New Zealand Health Practitioners Disciplinary Tribunal

Level 6, 80 The Terrace, Wellington 6011
PO Box 10509, The Terrace, Wellington 6143, New Zealand
Telephone: 64 4 381 6816 Facsimile: 64 4 381 6770
Email: dgainey@hpdt.org.nz
Website: www.hpdt.org.nz

DECISION NO	838/Phys16/338D
UNDER	the Health Practitioners Competence Assurance Act 2003
	-AND-
IN THE MATTER	of a charge laid by a Professional Conduct Committee pursuant to Section 91 of the Act against **MR N** of [ ], Physiotherapist

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HEARING held in Wellington on 29 and 30 June 2016

TRIBUNAL:	Mr Kenneth Johnston QC (Chair), Mr Tim Burns, Mr Jordan Salesa, Dr Margot Skinner and Ms Shail Stewart (Members)
IN ATTENDANCE:	Miss Debra Gainey (Executive Officer) Ms Jacqui Kennedy (Stenographer)
APPEARANCES:	Ms Rachael Schmidt-McCleave and Ms Kerrin Eckersley for Director of Proceedings Mr Christopher Stevenson for the Practitioner

Introduction

1. Is it always misconduct for a health practitioner to enter into a sexual relationship with a former patient? If not then in what circumstances is it misconduct? If it is misconduct at one point in time, at what subsequent point in time, if any, does it cease to be misconduct?

2. By Notice of Charge dated 21 December 2015 the Director of Proceedings charges the Practitioner with professional misconduct pursuant to s 100(1)(a) and (b) of the Health Practitioners Competence Assurance Act 2003.

3. Section 100(1) provides that the Tribunal may exercise its powers under s 101 to impose a penalty on a practitioner if:

> *"(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…"*

5. The Notice of Charge particularises the allegations of professional misconduct in these terms:

> *"…you acted unethically and/or breached professional boundaries in that you had sexual intercourse with Ms E on [ ], at or about 12 hours after your ninth treatment of her as your patient.*
>
> *The conduct is alleged to amount to malpractice and/or conduct that brings discredit to the physiotherapy profession under s100(1)(a) and/or s100(1)(b) of the Act."*

6. Thus, the essential allegation is that the Practitioner's conduct in engaging in a sexual relationship with the patient referred to in the Notice of Charge constituted malpractice

(in terms of s100(1)(a)) and conduct which brought or was likely to bring discredit to the profession (in terms of s100(1)(b)).

Evidence

7. Prior to the hearing the parties filed an Agreed Statement of Facts dated 6 May 2016, signed by both of them. This was the primary evidence of fact before the Tribunal. We set it out in full:

> ***"MAY IT PLEASE THE TRIBUNAL***
>
> ***THE PARTIES***
>
> ***Mr N***
>
> *1. Mr N is a registered physiotherapist carrying out his practice at [ ]. Mr N is the sole director of [ ], which operates a clinic in the [ ]. Mr N is qualified in sports medicine, rehabilitation and acupuncture.*
>
> *2. Mr N is also a level 1 certified [ ].*
>
> *3. [ ]*
>
> ***Ms E***
>
> *4. Ms E was aged [ ] years at the time of the events leading to the Charge.*
>
> *5. Ms E received physiotherapy from Mr N for nine sessions commencing early [ ], after sustaining a shoulder injury during a [ ] class taken by Mr N.*
>
> ***Physiotherapy relationship***
>
> *6. At or around the beginning of November 2013, Ms E joined [ ]. Ms E attended two [ ] classes per week. Mr N always ran the classes.*
>
> *7. Ms E and Mr N had known each other for many years before Ms E commenced attending [ ] classes, through attendance at the same [ ] in [ ].*

8. While at [ ] class in early [ ], Ms E developed shoulder pain. Ms E sought physiotherapy treatment for her shoulder pain from Mr N at [ ].

