NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

Level 13, 2-6 Gilmer Terrace, Wellington 6011
PO Box 10509, The Terrace, Wellington 6143, New Zealand
Telephone: 64 4 381 6816 Facsimile: 64 4 381 6770
Email: kdavies@hpdt.org.nz
Website: www.hpdt.org.nz

DECISION NO	893/Med16/372P
IN THE MATTER	of disciplinary proceedings under the Health Practitioners Competence Assurance Act 2003 ("the Act")
BETWEEN	**A PROFESSIONAL CONDUCT COMMITTEE** appointed by the MEDICAL COUNCIL OF NEW ZEALAND **Applicant**
AND	**DR KIM FRANCIS BRABANT** of Auckland, registered Medical Practitioner **Practitioner**

HEARING held at Auckland 20 February 2017

TRIBUNAL:	Ms M J Dew (Chair), Dr K Wallis, Dr P Thompson, Dr B Bond and Ms Amanda Kinzett (Members) Ms K Davies (Executive Officer) Ms H Hoffman (Stenographer)
COUNSEL:	Ms W Aldred and Mr E Foxall for Professional Conduct Committee No appearance for the practitioner.

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Introduction

1. Dr Brabant faces one charge of professional misconduct under s100(1)(a) and/or (b) of the Health Practitioners Competence Assurance Act 2003 ("the Act"). The particulars of the Charge are set out in full in Appendix A to this decision.

2. The Charge alleges that between 2012 and 2016, Dr Brabant failed to comply with the New Zealand Medical Council's requirements for continuing professional development (CPD), its recertification requirements through "Inpractice" and that he made two false entries in his Inpractice portfolio in 2014. The Professional Conduct Committee (the PCC) allege that these continued failures and the false entries, demonstrate a deliberate disregard for professional responsibilities, and amount, either separately or cumulatively, to professional misconduct.

3. Dr Brabant did not appear or otherwise participate in the Tribunal hearing. The Tribunal is satisfied that he was served with the Notice of Charge and that he has had an opportunity to participate in the hearing. Prior to the hearing, Dr Brabant advised the Tribunal that he did not wish to take part in the proceeding.

4. The PCC called evidence from the following witnesses:

   (a) Ms Helen Vercoelen, Team Manager of the Practising Certificates team at the Medical Council of New Zealand.

   (b) Mr Anthony Fraser, Manager of the Inpractice recertification programme.

   (c) Dr Sivaprakash Appanna, a general practitioner who worked with Dr Brabant in 2013 and 2014. The Tribunal agreed to admit Dr Appana's evidence by way of affidavit. He currently resides in Australia.

5. The PCC also produced a Bundle of Documents admitted into evidence, which includes Dr Brabant's registration details, the Medical Council discussion paper (dated October 2015) relating to Dr Brabant's

recertification conduct and Dr Brabant's responses to Medical Council recertification concerns between 2014 and 2015.

Background facts

6. Dr Brabant obtained a MB ChB from the University of Auckland in 1992 and became registered in the general scope of practice in January 1993. He previously worked in Australia but, since 2012, has practiced in Auckland. This mainly involved working with the Manly Medical Centre and Onewa Doctors.

7. As from 1 September 2014, a condition was placed on Dr Brabant's scope of practice under s92(2) of the Act, requiring him to provide satisfactory evidence of on-going participation in the Inpractice recertification programme as and when requested to do so by the Medical Council.

8. As from 22 October 2015, an additional condition was placed on Dr Brabant's scope of practice under s92(2), requiring him to complete his recertification requirements on a pro-rated quarterly basis, rather than on the standardised annual basis.

9. On 19 April 2016, Dr Brabant was advised he was suspended from practising by the Medical Council as a result of his failed recertification requirements. This suspension remains in effect.

Evidence for the PCC

10. Ms Vercoelen is the Team Manager of the Practising Certificates team at the Medical Council of New Zealand. She gave evidence on the Medical Council's CPD and recertification requirements for medical practitioners.

