

[215] Mr Holloway submitted that the risk of harm to Dr Goel's patients is two-fold. Dr Goel's evidence was that it would be impossible for him to continue working for the District Health Board or any other organisation in this or any other jurisdiction. Mr Holloway submitted that it would be unfair to regard that as speculation. Dr Goel cannot know in advance how damaging publicity will prove to his own health, confidence, and professional and therapeutic relationships. It is common sense that this is a real and grave risk. This is in the context of Dr Goel having accepted his errors. The Court has recognised, there is a public interest in not ending the career of a competent doctor.[59] The ending of Dr Goel's career would also leave a chronically short-staffed service even worse off and require a new supervisor to be found for the probationary international medical graduate.

[216] It was submitted that there also runs a risk of Dr Goel's patients losing faith in him. Reputation is essential for building a strong rapport with patients and gaining their trust. This is particularly acute in mental health, where those exposed to media about a psychiatrist may be less equipped to understand and evaluate the information presented.

---

[58] *Johns v Director of Proceedings* [2017] NZHC 2843.

[59] *A v PCC* HC Auckland CIV-2008-404-2927, 5 September 2008 at [82] cited in *Johns* at [177].

[217] Mr Holloway acknowledged that harm to reputation is acknowledged as being an inevitable consequence of an adverse disciplinary outcome but submitted that this must be considered amongst other factors. For example, in *H v Waikato Bay of Plenty Standards Committee*,[60] the High Court considered an appeal against the Law Practitioners Disciplinary Tribunal's decision involving a case of negligence, with a charge of "*negligence or incompetence in his professional capacity of such a degree also frequent as to reflect on his fitness to practice ... or as to bring the profession into disrepute*". The Disciplinary Tribunal described the practitioner's negligence as "*extremely serious*".[61]

[218] The threshold for granting name suppression in the law practitioners' jurisdiction is whether it is 'proper' to do so having regard to the interests of any person and to the public interest. This is similar to 'desirable'.

[219] When overturning the Tribunal's decision to decline permanent name suppression, the High Court said:[62]

> While the practitioner's misconduct was rightly characterised as serious, and in the usual way, there is an important interest to be served in full disclosure, the public interest was significantly lessened by the absence of any material protective element. Against that, the practitioner's personal circumstances were deserving of weighty consideration. A lengthy career in the law, associated with an impressive record of community service, had come to an ignominious end. While reputational concern or embarrassment associated with an adverse disciplinary finding are not in themselves a sufficient interest to warrant name suppression, in my opinion, the uncontested evidence of serious adverse consequences to the health of the practitioner decisively tips the balance against publication.

[220] Mr Holloway submitted that similarly, Dr Goel has had a lengthy and proud career. He has already experienced six years of stress and upset. Additionally, the harm to his reputation that will be caused by publicity and identification of his name will add considerable salt to the wound. Mr Holloway added that it is also an unfortunate reality that, at times, media cannot be relied on to put things in context or avoid sensational reporting.

---

60 *H v Waikato Bay of Plenty Standards Committee* [2013] NZHC 2090.
61 Above at [6].
62 Above at [26].

[221] Referring to *H v R*,[63] Mr Holloway submitted that on a cumulative basis, the factors supported name suppression.

[222] Weighing these personal factors against the public interest, Mr Holloway submitted that there is no suggestion Dr Goel is not fit to practise or that he poses a risk to the public.

[223] Mr Holloway also noted that this matter started as HDC complaints. Over the 2022/23 financial year, the HDC reported on approximately 25 investigations involving medical practitioners and concluded that 23 of them had breached the Code of Health and Disability Services Consumers' Rights.[64] In six cases the breach was severe. The relevant HDC reports named none of these practitioners.

[224] In *ANG*[65] the practitioner, a GP in a small community, was found guilty of professional misconduct for a charge relating to fraudulent entries in the controlled drug register and patient notes; forgery of colleague's signatures; as well as self-prescribing of drugs of dependence and/or abuse for his own use. The Court noted the safety of the practitioner's practice and held that there was not a public right to know, independent of any need to know. It said that s 95 was not "*predicated on the need for the doctor to be held to account publicly*".[66]

Director's response

[225] For the Director, Ms O'Sullivan emphasised the starting point is open justice, that publication is not about shaming a practitioner; it is about transparency, the public seeing that this is a proper process and that practitioners are held to account. Naming is part of that process as is recognised in section 95.

[226] Ms O'Sullivan emphasised the Supreme Court's decision in Erceg v Erceg that the party seeking suppression must show specific adverse consequences that are sufficient to justify an exception to the fundamental presumption of open justice and that the standard is a high one.

---

63 *H v R* [2019] NZHC 2664.
64 From a search of decisions published on <hdc.org.nz>.
65 *Ang v Professional Conduct Committee* [2016] NZHC 2949 (***ANG***).
66 *ANG* at [78].

[227] Ms O'Sullivan submitted that the assessment is not purely abut an individual practitioner's risk, but a wider consideration of public interest. She quoted the Court of Appeal in Y v Attorney General:

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

[228] Ms O'Sullivan submitted that the question for the Tribunal is whether there is sufficient cogent evidence of the private interest put forward by Dr Goel as a likely risk of harm that actually flows from publication, at such a high level as to warrant displacing those public interest factors which apply here, including the presumption of open justice.