9. Ms E had her first physiotherapy appointment with Mr N on 26 November 2013. Mr N provided treatment for Ms E's shoulder that consisted of soft tissue mobilisation, stretches, neural tension stretches, manipulative therapy and scapular setting guidelines. Mr N also gave Ms E strength and training options for on-going recovery of her shoulder after her appointments ended. The treatment provided by Mr N was standard treatment for a rotator cuff/shoulder injury.

10. Ms E attended 8 further appointments (a total of nine appointments) for the treatment of her shoulder injury, the last of which was on 30 December 2013.

The [ ] appointment

11. Ms E attended the [ ] appointment with her two children.

12. During the appointment, Ms E and Mr N discussed movies. Mr N offered to lend Ms E some of his DVDs.

13. Also during the appointment, Ms E's children were entertaining themselves by drawing on her with pens.

14. The clinical notes of the appointment record that Ms E's injury had settled and she was ready to recommence [ ] training in the New Year.

15. At the end of the appointment, Ms E did not book another appointment. There was no formal written discharge from treatment.

The evening of 30 December 2013

16. After the appointment, Ms E and Mr N exchanged Viber communications followed by a number of text messages, numbering 38 in total, on the afternoon and evening of [ ].

17. Mr N texted Ms E at 4.01pm stating: "That was really nice." At 4.50pm, Mr N texted Ms E and asked Ms E for her address, and at 5.20pm Ms E provided it.

18. *There were no text messages sent between 5.22pm and 6.58pm. The messages began again at 6.59pm with Mr N asking whether Ms E liked action movies. Ms E replied that she did.*

19. *At 7.02pm, Mr N sent a text message to Ms E saying: "I am heading To lock x ill drop a few off and c if we have same taste." Ms E replied: "K cool:)"*

20. *Mr N arrived at Ms E's house shortly after 7pm. Mr N was showing Ms E some DVDs when a pizza delivery arrived. Ms E invited Mr N to stay for some pizza.*

21. *Ms E put on a DVD called "Old School" to play on her laptop while they were eating. At that stage Ms E's daughter was in bed but her son was present.*

22. *Ms E then put her son to bed and, when she returned, the movie was still playing. Mr N was sitting on the couch, and she also sat on the couch. The movie continued playing and they talked from time to time.*

23. *Mr N and Ms E kissed, and engaged in sexual intercourse in Ms E's lounge room that evening. Mr N stayed with Ms E until 5.30am on 31 December 2013. During that time Mr N and Ms E had sex more than once.*

NAME SUPPRESSION

24. *Mr N consents to an order suppressing Ms E's name and identifying details.*

25. *Ms E is particularly concerned that she will be able to be identified through Mr N's name being published. For that reason, the Director of Proceedings abides an order suppressing Mr N's name.*

"Mr N"

Mr N

19/04/2016

Date"

8. The parties also filed an Agreed Bundle of Documents. This contained the Practitioner's notes relating to his treatment of the patient which commenced on 26 November 2013 and concluded on 30 December 2013, and the Physiotherapy Code of Ethics and Professional Conduct.

9. In addition to the Agreed Statement of Facts and the Agreed Bundle of Documents, the Tribunal heard from two witnesses. The Director called Mr Dennis Shepherd who was called as an expert to give opinion evidence. The Practitioner also gave evidence.

10. Mr Shepherd is a physiotherapist with approximately 38 years' experience. He has impressive credentials, and is well qualified to give opinion evidence. His evidence concerned:

> *"a. The expected standards of a physiotherapist with respect to sexual relations with a patient or a former patient.*
>
> *b. The usual practice of a physiotherapist with respect to the discharge of a patient at the end of treatment, including my view on when the profession relationship between physiotherapist and patient commences and ends."*

11. As a preliminary matter he told the Tribunal that he had read the Practitioner's clinical notes, and that he could not fault the Practitioner's clinical care of the patient.