11. Ms Vercoelen stated that the aim of these requirements is to ensure practitioners are competent to practice medicine. "Inpractice" is a Medical Council approved recertification programme provider for general practitioners in New Zealand. All GP's who have elected to use the Inpractice certification system are required to record their completion of CPD activities on-line. The Medical Council CPD year for Dr Brabant runs from 1 September to 31 August of the following year.

12. In her evidence, Ms Vercoelen detailed the history of Dr Brabant's non-compliance with Inpractice and CPD requirements between 2012 and 2016. She produced a significant amount of correspondence between the Medical Council and Dr Brabant during this period. The correspondence shows that the Medical Council had written to Dr Brabant on a number of occasions, in an attempt to ensure his compliance with CPD/recertification requirements.

13. It was clear to the Tribunal that the Medical Council had made considerable efforts to engage with, and assist, Dr Brabant to achieve compliance with his Inpractice requirements. Ms Vercoelen concluded her evidence by stating that Dr Brabant was one of a very small minority of doctors who consistently fail to comply with recertification requirements and that Dr Brabant seems unwilling to do so, despite the numerous opportunities and warnings about the consequences.

14. Mr Anthony Fraser is the manager of the Inpractice recertification programme. He explained the recertification requirements, and consequences of non-compliance, for doctors, and produced the Inpractice guide, which set those matters out in detail.

15. In summary, Dr Brabant was required to complete the following during each CPD year:

    (a) A professional development plan;

    (b) 20 hours of continuing medical education;

    (c) 10 hours of peer review;

    (d) One audit of medical practice;

    (e) Four meetings with the nominated collegial relationship provider (face-to-face, teleconference or videoconference).

16. Dr Brabant was also required to complete:

    (a) An online quiz on key areas of competence (the Essentials quiz) once every three years;

    (b) Feedback on his practice, once every three CPD cycles; and

(c) A regular practice review visit by an Inpractice reviewer.

17. Mr Fraser discussed the consequences of non-compliance with recertification requirements. Generally, any shortfall in completing CPD requirements is added to the practitioner's requirements for the next CPD cycle. The exception is collegial relationship meetings – if a practitioner fails to undertake the required number in a CPD year, the shortfall is not carried on to the next year, but instead the practitioner is required to complete the next years' meetings on a scheduled basis. Failure to complete requirements two years in a row, results in formal notification of unsatisfactory participation to the Medical Council.

18. Mr Fraser also stated that practitioners must pay an annual fee of $1,380 to Inpractice and, if payment is not made, are given up to three reminders and eventually suspended from Inpractice, preventing the practitioner from participating in the programme.

19. In evidence, Mr Fraser's confirmed that Dr Brabant had failed to pay his Inpractice fees as alleged. Mr Fraser produced a significant amount of email correspondence with Dr Brabant relating to requests for payment of Inpractice fees over the period 2012 to 2016.

20. Set out below, is a summary history of both the non-payment of Inpractice fees and failure to complete other CPD requirements.

2012 – 2013 CPD year

21. Dr Brabant failed to pay the Inpractice fee for the 2012-2013 year by the due date of 20 September 2012. As a result, on 4 April 2013 he was suspended from Inpractice and the Medical Council subsequently proposed to place conditions on his scope of practice.

22. Dr Brabant did not complete any of the mandatory requirements for recertification during this period. In particular, he failed to complete the required 20 hours of CME, 10 hours of peer review, audit of his medical practice/clinical audit and three, out of the required four, collegial relationship meetings.

2013-2014 CPD year

23. Dr Brabant failed to pay his Inpractice fee for the 2013-2014 year by the due date of 20 September 2013. His fee from the 2012-2013 year was also still outstanding.

24. On 14 October 2013, the Medical Council granted Dr Brabant an extension to pay the 2012-2013 fee, resume enrolment with Inpractice and comply with his recertification requirements, before the Council considered imposing conditions on his practice. Dr Brabant paid the 2012-2013 fee in November 2013 and his suspension from Inpractice was lifted, his account reactivated and the proposal to impose conditions on his practice revoked.

