New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO: 45/Nur05/19P

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of a charge laid by a Professional Conduct Committee pursuant to Section 91(1)(b) of the Act against **LESLEY JANE MARTIN**, registered nurse of Wanganui

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chairperson)
Ms K Carncross, Ms J Kilpatrick, Ms K Bolton and
Ms J Courtney (Members)

Executive Officer: Ms G Fraser

Stenographer: Mrs G Rogers

HEARING: Held in Wellington on 6 June 2006

APPEARANCES: Ms K P McDonald QC and Ms C Prendergast for the Professional Conduct Committee ("PCC")
Dr D Stevens QC and Ms P Jensen for Ms L Martin

Introduction

1 Ms Lesley Martin is a registered nurse. Ms Martin was injured while working at a hospital in Southport Queensland, in August 1997. That injury has prevented her practising as a registered nurse since August 1997.

2 On 17 November 2005 a Professional Conduct Committee ("PCC") laid a disciplinary charge against Ms Martin. The charge was laid pursuant to s.100(1)(c) Health Practitioners Competence Assurance Act 2003 ("the Act").

3 The PCC alleged that on 26 August 2003 Ms Martin was convicted in the High Court, Wanganui, of one charge of attempted murder laid pursuant to s.173 of the Crimes Act 1961. The PCC also alleged this conviction reflected adversely on Ms Martin's fitness to practise as a nurse.

4 Ms Martin fully accepted the fact she had been convicted of attempted murder, but challenged the claim that this conviction reflected adversely on her fitness to practise as a nurse.

5 There were unfortunate delays incurred in hearing the charge. Those delays related to issues associated with Ms Martin's application to receive legal aid in order to enable her to be represented before the Tribunal.

6 The Tribunal heard the charge on 6 June 2006. After considering submissions from both parties the Tribunal concluded Ms Martin's conviction did reflect adversely on her fitness to practise as a nurse. Thereafter the Tribunal heard submissions on penalty and determined that Ms Martin should only be able to practise as a nurse subject to conditions imposed pursuant to s.101(1)(c) of the Act. Those conditions are:

6.1 Ms Martin must satisfy the Nursing Council of New Zealand that she is competent to practise by undergoing and passing a full competence assessment;

6.2 Ms Martin must undergo an evaluation by either a psychiatrist or psychologist approved by the Nursing Council of New Zealand and establish that she is able to make appropriate decisions when working under pressure;

6.3 Ms Martin may only practise for the first three years after she resumes practice under strict supervision and only in her area of specialty, namely, intensive/critical care nursing.

7 This decision explains the reasons for the Tribunal's decision delivered on 6 June 2006. From the outset the Tribunal emphasises that its decision focuses on the issues raised by the charge and not the ethical debate about euthanasia. The Tribunal has put aside any views which Tribunal members may have about the morality of Ms Martin's conduct and her views on euthanasia.

Legal Principles

Onus and standard of proof

8 Ms McDonald unhesitatingly accepted the PCC carried the onus of proof.

9 New Zealand authorities currently require the Tribunal to assess the culpability of a health practitioner on the basis of the civil standard of proof, bearing in mind that serious allegations require a high level of proof. In *Brake v Preliminary Proceedings Committee*[1] a full Court of the High Court expressed the standard of proof in the following way:

> *"The standard of proof is not the criminal standard. The Preliminary Proceedings Committee is required to prove the charge to the civil onus, that is, proof on the balance of probabilities. But the authorities have recognised that the degree of satisfaction for which the civil standard of proof calls, will vary according to the gravity of the facts to be proved … The charges against the appellant were grave. The elements of the charge must therefore be proved to a standard commensurate with that gravity."*

10 In this case the allegations against Ms Martin are serious. Her registration as a nurse was always in jeopardy. In these circumstances the PCC is required to prove the elements of the charge to a high standard.

Conduct which reflects adversely on a practitioner's fitness to practise

11 Section 100(1)(c) of the Act provides that a registered health practitioner may be disciplined by the Tribunal where:

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

1 [1997] 1 NZLR 71

12 Section 100(2) of the Act provides the Tribunal can only make a finding under s.100(1)(c) if the practitioner has been convicted in relation to offences set out in thirteen specific statutes (none of which relate to the present case) or "*… for an offence punishable by imprisonment by a term of 3 months or longer"*.