12. Mr Shepherd confirmed that the Physiotherapists Code is the key document published by the profession setting out its expectations in terms of conduct, and he directed our attention to:

- Paragraph 2.9 which says that physiotherapists must *"...[not] exploit any patient/client whether physically, sexually, emotionally, or financially. Sexual contact of any kind with patients/clients is unacceptable…"*

- Paragraph 2.10 which says that physiotherapists must *"... [establish] and maintain appropriate professional boundaries with patients/clients and their whanau and families."*

- The commentary to paragraph 2.10 which says:

  "...our society trusts physiotherapists to act in the best interests of their patients/clients. A power imbalance exists within the therapeutic relationship that can easily lead to exploitation or abuse if that trust is not respected. Professional boundaries describe the limits to the relationship that a physiotherapist should observe when treating patients/clients and their family."

13. He then said that although the Practitioner and the patient may both have believed that treatment had come to an end, there are various circumstances in which it might conceivably continue or resume. Whilst we understand why Mr Shepherd felt it necessary to offer this evidence, we are prepared to deal with this case on the basis that the Practitioner's formal clinical engagement with the patient concluded at the end of the consultation on 30 December 2013.

14. Mr Shepherd went on to say that even if it were accepted that the Practitioner's formal clinical engagement with the patient came to an end on 30 December 2013, that did not bring to a conclusion his responsibility to comply with his professional obligations in his dealings with her.

15. As to this, his evidence is neatly captured in paragraphs 21 and 22:

"21. In terms of any sexual relationship, in my experience, it is common practice across the physiotherapy profession to apply a time period of a minimum of three months in the circumstances I have referred to in paragraph 20 above, but it is more widely accepted to apply a time period of six to twelve months before any sexual relationship would be considered acceptable. This is because physiotherapists are aware of the unequal position of power between therapist and patient by virtue of the therapist's training and knowledge, their personality characteristics and the social status derived by the therapist's position.

22. In my practice, I am guided by the well-known article published in 2001 within the textbook Family Practice (Oxford University Press) on this topic by Dr Katherine Hall, a senior lecturer at the Otago Medical school in General Practice, Medical Humanities, Ethics and Clinical Reasoning. That article, entitled "Sexualisation of the doctor-patient relationship: is it ever ethically permissible?" *is attached to my statement as annexure 3 and sets out the issues which may arise when a sexual relationship is embarked on between therapist and patient."*

16. In the final paragraph of his evidence, paragraph 23, no doubt because he was invited to do so, Mr Shepherd went beyond the proper scope of expert evidence by making his own assessment of whether or not the Practitioner had breached his obligations on the facts of this case. That is the issue which the Tribunal must determine. We put his evidence as to this to one side.

17. The Practitioner's evidence did not contradict the Agreed Statement of Facts, but rather provided additional background information.

18.

19. He explained that both he and the patient are members of a [ ] in the provincial town in which they live. It is obvious that the [ ] is a close-knit community. The Practitioner said that members consult the leader of the [ ] before making any important decisions in their lives. He told the Tribunal that he had known the patient as a fellow [ ] member *"... for many years..."*. The point he was making was that his relationship with the patient was that of a fellow [ ] member long before it was that of her physiotherapist. In the course of his evidence the Practitioner also told us that around the time of the events which are the subject of this charge the patient was a member of the [ ] which he owns and runs as an adjunct to his practice, and hoping to secure employment there.

20. The Practitioner told us that he *"... kept the physiotherapist-patient relationship strictly professional, but by the time I called at her home on the evening of 30 December 2013 to drop off some movies as pre-arranged, the course of physiotherapy treatment had completed. The interactions from this point were within the context of the prior relationship and knowledge of each other developed [over] the course of many years attendance at the same [ ]..."*.

21. He described the events of 30 December 2013. His description was consistent with the Agreed Statement of Facts, but he added that before he and the former patient had sexual intercourse he *"... confirmed with her – so that there could be no misunderstanding, that I was no longer seeing her in a professional capacity (which would have been obvious to her in any event). She confirmed that."*

22. The Practitioner then went on to address a point raised by Mr Shepherd in his evidence, that is to say that he – the Practitioner – had told the Director's office during the course of her investigation that he was under stress at the time. He told the Tribunal that it had not been his intention to raise this issue but as Mr Shepherd had mentioned it in his evidence, he thought he should clarify the point. He said that this stress arose as a result

of a number of things. He told us that he was suffering from cervical myelopathy which was causing him a significant amount of pain for which he was being treated with Tramadol. He said that legal proceedings in which he was involved had been very costly and this was putting a strain on his business. He said that his wife and children had left him on [ ]. He said that he was working long hours to keep his business interests going and that he had started very early on 30 December 2013 to cover for a staff member.

