MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 24463, Manners Street, Wellington • New Zealand
13th Floor, Mid City Tower • 139-143 Willis Street, Wellington
Telephone (04) 802 4830 • Fax (04) 802 4831
E-mail mpdt@mpdt.org.nz
Website www.mpdt.org.nz

DECISION NO: 247/03/99D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **IAN LINDSAY BREEZE** medical practitioner of Tauranga

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Mrs J Courtney, Dr J C Cullen, Dr R W Jones,

Associate Professor Dame N Restieaux (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Tauranga on Monday 25, Tuesday 26 and Wednesday 27 August 2003

APPEARANCES: Ms M McDowell and Mr J Tamm for the Director of Proceedings

Mr H Waalkens and Ms C Garvey for Dr I L Breeze.

Introduction

1. Dr Breeze is a general surgeon. He practises in Tauranga. On 26 March 2003 the Director of Proceedings[1] laid a disciplinary charge against Dr Breeze. The details of the charge are explained in paragraphs 8 and 9 of this decision.

2. The charge was heard in Tauranga on 25, 26 and 27 August. After the conclusion of the evidence and submissions from counsel for the parties the Tribunal retired to consider its decision. Later on the evening of 27 August the Tribunal advised that it found three of the particulars of the charge proven and that in respect of each of the three particulars Dr Breeze was guilty of professional misconduct. The Tribunal sought submissions on penalty and whether or not its interim orders granting Dr Breeze name suppression should be lifted. Counsel for Dr Breeze advised there were further matters he wished to explore before making submissions on penalty and name suppression. In those circumstances the Tribunal sought written submissions on penalty and name suppression from the Director of Proceedings by 3 September 2003 and submissions on those topics from counsel for Dr Breeze by 8 September 2003. The Tribunal has now received and considered the submissions filed by both parties.

3. Before the commencement of the hearing on 25 August the Tribunal received applications to suppress publication of the names of the hospitals identified in the evidence. The Tribunal heard submissions from Mr M Beech on this issue. Mr Beech's application became redundant because of the effect of the Tribunal's order extending its earlier order

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[1] Designated under the Health and Disability Commissioner Act 1994.

suppressing publication of Dr Breeze's name and anything that could identify him as a Tauranga practitioner until the Tribunal gave its decision in relation to the charge. On the evening of 27 August the Tribunal heard further submissions from Mr Beech on whether or not an order should be made prohibiting publication of anything which could identify the hospitals in question. At that stage the applications in relation to the various hospitals were extended to include employees of those hospitals who gave evidence to the Tribunal.

4. The Tribunal has determined Dr Breeze should pay $12,500 by way of a fine pursuant to s.110(1)(e) Medical Practitioners Act 1995 ("the Act"). The Tribunal also orders Dr Breeze pay costs in the sum of $37,825.94 pursuant to s.110(1)(f)(iii) and (iv) of the Act.

5. The interim orders made by the Tribunal suppressing Dr Breeze's name and any matters which could identify him as a medical practitioner in Tauranga are lifted. The Tribunal has also declined to make any order suppressing the names of Norfolk Community Hospital, Southern Cross Hospital and Tauranga Hospital, or employees of those hospitals who gave evidence to the Tribunal.

6. In this decision the Tribunal will explain the reasons for:

   6.1 the decision which it announced on 27 August,

   6.2 the penalties it imposes (including costs), and

   6.3 not continuing to suppress Dr Breeze's name, and

   6.4 not granting orders suppressing the identities of the various hospitals and their employees.

The Charge

7. On 21 July 2003 the Director of Proceedings applied to amend the charge. That application was not opposed.

8. The charge alleged Dr Breeze mismanaged a patient on whom he operated on 16 December 1999. The charge identified five alleged shortcomings on the part of Dr Breeze relating to the pre and post operative periods of the case. The Director of Proceedings sought findings that Dr Breeze's acts and omissions either separately or, in the alternative, cumulatively

constituted disgraceful conduct in a professional respect.[2] In the event the Tribunal was not prepared to make findings of disgraceful conduct the Director of Proceedings sought findings of professional misconduct.[3]