25. On 21 February 2014, Dr Brabant was suspended from Inpractice due to non-payment of the 2013-2014 fee and the Medical Council subsequently proposed to impose conditions on Dr Brabant's scope of practice. That proposal was revoked in March 2014, when Dr Brabant advised Inpractice he had brought his recertification requirements up to date and would be sending payment for his fee.

26. However, on 11 June 2014, the Medical Council imposed conditions on Dr Brabant's scope of practice because he had still not paid the 2013-2014 fee. Dr Brabant subsequently paid the fee on 13 August 2014, and his suspension from Inpractice was lifted.

27. On 18 August 2014, the Medical Council proposed to suspend Dr Brabant's registration because he had not entered his collegial relationship meetings into Inpractice. The proposal was revoked later that month after Dr Brabant entered his collegial relationship meetings into Inpractice. Before the Tribunal, the PCC provided evidence that one of those meetings did not actually occur.

28. During this CPD period, Dr Brabant did not complete the required clinical audit.

2014-2015 CPD year

29. On 30 October 2014, the Medical Council proposed to suspend Dr Brabant's registration because he had not completed a clinical audit (which was required for recertification) for two consecutive years.

30. On 10 December 2014, the Medical Council resolved to suspend Dr Brabant's registration, effective 22 December 2014. The suspension was lifted on 22 December 2014, after Dr Brabant entered his outstanding recertification requirements into Inpractice.

31. However, on 4 June 2015 the Medical Council proposed to impose further conditions on Dr Brabant's practice after learning that he had not complied with minimum certification requirements. That month, the Medical Council also discovered two of the collegial meetings Dr Brabant had recorded in Inpractice had not occurred. The Medical Council therefore proposed to suspend Dr Brabant's registration.

32. Over this CPD period Dr Brabant only completed six out of the required 10 hours of peer review and recorded only one out of the required four collegial relationship meetings. The PCC provided evidence before the Tribunal that the recorded meeting did not actually occur.

2015-2016 CPD year

33. Dr Brabant failed to pay his Inpractice fee for the 2015-2016 year by the due date of 20 September 2015. On 14 January 2016, he was suspended from Inpractice as a result.

34. On 22 October 2015, the Medical Council resolved to grant Dr Brabant a practising certificate but imposed further conditions on his practice, requiring him to comply with a structured recertification plan. He did not comply with this plan and therefore did not comply with his recertification requirements and the conditions on his practice.

False entries in Inpractice

35. In relation to Particular 3 of the charge, the PCC presented affidavit evidence from Dr Appanna. Dr Appanna's affidavit states that between

2006 and 2014, he owned Onewa Road Doctors in Auckland. In March 2013, Dr Brabant commenced work as a long-term locum GP at Onewa Doctors. As from March 2013, Dr Appanna worked in Australia but he visited Onewa Road Doctors every four to six weeks and sometimes worked shifts for Dr Brabant when he took time away from the practice. Dr Appanna sold Onewa Road Doctors in July 2014.

36. His affidavit states that during his professional relationship with Dr Brabant, he had no concerns about Dr Brabant's ability and competence. He confirms he did provide collegial support to Dr Brabant while he worked at Onewa Doctors, which involved reviewing patient notes and discussing any difficult cases. This collegial support by Dr Appanna ended upon his sale of the practice in July 2014.

37. Dr Appanna responded to Dr Brabant's claims that they had five collegial relationship meetings in 2014. Dr Appanna acknowledged that it was probable three of those meetings (in March, May and June 2014) occurred, as claimed by Dr Brabant. However, he denies two telephone conferences occurred in August and September 2014, as he had sold the practice by that date and is clear that their professional and collegial relationship ended at that date.

Dr Brabant's responses to the Medical Council

38. While Dr Brabant did not appear before the Tribunal, his correspondence with the Medical Council and Inpractice during the relevant periods, is before the Tribunal and has been considered.