23. Insofar as the sexual relationship was concerned, the Practitioner told the Tribunal that this was initiated by the former patient.

24. The Practitioner then returned to the theme that his formal clinical relationship with the patient had ended at the conclusion of the consultation on 30 December 2013. We do not need to revisit this issue. As already indicated, we are prepared to deal with this case on the basis that that is so (even accepting Mr Shepherd's evidence that the apparent conclusion of such a relationship does not mean that it will not continue or resume at any time in the future).

25. The Practitioner concluded his evidence in these terms:

> *"12. I am a dedicated physiotherapist and believe deeply in the improved health outcomes that can be obtained for patients of professional and skilled physiotherapists. For that reason I have continued with professional development as follows:*
>
> - *Post-graduate diploma in sports medicine;*
> - *Post-graduate diploma in rehabilitation;*
> - *Post-graduate diploma in acupuncture;*

- *Masters in Physiotherapy;*

- *Current doctorate in health service."*

26. To recapitulate at this point, it is clear from the Agreed Statement of Facts, and the *viva voce* evidence, that:

- At the time of the events in question in this case the [ ]. [ ];

- The last occasion at which the Practitioner saw the patient in a clinical setting was the consultation on 30 December 2013;

- By then the patient's injury had settled and both the Practitioner and the patient appear to have proceeded on the basis that in the absence of any adverse development there would be no more physiotherapy sessions, and none were scheduled;

- Although there was no formal discharge, in his notes, the Practitioner recorded that he had discharged the patient;

- Following the final consultation, the Practitioner and the patient exchanged text messages. Those which the Tribunal has seen were relatively innocuous. They demonstrate their shared interest in film, and the Practitioner offered to lend the patient some DVDs;

- In his last text message sent at 7.02pm, the Practitioner proposed that he call at the patient's home to drop off the DVDs;

- The patient replied immediately agreeing to that;

- The Practitioner called at the patient's home shortly after 7pm. He was invited to stay for pizza, which he did. Later that evening, the Practitioner and the patient had sexual relations;

- There is no suggestion that this was anything other than consensual. Who the instigator was is neither here nor there.

27. The question then is whether the Practitioner's conduct in engaging in a sexual relationship with his former patient in those circumstances constitutes professional misconduct.

Liability

28. As a rule, within the health-related professions, it is regarded as improper for a Practitioner to embark on a sexual relationship with a patient whilst they have a formal clinical relationship.

29. Why? The answer is that the nature of a professional relationship, involving as it does fiduciary obligations by which the Practitioner is obliged to put the interests of his or her patients above his or her own, coupled with an assumed imbalance of power, gives rise to the possibility of the Practitioner taking advantage of the situation.

30. Of course an examination of whether there is in fact an imbalance of power in any given situation is an intensely contextual one. In order to illustrate this it is only necessary to consider two examples of professional relationships. At one extreme, let us postulate a situation in which a senior psychiatrist is treating a young patient with serious psychological issues over a lengthy period of time and as a result knows a great deal about the patient's intimate personal background and vulnerable psychological state. The power imbalance here is obvious. On the other hand, take a situation in which a senior medical practitioner has had a minor accident and attends his local doctor's

surgery to have the resulting graze dressed by the surgery's young practice nurse. There is no doubt a clinical relationship between the nurse and his or her patient in that situation. But can it really be suggested that there is a power imbalance? If there is, then it is certainly one of a lesser magnitude.

31. Notwithstanding the wide range of contexts in which the issue arises for consideration, most professional groups in the health sector prohibit any sexual relationship between practitioner and patient while a formal clinical relationship exists, as we have already said. No doubt this, often rather melodramatically referred to as a *"zero tolerance policy",* reflects the view that the safest course is simply to prohibit any sexual relationship while there is an extant formal clinical relationship.