13 The maximum penalty that may be imposed on those convicted of attempted murder is 14 years imprisonment. Ms Martin was sentenced to 15 months imprisonment.

14 Section 109(1)(e) of the Medical Practitioners Act 1995 was virtually identical to s.100(1)(c) of the current Act. In addition there was a rider to the offence of "conduct unbecoming a medical practitioner" found in s.109(1)(c) of the Medical Practitioners Act 1995. That rider required prosecuting authorities to prove that a medical practitioner's conduct reflected adversely on their fitness to practise before they could be found guilty of "conduct unbecoming a medical practitioner".

15 In *Re Zauka*[2] the Medical Practitioners Disciplinary Tribunal, guided by observations of the District Court in *CAC v CM*[3], noted that to satisfy the test of reflecting adversely on a practitioner's fitness to practise:

> *"It was not necessary that the proven conduct should conclusively demonstrate that the practitioner is unfit to practise. The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree. While conduct will satisfy the requirements of the rider it cannot be decided solely by analysing the words of the sub-section. It is rather, a matter that calls for the exercise of judgment …"*

16 In *F v The Medical Practitioners Disciplinary Tribunal*[4], the Court of Appeal made it clear that the term *"reflects adversely on fitness to practise"* as it was used in the rider to s.109(1)(c) of the Medical Practitioners Act 1995, raised the threshold as to what constituted a disciplinary offence under s.109(1)(c) of that Act.

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

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2 236/03/103C, 17 July 2003
3 [1999] DCR 492
4 CA 213/04, 4 May 2005

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

Ms Martin's Conviction

18 The circumstances surrounding Ms Martin's conviction were carefully analysed by both Ms McDonald and Dr Stephens. Understandably each placed different emphasis on aspects of the case. It is convenient to deal first with the PCC's reasons why Ms Martin's conviction reflects adversely on her fitness to practise.

Case for the PCC

19 The PCC's summary of the circumstances relating to Ms Martin's conviction was based primarily on the sentencing notes of Wild J and a judgment of the Court of Appeal dated 14 February 2005 dismissing Ms Martin's appeal against conviction and sentence.

20 In December 1998 Ms Martin's mother, Joy Martin, was diagnosed with terminal bowel cancer. Ms Martin returned from Australia to nurse and care for her mother. Mrs Martin suffered post operative complications which resulted in an extensive period in hospital. She was discharged home on 24 April 1999 to be cared for by Ms Martin.

21 On 21 May 1999 a nurse persuaded Ms Martin to allow her to refer her mother to the Wanganui Hospice. The head nurse of the hospice made an initial assessment of Mrs Martin on 25 May 1999 and immediately rang Mrs Martin's general practitioner who visited Mrs Martin that day. Both health professionals who examined Mrs Martin on 25 May thought she was in pain. The general practitioner prescribed 100mg (10 x 10mg ampoules) of morphine which Ms Martin collected from a pharmacy and which she was to administer to her mother to relieve her pain. The doctor instructed Ms Martin to administer one ampoule every 4 to 6 hours, titrating that up as, and if necessary. He expected that 100mgs of morphine would be enough for about three days.

22 The PCC explained that on the night of 27 May 1999 Ms Martin injected her mother with a single 60mg dose of morphine. This dose was sufficient to kill Mrs Martin.

23 The Tribunal was told there were two reasons why Ms Martin injected 60mg of morphine into her mother. Those reasons were:

23.1 Ms Martin did not want her mother to die a long and lingering death;

23.2 Ms Martin had made a promise to her mother that she would ensure her mother did not suffer unnecessarily. Mrs Martin thought that on 27 May 1999 the time had come for her to keep her promise to her mother.

24 Ms Martin was interviewed by a Detective Sergeant within hours of her mother's death on 28 May 1999. He spoke privately to Ms Martin on the basis the discussion would be off the record. Following that discussion the Detective Sergeant arranged for another officer to attempt to take a statement from Ms Martin. Ms Martin declined to make a statement to the second officer. Ms Martin again refused to make a statement when she was requested to do so a few days later. The Detective Sergeant who had spoken to Ms Martin initially then committed to writing his recollection of the conversation which had taken place off the record on the night of Mrs Martin's death. Several years later, the Detective Sergeant gave evidence of what had been said during that conversation. That evidence was given at Ms Martin's deposition hearing.