39. The Tribunal notes that, in general, Dr Brabant's responses to Inpractice and the Medical Council were sporadic. Dr Brabant appears not to have acknowledged much of the correspondence sent to him by the Medical Council. There are also some emails in which Dr Brabant made brief, general excuses for his non-compliance, such as being busy, being on vacation, forgetting or being unaware of deadlines or believing he did not need to participate in Inpractice.

40. Dr Brabant identified his financial constraints as the main reason for non-compliance with the Inpractice requirements. He stated his difficulty in finding full time work after returning from Australia, resulted in a reduction in income.

Inpractice did offer him the opportunity to complete a low income declaration, but there is no evidence that this was ever completed by him.

41. Dr Brabant did acknowledge in correspondence with the Medical Council that Dr Appanna had sold his practice in July 2014. His correspondence suggests that in fact he had the later meetings with the doctor that purchased the Onewa Doctors practice. He stated that he is certain the meetings recorded in Inpractice took place around the dates he stated, though he may be mistaken as to the exact dates. He also stated he did not record additional meetings he had with the new owner of the practice as he believed he had already recorded enough meetings. Dr Brabant acknowledged in his correspondence that he had not updated the name of his collegial relationship provider to the new doctor, as he knew he would not stay much longer at that practice.

42. Dr Brabant also referred to difficulties finding a collegial relationship provider. He stated that all the doctors at his current practice had refused this role and that he did not know many other doctors in New Zealand. In September 2015, Dr Brabant again raised his difficulties in finding a collegial relationship provider because of other doctors' unwillingness to mix the role with a business relationship, and the fact he had lost contact with colleagues when he moved to Australia. He also stated he would make enquires with Australian practitioners, but was told by Ms Vercoelen the provider would need to be a New Zealand doctor.

43. The Tribunal has taken account of these explanations as best it can during the course of the hearing. However, we note the limited weight to be ascribed to these explanations given the lack of other direct evidence from Dr Brabant.

Relevant law under HPCA Act

Professional misconduct

44. The Tribunal and the Courts have considered the term "professional misconduct" under s100 (1)(a) of the Act on numerous occasions. In *Collie v Nursing Council*, [2000] NZAR 74, Gendall J states at paragraph [21]:

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

45. The Tribunal has also consistently adopted common usage definitions of "malpractice" as being:

> *"the immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct";*[1] and *"Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer… a criminal or illegal action: common misconduct."*[2]

46. Under s100(1)(b) of the Act , the Tribunal must also consider whether the alleged conduct has or is likely to bring discredit on the medical profession. In *Collie* at [28], Gendall J discussed the meaning of this phrase which is substantially unchanged from the previous legislation, and stated:

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

1 Collins English Dictionary, 2nd Edition.
2 The New Shorter Oxford Dictionary, 1993 Edition.

reputation and good-standing of the nursing profession was lowered by the behaviour of the nurse concerned."

47. There is a well-established two stage test for determining professional misconduct set out in previous cases of the Courts and this Tribunal.[3] The two key steps involved in assessing what constitutes professional misconduct are:

(a) First, an objective analysis of whether the practitioner's acts or omissions can reasonably be regarded by the Tribunal as constituting malpractice, negligence or otherwise bringing, or likely to bring, discredit on the profession; and

(b) Secondly, the Tribunal must be satisfied that the practitioner's acts or omissions require a finding that a disciplinary sanction is warranted for the purposes of protection of the public or maintaining professional standards or punishing the practitioner.

48. In *McKenzie v Medical Practitioners Disciplinary Tribunal*,[4] Venning J confirmed the test for professional misconduct is a two-stage test requiring an objective assessment by the Tribunal at each stage. This has also been the approach adopted by this Tribunal under the current HPCA Act. The often-cited passage from *McKenzie* is at [71]:

> *"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*

[3] *McKenzie v MPDT* [2004] NZAR 47 at [71] and *PCC v Nuttall* (8Med04/03P).
[4] *McKenzie v MPDT* [2004] NZAR, 47

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."