[229] Ms O'Sullivan traversed various public interest factors, including the fact that in this case Dr Goel's conduct was in front of, and in correspondence with, other health professionals. It is important that those other professionals can see that the conduct, which came from a leader and senior professional, is not a model that should be followed.

[230] The patients and their families are interested members of the public who oppose name suppression, out of concern that this would mean that Dr Goel was not held properly accountable, and that this would limit the protection that the proceedings bring to current and future patients, and potentially past patients who have not come forward.

[231] The Director submitted that:

(a) Dr Goel's engagement with the HDC and disciplinary process are insufficient grounds for making a non-publication order. Practitioners are expected to engage proactively in the process.

(b) Dr Goel has provided no objective evidence that it would be "impossible" for Dr Goel to continue working as a psychiatrist at Southland Hospital.

(c) There is no evidence to support the submission that Dr Goel's son would be adversely affected by publication.

Discussion

[232] The Tribunal finds that potential embarrassment or stress for Dr Goel's son is not sufficient grounds for name suppression, as this could apply to any practitioner with children. Dr Goel has not identified a private interest that would warrant consideration.

[233] Dr Goel contends that awareness of his prior conduct may affect his ability to deliver mental health services and yet during the five years related to the disciplinary charge, he did not consider this an issue. Dr Goel may need to address such concerns with his patients. It is expected that the education programmes he has engaged in will assist him with this communication.

[234] There is no evidence from Dr Goel's employer or colleagues as to the likely impact that publication would have on Dr Goel's ability to continue his role. That makes it difficult for the Tribunal to reach a conclusion that is more than speculation.

[235] The Tribunal accepts the submissions made on behalf of the Director including the various public interest factors. The wishes of Dr Goel's patients and their families are important considerations as is the risk of unfairly impugning other psychiatrists, should Dr Goel's name not be published. There is insufficient evidence to support any of the grounds advanced by Dr Goel, so he has not persuaded the Tribunal that even the combination of those grounds outweighs the public interest in publication of his name.

[236] The applications for name suppression of the patients are not opposed. The Tribunal agrees that their personal interests in anonymity outweigh any public interest in publication of their names. The patients were vulnerable people engaged in the mental health system. They have been affected by Dr Goel's behaviour and the disciplinary process should not add to their trauma or their families'. Patients should not be deterred from complaining about their health providers or participating in a disciplinary process for fear of publication of their names. It is desirable that there are orders for non-publication of the names and identifying details of:

(a) [Mr E]

(b) [Ms S]

(c) [Mr N]

[237] There are further orders for non-publication of the following details:

(a) The cause of death for [Mr E].

(b) Reference to [Ms S]' health conditions, [the procedure] [health condition].

DATED at Feilding this 30th day of October 2025

T Baker
Chair
Health Practitioners Disciplinary Tribunal

APPENDIX A: NOTICE OF CHARGE

TAKE NOTICE that pursuant to sections 91,100(1)(a) and 100(1)(b) of the Health Practitioners Competence Assurance Act 2003 ("the Act"), the Director of Proceedings has reason to believe that a ground exists entitling the Tribunal to exercise its powers against you and charges that between November 2014 and March 2019 you, being a registered psychiatrist at the time, in your dealings with your patients, [Mr E] (deceased), [Ms S], and [Mr N], acted in such a way that amounted to professional misconduct.

IN PARTICULAR:

[Mr E]

1. Between November 2014 and February 2018, you failed to uphold professional and ethical standards when, in the clinical notes and/or in the written communications to third parties regarding [Mr E] (listed in Appendix A), you used language that was unprofessional, and/or inappropriate, and/or disrespectful to [Mr E].

AND/OR

[Ms S]

2. Between October 2016 and March 2019, you failed to uphold professional and ethical standards when, in the clinical notes and/or in the written communications to third parties regarding [Ms S] (listed in Appendix B), you used language that was unprofessional, and/or inappropriate, and/or disrespectful to [Ms S].

AND/OR

3. On or around 7 October 2016, during a consultation with [Ms S], you failed to uphold professional and ethical standards when you acted in a manner that was unprofessional, and/or inappropriate, and/or disrespectful to [Ms S].

AND/OR

[Mr N]

4. In March 2019, you failed to uphold professional and ethical standards when, in the clinical notes and/or in the written communications to third parties regarding [Mr N] (listed in Appendix C), you used language that was unprofessional, and/or inappropriate, and/or disrespectful to [Mr N].

AND/OR

5. On or around 27 March 2019, during an appointment with [Mr N] and his mother, you failed to uphold professional and ethical standards when you acted in a manner that was unprofessional, and/or inappropriate, and/or potentially dangerous to [Mr N].

The conduct alleged in the above particulars separately and/or cumulatively amounts to professional misconduct. The conduct is alleged to amount to malpractice and/or negligence and/or conduct that brings discredit to the psychiatric profession under sections 100(1)(a) and 100(1)(b) of the Act.