25 In the meantime Ms Martin had written and published a book entitled "To Die Like a Dog" in which she described events in essentially the same way she had disclosed to the Detective Sergeant on 28 May 1999. Ms Martin had told the Detective Sergeant that as her mother's illness got worse her mother was on a number of medications. On one occasion, while in hospital, Mrs Martin had asked Ms Martin to help her end her life, helping her commit suicide using the pills she was prescribed. Ms Martin said she was disturbed by her mother's request and had told her mother she could not assist her mother end her life. Her mother was determined and the conversation ended with Ms Martin agreeing that should her mother's condition get to the point where she had no quality of life, then she would help her die.

26 In the course of the conversation on 28 May 1999 Ms Martin stated that her mother had been prescribed 10mg of morphine over a 24 hour period and that extra ampoules of morphine had been made available to Ms Martin should her mother require more for extra pain management. Ms Martin said that her mother was in real pain and that it was impossible for her to sit and watch her mother slowly die a painful death. The police notes recorded that Ms Martin had said on the night of 27 May 1999 she had given her mother 60mg of morphine as well as the 10mg prescribed by the doctor; and that she thought this would end her mother's suffering. She said that the following day her mother had received a visit from a hospice nurse and that she had told the nurse she had given morphine to end her mother's suffering. She also said that on the night of

27 May 1999 she had given her mother the last of the morphine and had then taken her mother's favourite pillow and cuddled her mother with the pillow until her mother passed away.

27 In August 2002 Ms Martin met with the Detective Sergeant who had interviewed her on 28 May 1999. She told him she was going to publish a book about her mother's death. The Detective Sergeant told her that if she published a book the police would re-open the investigation into her mother's death. The book was subsequently published. On the front cover, under the title, appeared the words "a mother, a daughter, a promise kept …". On the flyleaf above the title can be found the words "the personal face of the euthanasia debate". In the foreward Ms Martin asserted that her book was a true story. The narrative of the book traced the deterioration and distress of Mrs Martin, her request to Ms Martin not to let her die in hospital, and Ms Martin's promise to her mother that she would know when "it was time" and that she would not leave her mother suffering. Ms Martin described taking morphine ampoules from their box, breaking the glass necks and drawing the contents into a syringe and injecting the contents into her mother's thigh. Later in the book she described the incident with the pillow.

28 In early 2003 the Detective Sergeant bought a copy of the book and went to Ms Martin's address and executed a search warrant. A notebook, manuscripts and a CD rom disk relating to the book "To Die Like a Dog" were handed over. When Ms Martin gave a statement at the Wanganui Police Station she acknowledged having written the book and had agreed the book was a true account of what happened with her mother ("with a degree of literary licence"). Ms Martin confirmed that the passages in the book on which the indictment counts were founded, were correct. She said that "to keep a promise to someone, to help them die, peacefully and painlessly, was illegal" and indicated she had kept the matter secret because she knew what she was doing was illegal. She said she had given her mother the 60mg of morphine thinking it would end her mother's life. When informed that she was about to be arrested and charged with attempted murder she replied "I am not a murderer, helping someone to die whom you love according to their wishes is not murder".

29 Ms Martin was charged with two counts of attempted murder under s.173 of the Crimes Act 1961. She pleaded not guilty to both counts. In relation to the count in respect of which she was convicted, it was the Crown's case that Ms Martin's intention was to end her mother's life and that she injected her mother with 60mg of morphine for that purpose.

30 The PCC explained Ms Martin defended herself on the basis that what she said in her book (and in her other statements) was unreliable.

31 In relation to Ms Martin's defence the Court of Appeal observed:

> *"It is difficult to imagine a case where an accused had made so many deliberate, repetitive, private and public admissions of conduct carried out in the knowledge of its criminality. It is not surprising therefore that having elected to defend the prosecution, the appellant found herself constrained to defend on the basis that her admissions were untruthful, or, as her counsel put to this Court on appeal, were unreliable. She did not however, recant those admissions or her description of them as untruthful."*

32 When sentencing Ms Martin, Wild J relied on a pre-sentence report from a probation officer. That report disclosed that Ms Martin had asserted that she would repeat her actions if the same situation arose in the future. When asked if she was likely to reoffend Ms Martin's response to the probation officer was:

> *"I am making this political stand in the hope that I will never be placed in this situation again. If you are asking me whether I would reoffend I can say that if someone else I loved dearly was suffering and asked me to help them to die, and we continued to live in our current legal environment I would help again"*.