Burden and standard of proof

49. The burden of proof in the present case is on the PCC. This means that it is for the PCC to establish that the practitioner is guilty of professional misconduct. The PCC must produce evidence that establishes the facts on which the charge is based to the appropriate standard of proof.

50. The standard of proof is the civil standard of proof; that is proof which satisfies the Tribunal that on the balance of probabilities the particulars of the charge are more likely than not. The Tribunal must apply a degree of flexibility to the balance of probabilities taking into account the seriousness of the allegation, and the gravity of the consequences flowing from a particular finding.[5]

51. The Tribunal is also required to consider each particular of the Charge independently and then cumulatively, in the context of determining whether the overall charge is established.

Specific provisions in the HPCA Act on recertification

52. Section 41(1) of the Act empowers the Medical Council to set or recognise recertification programmes "*For the purpose of ensuring that health practitioners are competent to practise within the scopes of practice in respect of which they are registered*". The rest of that section then sets out more detail about what a recertification programme may require.

53. Section 43 of the Act deals with the consequences of failure to complete the requirements of a recertification programme. The Medical Council can make an order altering the services the practitioner is permitted to perform,

[5] *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1 followed by this Tribunal in *PCC v Karagiannis* 181/Phar08/91P.

including conditions it considers appropriate or ordering suspension of the practitioner's registration. Such orders remain in effect until the practitioner has satisfied the requirements of the recertification programme.

54. However, s43(5) provides the following:

> *"The failure of a health practitioner to satisfy the requirements of any competence programme or recertification programme that applies to the health practitioner is not, of itself, a ground for taking disciplinary action under Part 4 against that health practitioner."*

55. The PCC submitted that s43(5) is intended to protect health practitioners who make genuine and honest mistakes and oversights, in order to provide an opportunity to rectify any non-compliance. However, the phrase "*is not, of itself, a ground for taking disciplinary action."* indicates some additional feature is required to warrant disciplinary sanction, such as a repeated and flagrant failure to comply with recertification requirements or dishonesty.

56. The PCC referred the Tribunal to a number of previous decisions involving midwives in which, among other things, some of the key allegations related to failure to engage with and complete recertification requirements. In those cases, the Tribunal made findings of professional misconduct against the practitioner, in large part due to the failure to comply with recertification requirements.[6] The PCC also referred to *Dr U*,[7] in which the Tribunal held the practitioner's act of making false declarations on her practising certificate application that she was complying with recertification requirements constituted professional misconduct. In that case, the Tribunal made the following comments at paragraph 92:

> *"What is significant is the maintenance of standards and protection of the public. Standards can only be maintained in the case of medical practitioners (and indeed other health*

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6 *Tolland* 325/Mid10/146P; *Mason* 465/Mid12/204P; *Flavell-Neville* 572/Mid13/253P; *Laufiso* 606/Mid13/254P.

7 699/Med14/298P.

professionals) if forms, such as applications for APCs are accurately and comprehensively completed."

57. We accept the PCC's interpretation of s43(5). A practitioner may be sanctioned for failure to comply with recertification requirements where there has been some special feature of the non-compliance that renders it particularly serious, such as repeated and flagrant non-compliance or dishonesty.

58. The Tribunal was also referred to the 2008 and 2013 versions of the Medical Council's publication, *Good Medical Practice: A guide for doctors.* The opening comment of both editions refer to good doctors as ones who "*keep their knowledge and skills up to date*".

59. Both versions of the guide relevantly state that doctors are to "*work with colleagues and patients to maintain and improve the quality of your work and promote patient safety*", which includes a requirement to "*take part in clinical audit, peer review and continuing medical education*" as well as to "*respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary*".[8] The guide provides that doctors are to keep knowledge and skills up to date, including taking part in education/professional development activities.[9] The guide also emphasises honesty and trustworthiness.