9. The amended notice of charge contains the following particulars:

> *"1. On or about 16 December 1999, [Dr Breeze] failed to ensure the adequate preparation of Mr Lionel Crowley's bowel prior to surgery in that [he]:*
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> *…*
>
> *Failed to ensure that adequate corrective bowel preparation agents were administered to Mr Lionel Crowley on becoming aware that Mr Lionel Crowley had broken his fast;*
>
> *AND/OR*
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> *Failed to adequately assess Mr Lionel Crowley post-operatively; before 1200 hours on 18 December 1999;*
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> *AND/OR*
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> *Failed to adequately and appropriately respond to Mr Lionel Crowley's clinical presentation in that [he] failed to re-operate, at any time after 0700 hours and between 2400 hours on 17 December 1999;*
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> *AND/OR*
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> *Between 1100 hours on 17 December 1900 and 1200 hours on 18 December 1999 failed to consult with, and/or transfer care of [the patient] to an appropriately qualified specialist surgeon in a timely manner;*
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> *AND/OR*
>
> *Failed to adequately, and in a timely fashion, document in the clinical notes [his] operative and/or post-operative care in relation to Mr Lionel Crowley".*

Chronology

10. The patient in this case, Mr Lionel Crowley, was a 65 year old with diet controlled diabetes. Mr Crowley was referred to Dr Breeze with a history of passing blood with his faeces. Dr Breeze saw Mr Crowley on 6 December 1999. A clinical examination revealed a

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2 Section 109(1)(a) of the Act
3 Section 109(1)(b) of the Act

polypoidal cancer of the rectum, 9cm from the anal verge. A biopsy confirmed the tumour was malignant.

11. Dr Breeze arranged for Mr Crowley to undergo a colonoscopy at Norfolk Community Hospital on 15 December 1999. The purpose of the colonoscopy was to exclude the presence of any other growths further up the rectum from the tumour which had been identified. When Dr Breeze arranged for Mr Crowley to undergo colonoscopy he also made arrangements for bowel surgery the day after the colonoscopy. The bowel surgery was to be performed at Southern Cross Hospital on 16 December 1999.

12. Before Mr Crowley left Dr Breeze's rooms on 6 December Dr Breeze gave Mr Crowley an information sheet which answered a lot of common questions about colonoscopy. Dr Breeze also provided Mr Crowley with a prescription for oral Fleet the purpose of which was to ensure as much faecal material as possible was evacuated from the colon before surgery commenced. Oral Fleet contains sodium biphosphate and sodium phosphate. It is an alimentary tract cleanser and is regarded as an effective preparation agent for bowel surgery.

13. There is no dispute Dr Breeze also gave Mr Crowley verbal instructions concerning food and fluid intake before colonoscopy and surgery. Dr Breeze believes he also provided Mr Crowley with a sheet headed "Instructions for Bowel Prep for Colonoscopy or Surgery". Mrs Crowley is adamant that information sheet was not given to Mr Crowley. It is not necessary for the Tribunal to determine whether or not written instructions for bowel preparation were given to Mr Crowley.

14. Mr Crowley had a colonoscopy on 15 December. The colonoscopy did not reveal any other tumour. It would appear that the nurse discharging Mr Crowley from the Norfolk Hospital's endoscopy facility on 15 December advised Mr Crowley to have a sandwich before leaving the hospital and a light meal that evening. That advice was based on the concern Mr Crowley was a borderline diabetic. Mr and Mrs Crowley were concerned about the nurse's instructions but decided she must have had good reason for encouraging Mr Crowley to break his fast. Mr Crowley ate the sandwich and had a light meal on the evening of 15 December.

15. When Mr Crowley arrived at Southern Cross Hospital on 16 December he told the admitting nurse that he had eaten a light meal the previous evening. The nurse was obviously concerned. She telephoned Dr Breeze's rooms but was unable to speak to him directly. The message relayed to the nurse from Dr Breeze was that Mr Crowley should receive a "Microlax" enema. Dr Breeze maintained in his evidence before the Tribunal that he instructed that Mr Crowley be given a Fleet enema as it is a fast acting colonic laxative. Dr Breeze's evidence to the Tribunal was slightly different from a statement he had made to Southern Cross during its investigation of Mr Crowley's case. In a letter to Southern Cross on 18 June 2000 Dr Breeze said:

> *"I did not recommend a microlax enema but would have expected the nursing staff to have given further fleet preparation"* (ie oral Fleet)

16. Regardless of what instructions Dr Breeze gave it is clear Mr Crowley received a Microlax enema which was less effective than Fleet preparation or enema. A Microlax enema only cleans the rectum, not the colon or caecum. The fact that only a Microlax enema was administered is clearly documented in the nursing notes.