32. The Physiotherapists Code reflects this thinking. As Mr Shepherd pointed out, clause 2.9 provides that *"Sexual contact of any kind with patients/clients is unacceptable…"*. So too do the corresponding codes of practice for doctors, nurses and other health professionals.

33. As we have already said, the Tribunal is prepared to consider this case on the basis that the formal clinical relationship between the Practitioner and the patient concluded at the end of the consultation on 30 December 2013.

34. In his evidence, the Practitioner emphasised that on the evening of 30 December 2013 he clarified with his former patient that their formal clinical relationship had concluded and she accepted that. The Tribunal infers from this that at least at the time the Practitioner regarded that as sufficient to establish that he was free to embark on a sexual relationship with her.

35. But simply because a practitioner's formal clinical relationship with a patient has come to an end, it does not follow that he or she no longer has a professional responsibility to the former patient.

36. Thus arises the issue we identified at the outset of how long those professional obligations makes entering into a sexual relationship with the former patient inappropriate.

37. The Tribunal does not accept by Mr Shepherd's evidence as to that. It will be recalled that Mr Shepherd told us in effect that at least three months and as long as 12 months needed to pass *"... before any sexual relationship would be considered acceptable..."*.

38. In the Tribunal's view, it is not a matter of whether the formal clinical relationship ended immediately prior to the Practitioner embarking on a sexual relationship with the patient, or within three or six months, or within any other period of time. The question is whether, at the time that the Practitioner entered into the sexual relationship with the former patient the circumstances were such that any power imbalance arising from the professional relationship had the potential to influence the patient's judgement.

39. So, going back to the examples we gave earlier, we suspect that if the senior psychiatrist entered into a sexual relationship with his or her young patient, even years after the formal clinical relationship had come to an end, doing so might still be regarded as improper. On the other hand, we doubt whether the young nurse entering into a sexual relationship with his or her senior medical practitioner patient shortly after their formal clinical relationship had come to an end would be viewed similarly.

40. The approach we have outlined, not based on temporal considerations but on a case-by-case analysis in order to determine whether the former clinical relationship still has the potential to influence the situation, is the very approach which seems to be advocated

by Katherine Hall in the article to which Mr Shepherd referred in his evidence. More importantly though, it is the approach which the courts have sanctioned: see for example *O v The Professional Conduct Committee* (unreported), High Court, Auckland, Allan J., 30 June 2011 at [81] – [84].

40. We are quite satisfied that in this case the imbalance of power between the Practitioner and the patient which existed during the course of the formal clinical relationship continued after the conclusion of the consultation on 30 December 2013, and that there was therefore a real risk of the Practitioner being able to exploit the relationship (in terms of paragraph 2.9), that he failed to maintain proper professional boundaries between himself and the patient (in terms of paragraph 2.10), and that he therefore breached the Physiotherapists Code by entering into the relationship.

41. It is well established that not every breach by a practitioner of the code of conduct pertaining to his or her profession necessarily constitutes a professional "offence" which should attract a penalty. Accordingly, the next issue is whether that breach by the Practitioner of the Code of Conduct constitutes professional misconduct in terms of s100(1)(a) or (b) of the Act.

42. In considering that issue, it appears to the Tribunal that the following are the most critical factors:

44.1 There was a significant age gap between the Practitioner and the patient, with the Practitioner being the patient's senior by more than twenty years;

44.2 The evidence was that the Practitioner and the patient were [ ]

44.3 The Practitioner owned and ran a [ ] in conjunction with his practice, and the patient was actively seeking employment in the [ ];

44.4 This was a standard professional engagement involving a lay patient. As a result, there was an imbalance insofar as clinical knowledge was concerned.