Tribunal consideration of the Charge

Particular 1 – Failure to comply with Inpractice CPD and registration, 2012 to 2016

60. There are four separate sub particulars which must be considered to determine whether this particular is established, including the allegations of:

(a) Failure to complete education, peer review, audit and collegial relationship CPD activities, between 1 September 2012 and 1 September 2013;

[8] The 2008 Guideline 72, is in substantially similar terms in the 2013 Guideline 82.
[9] 2008 Guideline 73 and 2013 Guideline 83.

(b) Failure to complete audit and collegial relationship CPD activities, between 1 September 2013 and 1 September 2014;

(c) Failure to complete peer review and collegial relationship CPD activities, between 1 September 2014 and 1 September 2015; and

(d) Failure to maintain registrations with Inpractice for the periods, April to October 2013, February to August 2014 and January to April 2016.

61. The Tribunal is satisfied on the evidence provided by the PCC sub-particulars (a) to (d) are all established. Dr Brabant did fail to complete each of these CPD requirements and therefore failed to comply with the Medical Council's recertification requirements through Inpractice. It is also clear that he failed to pay his Inpractice fees in a timely manner and this resulted in his inability to maintain registration with Inpractice.

62. The Tribunal has determined that this conduct amounts to both negligence and conduct that is likely to bring discredit to the medical profession.

Particular 2 – Deliberate disregard for recertification requirements, 2012 to 2016

63. This particular requires the Tribunal to consider whether there is sufficient evidence to establish that between September 2012 and April 2016, Dr Brabant demonstrated a deliberate disregard towards his recertification requirements by his repeated failure to complete CPD activities and/or provide adequate explanations to the Medical Council.

64. The Tribunal is equally satisfied that this particular is established. The evidence of repeated failure to comply over more than three years, has been presented to the Tribunal. There were ample opportunities for Dr Brabant to remedy the situation over that period. Dr Brabant was given warnings and opportunities to rectify his non-compliance. Many of these opportunities and reminders, by both Inpractice and the Medical Council, were either ignored or responded to with excuses or vague assurances that matters would be remedied when they were not. The length of time that this conduct continued leads us to conclude that this amounts to a deliberate

disregard towards Dr Brabant's CPD responsibilities as a medical practitioner.

65. This conduct also amounts to both negligence and conduct that is likely to bring discredit to the medical profession.

Particular 3 – False entries in Inpractice, August and September 2014

66. Finally, the Tribunal is satisfied that Dr Brabant did make false entries in his Inpractice portfolio, recording that he had attended collegial meetings by phone with Dr Appanna on 25 August 2014 and 10 September 2015.

67. The Tribunal accepts the undisputed evidence of Dr Appanna that after he sold the Onewa practice in July 2014, he ceased any collegial relationship with Dr Brabant. The entries are therefore false and we are satisfied that Dr Brabant was at the least highly reckless about the accuracy of these records. This conduct also amounts to both negligence and conduct that is likely to bring discredit to the medical profession.

Is the established conduct sufficient serious to amount to professional misconduct?

68. The extended history of non-compliance makes this case exceptional. As Ms Vercoelen notes in her evidence, this type of conduct is only typical of a small minority of medical practitioners. The conduct cannot be explained by simple oversight, a period of ill health or a lapse of judgment. The conduct has been sustained over such a period and been the subject of so much communication from the Medical Council and Inpractice, that it can only be viewed as deliberate by Dr Brabant.

69. The failure to attend to CPD and recertification requirements over such a lengthy period, does raise serious public safety and professional standards concerns. The public and the profession are entitled to expect that registered health practitioners will diligently attend to their CPD activities and comply with all recertification requirements. Ultimately, this Tribunal must take disciplinary action once a practitioner has been given a reasonable opportunity to come into compliance.

70. This case is one in which there are additional features, beyond mere noncompliance under s43(5) of the Act, that justify disciplinary sanction.

Penalty

71. The Tribunal, once satisfied a charge is established, must go on to consider whether it is appropriate to order any penalty under s101 of the Act.