33 Victim impact statements from Ms Martin's brother and younger sister were also before the Court on sentencing. While Ms Martin's brother was wholly supportive of his sister's actions, Ms Martin's sister described a deep sense of deprivation, despair and anger at being deprived of the opportunity to say goodbye to her mother. She maintained that Ms Martin did not tell her that her mother was dying and she did not see her mother for the last week of her life. Her sister described how her children shared those feelings of sadness that they had not been able to say goodbye to their grandmother.

34 The PCC drew the Tribunal's attention to a decision of the Medical Practitioners Disciplinary Tribunal, *Re Simpson*[5]. Ms McDonald said that case was similar to the circumstances of the case before the Tribunal. Ms McDonald told the Tribunal Dr Simpson was convicted of the manslaughter of his terminally ill mother. The High Court apparently characterised Dr Simpson's acts as a mercy killing. The Medical Practitioners Disciplinary Tribunal found Dr Simpson's conviction reflected adversely on his fitness to practise as a medical practitioner because his actions in administering drugs to his mother and attempting to kill her conflicted with his obligations as a

[5] 256/03/111C

medical practitioner. That Tribunal removed Dr Simpson's name from the register of medical practitioners.

35 The PCC submitted "there can be no doubt that the circumstances of Ms Martin's offending reflect adversely on her fitness to practise as a nurse". The PCC emphasised:

35.1 The offence of attempted murder is undoubtedly very serious;

35.2 Ms Martin's actions were pre-meditated and deliberate;

35.3 Ms Martin failed to seek objective help and instead took matters into her own hands;

35.4 Ms Martin breached the trust which doctors and nurses caring for Mrs Martin had placed in Ms Martin;

35.5 Ms Martin had little appreciation regarding the significance of her actions from a professional point of view.

36 The PCC stressed "Ms Martin has indicated she would do the same thing again if necessary. Clearly Ms Martin has no insight into the seriousness of her actions, and she has shown no remorse".

The Case for Ms Martin

37 In his detailed submissions Dr Stevens explained that Ms Martin's actions were of a daughter relieving the pain and suffering of her mother. He said the actions which led to Ms Martin's convictions were not performed in the course of her work as a registered nurse.

38 Dr Stevens also placed considerable weight on the fact that Ms Martin had practised as a nurse for 17 years without incident – indeed she was described in glowing terms as a committed, dedicated and very professional nurse.

39 Dr Stevens drew the Tribunal's attention to nine matters which he described as "failings in the health system" which impacted upon both Mrs and Ms Martin. The nine matters identified by Dr Stephens were:

39.1 *Failure to treat nausea and vomiting.* Dr Stevens said those responsible for the medical care of Ms Martin failed to adequately explore the causes of

continuing nausea and vomiting (which afflicted Mrs Martin over the last weeks of her life) and failed to adequately treat it. This was a serious condition, which would, according to a defence witness, Professor MacLeod, a specialist in palliative care at Otago University, have "seriously impacted on the way Mrs Martin perceived her living". The Professor said at Ms Martin's trial that the medical profession should be able to achieve the relief of nausea in almost all cases. He said the approach taken in Mrs Martin's case was not acceptable.

39.2 *Failure to hold a palliative care conference*. Dr Stevens explained that at the time of Mrs Martin's final discharge from hospital, there should have been a palliative care conference attended by the professionals who had been involved in her care in hospital and those to be involved in her care in the community. Such a conference should have set up a management plan for Mrs Martin's care and treatment in the community. The plan should have focussed on the treatment at home, on Mrs Martin's vomiting and nausea, and on the other needs of a terminally ill person.

39.3 *Failure to properly manage medical care in the community*. Dr Stevens said there was a lack of co-ordination between those responsible for Mrs Martin's care. The surgeon apparently said that once Mrs Martin was discharged from hospital the general practitioner was responsible for her care; but the general practitioner apparently thought the surgeon was responsible for Mrs Martin's ongoing care. As a result no doctor was taking responsibility for Mrs Martin's ongoing medical care.