45. The considerations that we have identified have lead us to conclude that there was in this case a significant power imbalance in the relationship between the Practitioner and his former patient, which certainly had the potential to undermine the latter's capacity to make an independent judgement. The power imbalance was not of the magnitude which would exist between our hypothetical senior psychiatrist and his young patient, but appreciably greater than any power imbalance which might be said to exist between our junior practice nurse and his or her senior medical practitioner patient. Certainly, in our view, the power imbalance was such that Principle 2, paragraph 2.9 of the Physiotherapy Code came into play, rendering it improper for the Practitioner to embark upon any romantic or sexual relationship with this former patient.

46. Did the Practitioner's conduct amount to malpractice? As Ms Schmidt-McCleave submitted, the law is clear that the term "malpractice" as it is used in s100(1)(a) is not limited to clinical malpractice. It extends to any conduct which falls seriously short of that considered acceptable by competent, ethical and responsible practitioners: *Collie v Nursing Council of New Zealand* [2000] NZAR 74(HC) at [21], and includes *"... immoral, illogical, or unethical conduct or neglect of professional duty. Any instance of improper professional conduct…":* *PCC v Schubert,* 671/Psy 14/288P (quoting Collins' English Dictionary, Second Edition).

47. In the Tribunal's view, for any physiotherapist to breach the provisions of the code of conduct by embarking upon a romantic or sexual relationship with a former patient in circumstances which are proscribed by that code (as we have concluded the Practitioner's actions were here) falls seriously short of those standards, and constitutes malpractice and serious misconduct pursuant to s100(1)(a).

48. Does the Practitioner's conduct also constitute professional misconduct under s100(1)(b) because it has brought or was likely to bring discredit to the physiotherapy profession? The concept of bringing discredit to a profession is not a complex one. Discredit simply means whether, objectively assessed, reasonable and informed members of the public would conclude that the reputation of the profession was lowered by the Practitioner's behaviour: *Collie* at [21].

49. We are in no doubt that reasonable members of the public fully informed as to the circumstances of this case would regard the Practitioner's behaviour as having brought harm to the reputation of the profession. Accordingly, our conclusion is that the Practitioner's behaviour constituted professional misconduct in terms of s100(1)(b) of the Act.

50. In the course of her submissions Ms Schmidt-McCleave referred us to previous Tribunal decisions concerning physiotherapists and other health professionals in which behaviour broadly comparable to that of the Practitioner in this case had been held to fall within s100(1)(a), (b) or both. The Tribunal's view is that this case is so clear that it is unnecessary for us to refer to those cases in detail. For the sake of completeness, the cases are *Derry* HPDT 143/Phys 07/79D (21 December 2007); *Samiyullah* HPDT 169/Phys08/90D (13 August 2008) and *Singleton* HPDT 373/Phys/10/158P (16 May 2011).

Penalty

51. Having concluded that the Practitioner's conduct constitutes professional misconduct, the next question which arises is whether it is serious enough in its nature to justify the imposition of a disciplinary penalty.

52. The Tribunal has had little difficulty in concluding that the Practitioner's professional misconduct does justify the imposition of a disciplinary penalty. The Practitioner embarked upon a sexual relationship with a former patient in circumstances which we have concluded constituted a breach of the Physiotherapists Code, and where there was a significant risk that he was taking advantage of the power imbalance which existed between him and his former patient so that her capacity to make a free and unfettered judgment is in doubt. That, in the Tribunal's view, constituted a serious breach of his professional obligations.

53. The Tribunal's obligations in terms of assessing the appropriate penalty are well settled. The principal purposes of professional disciplinary proceedings are the protection of the public and the maintenance of professional standards. The imposition of any penalty involves an element of punishment, and it is important that any punishment is balanced against the prospect of the Practitioner's rehabilitation. There is an important principle of consistency. Like cases should result in like outcomes. For that reason, it is important to have regard to any earlier cases which are genuinely comparable. In considering penalty the Tribunal must consider all available options and combinations thereof. Its responsibility is to identify the least restrictive penalty which properly reflects the seriousness of the case, and enables it to discharge its responsibilities to the public and the profession as already identified. As Collins J said in *Roberts v PCC* [2012] NZHC 3354 at [44] – [51], in the end, the Tribunal must identify a fair, reasonable and proportionate penalty

54. There are a range of matters which the Tribunal regards as important in considering penalty in this case, all of which were canvased by Ms Schmidt-McCleave and Mr Stevenson in the course of their submissions as to penalty.