72. The Tribunal adopts the sentencing principles as contained in *Roberts v Professional Conduct Committee*[10] in which Collins J identified eight factors as relevant, whenever the Tribunal is determining an appropriate penalty. In particular, the Tribunal is bound to consider what penalty:

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

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

(c) punishes the practitioner;

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

(e) promotes consistency with penalties in similar cases;

(f) reflects the seriousness of the misconduct;

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

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

73. The PCC submit there are a number of aggravating factors, present in Dr Brabant's case:

(a) Dr Brabant's awareness of recertification requirements and the repeated requests made of him to comply with requirements between September 2012 and April 2016;

(b) The risk to the public when doctors do not complete their CPD and recertification;

[10] [2012] NZHC 3354 at [44]-[51].

(c) The dishonesty of Dr Brabant's recording of collegial relationships meetings, which did not occur with Dr Appanna; and

(d) Dr Brabant's failure to cooperate with the PCC investigation or appear at the Tribunal hearing.

74. The PCC submits there are no, or limited, mitigating factors in this case. The PCC noted Dr Brabant's references to his financial circumstances, but emphasised that the Tribunal had no evidence of his current financial circumstances.

75. The PCC seeks a penalty to include a condition as to supervision on Dr Brabant's scope of practice for 36 months, censure and a fine of $5,000. The PCC submitted supervision was appropriate as it would ensure protection of the public whilst allowing rehabilitation. The PCC also submitted censure and the imposition of a fine would have a deterrent effect and send an appropriate message to the profession.

76. The PCC referred to a number of Tribunal determinations in its submissions on penalty to demonstrate the type of penalties awarded in similar cases.[11]

77. The Tribunal accepts the PCC's formulation of the aggravating factors in this case. It is of particular concern to the Tribunal that the period of non-compliance was so lengthy and that ultimately, Dr Brabant resorted to falsely recording two collegial relationship meetings to attempt to satisfy his CPD requirements.

78. Dr Brabant has referred in correspondence to financial difficulties playing a part in his non-compliance. However, it is not possible to assess this possible mitigation, without any evidence of Dr Brabant's financial circumstances at the time, or now.

79. It is also concerning that Dr Brabant has chosen not to appear before the Tribunal and explain his conduct. In the circumstances, we agree with the PCC that a period of supervision is appropriate to ensure the protection of

[11] *Tolland* 325/Mid10/146P; *Mason* 465/Mid12/204P; *Flavell-Neville* 572/Mid13/253P; *Laufiso* 606/Mid13/254P; *Dr U* 699/Med14/298P.

public safety and that professional standards are maintained, while allowing for rehabilitation of the practitioner.

80. The appropriate penalty, that is both fair and proportionate overall, is as follows:

(a) Censure;

(b) A condition of supervision to be imposed on the practitioner, for the period of 18 months, as from the date Dr Brabant recommences practice; and

(c) A fine to be paid by Dr Brabant of $3,000.

Costs

81. The PCC also seeks an order for 30% of costs against Dr Brabant, for the following reasons:

(a) It was not reasonable for the profession to bear the entire cost of the prosecution;

(b) Dr Brabant's decision not to participate in the Tribunal's process meant there was no agreed summary of facts and the PCC was put to the cost of proving all elements of the charge at the hearing; and

(c) Dr Brabant has not provided any evidence as to his ability to pay costs.

82. The Tribunal has been informed by the PCC that its costs are $32,071. The Tribunal costs, as estimated and produced at hearing amount to $20,991.

83. The Tribunal records that it has used as a starting point that a health practitioner will generally be expected to contribute 50% of the actual and reasonable costs of the Tribunal and PCC.[12] In the present case, the Tribunal has determined that 30% is the appropriate contribution to costs. While the hearing was not defended by Dr Brabant, he may not have been aware that his lack of engagement in the hearing had the effect of putting the PCC to additional cost by having to call evidence to satisfy the Tribunal.

[12] *Coorey v PCC*, AP 23/94, 14 September 1995, Doogue J.