39.4 *Failure to notify hospice for almost one month of Mrs Martin's final hospital discharge*. Dr Stevens said that although Mrs Martin went home on 24 April, the hospice was not notified of this until 21 May. It was left to a social worker, with no medical or nursing qualifications to decide when a referral to the hospice should be made.

39.5 *Delay in notifying general practitioner of patient's discharge from hospital*. The Tribunal was told the hospital took 18 days to advise the general practitioner of Mrs Martin's final discharge from hospital. At Ms Martin's trial Professor MacLeod said that delay should never have occurred as "the hospital was discharging home a very sick woman". The Professor described that as a "major deficiency".

39.6 *Discharge notice inadequate*. Dr Stevens said the discharge notice sent to the general practitioner by the hospital on the final discharge from hospital did not contain the information which Professor MacLeod described as necessary to enable the general practitioner to provide the patient with medical care in her home.

39.7 *Failure of general practitioner to contact patient for 14 days*. The general practitioner knew on 11 May that his patient was at home terminally ill. Dr Stevens said the general practitioner made no contact with the patient until 25 May, two days before she died. Furthermore, the Tribunal was told the general practitioner only made contact after the hospice nurse telephoned him. Apparently Professor MacLeod said at Ms Martin's trial that the failure to make early contact by the general practitioner was unsatisfactory. It meant that the general practitioner did not see the patient until the situation had become desperate, some 31 days after Mrs Martin's discharge from hospital.

39.8 *Failure of hospice to undertake full palliative care assessment*. The Tribunal was told the hospice nurse first visited Mrs Martin on 25 May. At Ms Martin's trial Professor MacLeod was of the view that the hospice nurse should have made a full assessment of the patient's needs at this time. She did not. Professor MacLeod found it difficult to understand how a hospice nurse could encounter a person who was "dehydrated and very toxic" and "leave within a short time period without exploring what the needs were".

39.9 *Failure to adequately treat pain*. Dr Stevens explained Mrs Martin's general practitioner saw Mrs Martin on 25 May. He determined then that she had been in severe pain and needed narcotics. He left a prescription with Ms Martin for 10 ampoules of 10mgs of morphine. Ms Martin was to obtain the morphine immediately and give her mother a 10mg injection. The doctor considered this would be effective for 6-8 hours. Ms Martin was to repeat the dose after that time as required. The general practitioner envisaged 3-4 ampoules being administered every 24 hours. On 26 May the hospice nurse set up a syringe pump (which administers morphine progressively over 24 hours) and on the general practitioner's instructions placed only 10mgs in the syringe pump. This meant that the amount of morphine being administered for pain relief was significantly reduced. Before instructing the nurse to set up 10mgs in the syringe driver the general practitioner failed to contact Ms Martin and find out how many of the 10 ampoules she administered over the preceding 18½ hours.

> At Ms Martin's trial the general practitioner accepted he should have done so. The nurse who set up the syringe pump on the doctor's orders, said she was unaware that the doctor had given Ms Martin a prescription for 10 ampoules of morphine the previous night. The doctor had failed to tell the nurse about the prescription. If he had done so, the nurse stated, she would not have started Mrs Martin on only 10mgs. Professor MacLeod described such a dose, in the circumstances, as "inadequate". He considered that, as a result, the level of pain could have returned almost to the same severe level of pain Mrs Martin was experiencing before any morphine was given. The Professor described the management of the pain as inadequate and something that was unsatisfactory in this country. The result was that Mrs Martin's level of pain could have become severe on the night of 26/27 May.

40 Dr Stevens told the Tribunal that as a result of these failings the Crown accepted at Ms Martin's trial that there had been some "systemic failures" and suggested that the whole country might learn something from them. Dr Stevens said the trial Judge thought the jury might agree this was a proper concession.

41 The Tribunal's attention was drawn to the case of *R v Cox*[6]. Dr Cox was convicted by a jury in 1992 at the Winchester Crown Court of the attempted murder of a patient. The patient, Lillian Boyes was 70 years old and had been Dr Cox's patient for 13 years. She suffered from rheumatoid arthritis complicated by internal bleeding, gangrene, anaemia, gastric ulcers and pressure sores. As a result she was in acute and constant pain from which standard pain-killing drugs did not offer relief. During the last few days before her death, she repeatedly asked Dr Cox to end her life. He reassured her that her last hours would be as free of pain and as dignified as possible. He injected her with a potentially lethal dose of potassium chloride, a drug without recognised pain killing properties. His intention was to end the life of his patient. She died within minutes of the injection.