55. For a physiotherapist to breach the Code by entering into a sexual relationship with a former patient is a serious act of professional misconduct. That said the Practitioner's conduct in this case is not at the most serious end of the scale of misconduct of this type. It is fair to record that the Practitioner and the patient had a pre-existing relationship; that there is no evidence of any impropriety during the time that the formal clinical relationship was extant; that both the Practitioner and the patient believed that the formal clinical relationship was at an end at the time that they embarked on a sexual relationship; and that the evidence is that sexual relationship was a consensual one.

56. In the Tribunal's view it would have been open to the Director to submit that this was a case in which the penalty should include cancelling the Practitioner's registration. But Ms Schmidt-McCleave's submission was that the appropriate outcome in this case was an order censuring him and suspending him from practice for a period of time (and ancillary orders).

57. Nevertheless, the Tribunal has considered whether, in order to discharge its responsibilities to the public and the profession as already described, it is obliged to order the Practitioner's deregistration. In the end we have reached the conclusion that it is not.

58. Another important factor in this case is balancing the punitive outcome of any penalty against the important consideration of the Practitioner's rehabilitation. On this score, there was evidence that the Practitioner is a skilled and dedicated physiotherapist. Furthermore, the Tribunal had evidence before it from [ ], who is currently providing supervision for the Practitioner, from [ ] who is a colleague of the Practitioner and from three character referees (all current or former patients of the Practitioner) which was very supportive of him, and which suggests that there is every prospect of him going

on to provide quality professional services to his community. There is also the evidence which the Practitioner himself gave of his ongoing commitment to the profession.

59. In those circumstances, the issue of rehabilitation becomes important. We have considered how we can deal with this matter in a way which reflects the seriousness of the Practitioner's departure from proper professional standards, discharges the responsibilities we owe to the public and the profession, and at the same time facilitates the Practitioner's rehabilitation.

60. We have also given consideration to the principle of consistency.

61. In this regard, Ms Schmidt-McCleave and Mr Stevenson canvased the cases already cited, and others.

62. None of these cases appear to us to be directly comparable with the present. For a start, the conduct of the practitioners involved appears, in all of the cases to which counsel referred, to have taken place in the context of an extant formal clinical relationship. Additionally, all appear to have involved unwanted sexual advances at one level or another by the practitioner. Whilst the present case involves a full sexual relationship, we reiterate that the Practitioner's evidence that this was consensual is unchallenged.

63. In the end, we have concluded that none of the cases referred to by counsel, or of which the Tribunal is independently aware, are sufficiently comparable to the present case to oblige us to take any particular course in terms of the imposition of a penalty.

64. Ms Schmidt-McCleave submitted that there were a number of aggravating features of this case. One, she submitted, was the relative ages of the Practitioner and the patient. In this context, she described the patient as *"... a vulnerable [ ] year-old single mother of two young children..."*. As far as the Tribunal is aware there was no evidence suggesting that the patient was especially vulnerable, other than the vulnerability arising

out of the situation itself. Ms Schmidt-McCleave also referred to the text exchanges between the Practitioner and the patient. We have already said that those we have seen are comparatively innocuous. She mentioned the fact that the Practitioner initiated personal contact. She emphasised the short passage of time between the conclusion of the formal clinical relationship and the sexual relationship. And, finally she referred to the Practitioner's refusal to acknowledge the inappropriateness of his actions throughout the Director's investigation and before the Tribunal, which she submitted *"… demonstrates an acute lack of insight into the seriousness of his behaviour and a misunderstanding of his professional obligations…"*.

65. The last of those points is a difficult one. Given the Tribunal's conclusions as to liability, it might be said that there is something in Ms Schmidt-McCleave's submission that the Practitioner has demonstrated a lack of insight. On the other hand, it should be acknowledged that, as Mr Stevenson submitted, a Practitioner is entitled to defend an accusation of professional misconduct, and the fact that such an accusation is defended cannot – in and of itself – be treated as an aggravating aspect of the case affecting penalty.