We have applied some discount to the starting point on costs but agree that a 30% costs contribution by Dr Brabant is reasonable. The costs ordered to be paid are therefore $15,918.30 in total, being a $6,297 contribution to the Tribunal's costs and a $9,621.30 contribution to the PCC's costs.

Orders of the Tribunal

84. The Orders of the Tribunal are set out below.

(a) The Tribunal finds that the charge of professional misconduct laid against the practitioner is established under both s100(1)(a) and (b) of the Act. The three particulars of the charge are each established and on a cumulative basis only they amount to professional misconduct;

(b) The Tribunal censures the practitioner under s101(1)(d) of the Act;

(c) A supervision condition is placed on the practitioner's practice under s101(1)(c) of the Act, that he must for the period of 18 months, as from the date the practitioner re-commences practice in the following terms:

"Dr Brabant should practise under professional supervision for a period of 18 months following his return to practice. The supervisor and the requirements of supervision should be determined by the Medical Council, with the supervisor reporting back to the Medical Council quarterly, or as otherwise determined by the Medical Council. The focus of the supervision is to be on Dr Brabant's engagement and participation in his recertification requirements, professional responsibility, and any other matter or matters that the Medical Council considers appropriate. Dr Brabant should meet the cost of this supervision."

(d) The practitioner is ordered to pay a fine of $3,000 to the Tribunal under s101(1)(e) of the Act;

(e) The practitioner is further ordered to pay a contribution to the costs of the PCC and the Tribunal; being $9,621.30 to the PCC and $6,297 to the Tribunal under s101(f) of the Act;

(f) In accordance with s157 of the Act, the Tribunal directs the Executive Officer to publish a copy of this decision and a summary of it on the Tribunal website and to arrange for a summary of this decision to be published in the New Zealand Medical Journal.

DATED at Auckland this 13th day of June 2017

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MJ Dew, Chairperson
Health Practitioners Disciplinary Tribunal

APPENDIX A

PARTICLARS OF THE CHARGE

Pursuant to section 81(2) of the Act the Committee charges that Dr Kim Francis Brabant:

1) Failed to comply with the Medical Council's recertification requirements by:

   a. Between 1 September 2012 and 1 September 2013, failing to complete the following continuing professional development ("CPD") activities required by his recertification programme provider "Inpractice":

      i. Continuing Medical Education (20 hours); and/or

      ii. Peer Review (10 hours) and/or

      iii. Medical Practice Audit; and/or

      iv. Meetings with Collegial Relationship Provider (4 meetings); and/or

   b. Between 1 September 2013 and 1 September 2014, failing to complete the following CPD activities required by Inpractice:

      i. Medical Practice Audit; and/or

      ii. Meetings with Collegial Relationship Provider (4 meetings); and/or

   c. Between 1 September 2014 and 1 September 2015, failing to complete the following CPD activities required by Inpractice:

      i. Peer Review (10 hours); and/or

ii. Meetings with Collegial Relationship Provider (4 meetings); and/or

d. Failing to maintain registration with Inpractice for the following periods:

i. 4 April 2013 to 31 October 2013; and/or

ii. 21 February 2014 to 13 August 2014; and/or

iii. 14 January 2016 to 18 April 2016; and/or

2) Between on or about 1 September 2012 and 18 April 2016, demonstrated deliberate disregard towards compliance with his recertification requirements by repeatedly failing to:

a. complete the CPD activities required by Inpractice since his enrolment on 1 September 2012; and/or

b. provide the Medical Council with an adequate explanation for his failure to comply with his recertification requirements despite reminders by Inpractice and the Medical Council of these requirements; and/or

3) Made false entries in his Inpractice portfolio, recording that he had attended collegial meetings with Dr Sivaprakash Appanna on the following dates, when Dr Appanna was in Australia and had ceased to provide collegial support to Dr Brabant:

a. On 25 August 2014, by telephone; and/or

b. On 10 September 2014, by telephone.

and the conduct alleged above either separately and/or cumulatively amounts to professional misconduct under section 100(1)(a) and/or (b) of the Act.