42 Dr Cox was sentenced to 12 months imprisonment. That sentence was however suspended. Professional disciplinary proceedings were taken against Dr Cox. The Professional Conduct Committee of the General Medical Council admonished Dr Cox for his conduct in the case describing it as "both unlawful and wholly outwith a doctor's professional duty to a patient". The Professional Conduct Committee

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6 (1992) 12 BMLR 38

nonetheless expressed its "profound sympathy" for his situation and declined to suspend his registration or take further action against him.

43 Dr Stevens submitted that case involved a breach of a doctor's professional duty to a patient. He said that "in terms of liability it must be distinguished from the case of a daughter, who is incidentally a health professional, caring for a terminally ill much loved mother". Dr Stevens said:

> *"That Dr Cox was admonished without any other sanction demonstrates the compassionate approach that health practitioner disciplinary tribunals will take to cases of mercy killing, with their exceptional circumstances. Such an approach is recognition of the fundamental human instinct that drives decent people to alleviate human suffering and to provide others with dignity in death. In the case of a daughter caring for her mother this instinct will be at its most acute"*.

44 Dr Stevens submitted that *Re Simpson*[7] was significantly different from the case before the Tribunal. Dr Stevens relied upon the sentencing notes of Potter J in the High Court when sentencing Dr Simpson to three years imprisonment. Dr Simpson was the son of the deceased and a medical doctor. He was not involved in his mother's treatment. Dr Simpson injected his mother with drugs designed to kill her. When she did not die he gave her a further injection. At the time Dr Simpson was in his mother's home socialising and drinking brandy. Dr Simpson left the windows to his mother's room open so that her body was exposed to the air. These actions still did not result in the death of Dr Simpson's mother. He therefore tried to suffocate her by placing a pillow over her face and lying on top of her. Dr Simpson then strangled his mother using the cord of the morphine pump for this purpose. He was said by the Judge to have proceeded with a series of actions that were "bizarre" and to have had little empathy for his victim who was defenceless and who wanted to die in peace and with dignity. There was no evidence that Dr Simpson's mother had requested her life be terminated. Moreover Dr Simpson was "not involved with her during her illness on a day to day or hour to hour basis". In fact, he had "deliberately distanced himself from her care, declining a request to participate in the roster for her care at home". Justice Potter noted that the defendant was "certainly not in the situation of a family member carrying out the responsibility of the day to day, hour to hour care, of a dying relative who was in a state of unrelieved pain".

45 The Tribunal believes Ms Martin's circumstances are significantly different from those relating to Dr Simpson. His culpability was in a greater league than Ms Martin's. The

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[7] supra

Tribunal believes Ms Martin's offending was more closely aligned to that of Dr Cox, both of whom appeared to act out of care and compassion for their victims.

Finding that Conduct Reflects Adversely on Ms Martin's Fitness to Practise

46 The Tribunal had little difficulty in concluding that Ms Martin's conviction for the attempted murder of her mother reflected adversely on her fitness to practise as a nurse.

47 Ms Martin's actions in prematurely ending the life of her mother were not compatible with the fundamental obligation of all health professionals to respect the sanctity of life. Ms Martin's actions were pre-meditated and clearly designed to cause her mother's premature death. Ms Martin accepted the responsibility of caring for her terminally ill mother, and was trusted to administer appropriate levels of morphine to achieve pain relief. Ms Martin was trusted to carry out the responsibility of being her mother's primary care giver because of her nursing experience.

48 The Tribunal accepts, as did Wild J in the High Court, that Ms Martin did not have "malice forethought", that she was candid in her admissions in her book and that her mother's life is likely to have been prematurely terminated by a relatively short time (possibly only hours).

49 Notwithstanding these facts the Tribunal is firmly of the view that serious questions are raised about a health professional's fitness to practise if they are convicted of attempted murder when prematurely terminating the life of a critically ill patient. The Tribunal accordingly announced on 6 June that the PCC had discharged the onus of establishing that Ms Martin's conviction constituted a disciplinary offence under s.100(1)(c) of the Act.