66. In the end, we have reached the conclusion, having regard to our responsibilities to the public and the profession, and having regard also to what we perceive to be the genuine aggravating and mitigating features of this case, that the least restrictive outcome which we can impose in this case is to censure the Practitioner for his professional misconduct, fine him $5,000 in order to mark the seriousness of the case, make an order for the continuation of the conditions imposed by the Physiotherapy Board of New Zealand (which appear to us to have been carefully thought through) and restrict his research involving female patients until such time as he complies with certain condition we are proposing to impose on his practising certificate, focussing on maintaining proper professional boundaries. Those penalties appear to us to be the least restrictive ones

that we can impose, adequately to mark the seriousness of Practitioner's departure from proper professional standards, discharge our primary responsibilities to the public and the profession, balance their punitive effect against the important objective of the Practitioner's rehabilitation and be broadly consistent with the penalties imposed in other cases. In other words, we are satisfied that that outcome is one which is fair, reasonable and proportionate (again, see *Roberts*).

Costs

67. The Director seeks costs.

68. There is no reason why she should not have her costs in this case, and we will order that the Practitioner pay 40% of the Tribunal's costs and 40% of those of the Director.

Suppression

69. Name suppression is a difficult issue in this case. The patient is of course entitled to name suppression.

70. Ms Schmidt-McCleave addressed the key principles in a helpful way, but it is unnecessary for the Tribunal to rehearse those.

71. The Practitioner seeks name suppression. Without putting too fine a point on it, the Tribunal would not be inclined to make an order suppressing the Practitioner's name, were it not for one important consideration which both Ms Schmidt-McCleave and Mr Stevenson referred to in their submissions, which is the practical impact of the publication of the Practitioner's name on the patient. As already recorded, the Practitioner and the patient both live in a small provincial town and are both members of the same [ ] community. If the Practitioner's name were to be published, the reality is that residents of that town and members of the [ ] community would be able to identify

the patient, and the Tribunal perceives that that would result in real anxiety and embarrassment for her. In recognition of that the Director takes a neutral position in relation to the Practitioner's application.

72. On that basis, the Tribunal concludes in terms of s 95(2)(d) of the Act that it is desirable that it prohibit the publication of the Practitioner's name. Putting the matter another way, the Tribunal has concluded that the presumed public interest in the open administration of justice must give way to the private interest of the Practitioner's former patient in maintaining anonymity.

Conclusion

73. The Tribunal's formal orders are as follows:

73.1 The Tribunal censures the Practitioner for his serious misconduct;

73.2 The Tribunal orders the Practitioner to pay a fine of $5,000;

73.3 The Tribunal orders the Practitioner to continue the supervision regime imposed by the Physiotherapists Board, not to treat female patients and not to undertake formal research involving direct contact with female participants until such time as he has complied with the conditions imposed in paragraph 73.4 below;

73.4 The Tribunal imposes the following conditions on the Practitioner's Practising Certificate:

Within six months of the date of this decision, the Practitioner, at his own expense, is successfully to complete a continuing professional development course to be approved by the Physiotherapy Board of New Zealand, the focus of which is proper boundaries between health professionals and their patients.

73.5 The Tribunal orders the Practitioner to pay the sum of $7,519 by way of a contribution to the Tribunal's costs in this proceeding;

73.6 The Tribunal orders the Practitioner to pay the sum of $13,154 by way of a contribution to the Director's costs in this proceeding;

73.7 Pursuant to s95 of the Act the Tribunal makes an order suppressing the Practitioner's name, the name of his former patient who features in the Notice of Charge, their places of residence and work, and any other identifying details;

73.8 Details of the decision other than the information which has been suppressed are to be published on the Tribunal's website and in the newsletter of the Physiotherapy Board.

DATED at Wellington this 19th day of August 2016

……..

Kenneth Johnston QC
Chair
Health Practitioners Disciplinary Tribunal