Penalty

50 In assessing the appropriate penalty the Tribunal has borne in mind that disciplinary proceedings can have a number of functions. Those functions include:

50.1 Protecting the public.

The primary objective of the Tribunal is to protect the public. This objective is codified in s.3 of the Act which explains that the principal purpose of the Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise

their profession. The Tribunal is one of the mechanisms created by the Act to achieve this objective.

50.2 Maintaining professional standards.

This objective was emphasised in *Taylor v General Medical Council*[8] and *Dentice v The Valuers Registration Board*[9].

50.3 Punishment.

Disciplinary proceedings can be used to punish a practitioner. This point was made by the former Chief Justice in *Dentice v The Valuers Registration Board*.[10].

50.4 Rehabilitation.

Disciplinary proceedings can be used to rehabilitate practitioners worthy of this course of action.

51 It was not an easy task for the Tribunal to determine the appropriate penalty in this case. Some members of the Tribunal initially believed the only appropriate course of action was to accede to the PCC's request and remove Ms Martin's name from the register of nurses.

Punishment

52 The Tribunal was readily able to resolve that there was no need to impose a penalty that was designed to punish Ms Martin. The Tribunal believes Ms Martin has already been appropriately punished by society through her conviction and prison sentence.

Protecting the Public and Maintaining Professional Standards

53 The Tribunal's deliberations focused upon how it could achieve the objectives of protecting the public and maintaining professional standards.

54 In settling upon a penalty that achieved these objectives the Tribunal bore in mind that Ms Martin has not been the subject of previous disciplinary charges, and prior to the offence giving rise to this hearing, she had been an exemplary member of the nursing profession. She had also demonstrated a wide range of skills outside of the nursing

8 [1990] 2 All ER 263
9 [1992] 1 NZLR 720
10 supra

profession, including the obtaining of a commercial pilot's licence and a real estate sales person qualification.

55 Balancing against the mitigating factors is the distressing fact that Ms Martin has shown no remorse for her offending and steadfastly believes that she did "the right thing" when she prematurely ended her mother's life. Ms Martin's lack of remorse is profoundly evidenced by her assertion that if she were placed in the same circumstances again she would offend in the same way.

56 Had Ms Martin shown the remorse and contrition displayed by Dr Cox the Tribunal may have been willing to impose a penalty of a similar nature to that imposed by the General Medical Council against Dr Cox.

57 Ms Martin's steadfast adherence to her belief that she did no wrong, and would act in the same way if similar circumstances arose in the future, leaves the Tribunal with no option other than to impose conditions on Ms Martin's ability to practise that will render it very difficult for her to practise as a nurse ever again.

58 The Tribunal has, by a very narrow margin, resolved not to remove Ms Martin's name from the register. The Tribunal has unanimously decided that response would have unreasonably equated Ms Martin's case with that of Dr Simpson.

59 Part of the Tribunal's role is to ensure all health professionals are treated in a similar manner when charged with disciplinary offences. The Tribunal has already explained that in its view it is not appropriate to regard Ms Martin's conduct in the same light as Dr Simpson's "bizarre" behaviour and accordingly, the Tribunal has decided not to punish Ms Martin in the same way that the Medical Practitioners Disciplinary Tribunal punished Dr Simpson.

60 Ultimately the Tribunal resolved to impose conditions on Ms Martin's ability to practise as a nurse. Those conditions are imposed pursuant to s.101(1)(c) of the Act. The conditions which are imposed are:

60.1 Ms Martin must satisfy the Nursing Council of New Zealand that she is competent to practise by undergoing and passing a full competence assessment;

60.2 Ms Martin must undergo an evaluation by either a psychiatrist or psychologist approved by the Nursing Council of New Zealand and establish that she is able to make appropriate decisions when working under pressure;

60.3 Ms Martin may only practise for the first three years after she resumes practice under strict supervision and only in her area of specialty, namely, intensive/critical care nursing.

61 Ms Martin is in receipt of legal aid. In these circumstances s.40 of the Legal Services Act 2000 makes it inappropriate for the Tribunal to award costs against Ms Martin.

62 The Executive Office is required to arrange for a copy of this decision to be published in *Kai tiaki* and the newsletter of the Nursing Council of New Zealand. This order is made pursuant to s.157(2) of the Act.

DATED at Wellington this 16th day of June 2006

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Dr D B Collins QC
Chairperson
Health Practitioners Disciplinary Tribunal