17. The operation commenced at 1545 hours and finished at 1800 hours. The anaethetist was Dr. Cooke.

18. The procedure followed by Dr Breeze involved a lower anterior resection and the formation of a loop ileostomy. That is to say the rectum was divided below and above the tumour and rejoined. The loop ileostomy was formed proximal to the colon to divert from the joined portion of the rectum materials passing down the colon. The joined section of the rectum is called an anastomosis. It is critical that the surgeon ensure the anastamosis is intact. If the anastamosis is not complete and leakage occurs there is a real risk of infection and even greater complications. The Tribunal had the benefit of a demonstration on how an anastomosis is formed. Dr M Neill, an expert witness called by the Director of Proceedings demonstrated the technique for creating an anastamosis using a "double-stapling" method that is achieved using a device that joins and staples the severed sections of the rectum. Part of the "double stapling" technique involves a simultaneous slicing of a small portion of the ends of the rectum that are joined. These cut portions are called "donuts" and are

extracted from the anvil of the stapling device. Each "donut" is about the size of a 1 cent coin. The surgeon should check the "donuts" to ensure they are intact. A "donut" that is not complete indicates that the anastamosis may not be intact and may leak.

19. In Mr Crowley's operation the stapling device was inserted and fired by Dr Cooke. It is not unusual for some anaesthetists to assist the surgeon in this way. Dr Cooke had performed this procedure for Dr Breeze on a number of occasions. Dr Cooke told the Tribunal that when he examined the "donuts" he was concerned that one of the "donuts" was equivocal. In his evidence in chief Dr Cooke told the Tribunal:

> *"I had to give [the donuts] a very careful look because the one donut which I previously referred to in my statement as equivocal was quite hard to see and to me it appeared not to be complete and possibly not complete and a very small part of it* [sic]. *If it was complete at all it was held together with a strand of mucous or some other material, it wasn't complete. It did form a ring but it was so thin I wasn't happy with it. I do recall offering Mr Breeze specifically the opportunity to closely scrutinize it but he declined that opportunity."*[4]

20. Dr Breeze was standing approximately four feet from Dr Cooke. Dr Breeze suggested he could see the donuts and was satisfied they were intact. Dr Breeze also says he examined the donuts at the end of the operation when they were in a container. In his surgical note typed at some point in time after the operation he said that the procedure he used:

> *"…produced a tension free well perfused anastamosis with two intact donuts".*

In his letter to Southern Cross dated 18 June 2000 Dr Breeze referred to the donuts as:

> *"Intact although the upper one was very thin at one point".*

Dr Breeze's evidence in chief before the Tribunal on this topic differed slightly from his earlier statement. He said:

> *"…both stapled donuts were visible to me, and were intact, although one of these, the distal one,*[5] *was thin at one point".*[6]

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4 Transcript p.33 lines 9-16

5 Lower donut

6 Paragraph 17, I Breeze

21. Dr Cooke told the Tribunal that at the end of the operation Dr Breeze performed a digital rectal examination to test the anastamosis. Dr Breeze did not check the anastamosis by testing for air leaks.

22. Dr Breeze's handwritten operation note is extremely brief. It comprises just ten words and is not very informative.

23. Mr Crowley was transferred to the ward at 1900 hrs. He had a continuous epidural infusion. Initially Mr Crowley was mildly hypothermic and was noted to be shivering. Mr Crowley continued to shiver during the evening. The duty nurse telephoned Dr Cooke at 2200 hrs, and Dr Breeze at 2210 hrs concerning pain in the left side of Mr Crowley's abdomen and his shivering. Dr Breeze gave no new instructions.

24. Dr Cooke assessed Mr Crowley at 2345 hrs. This was the second visit that Dr Cooke made to Mr Crowley that evening. He had previously checked on Mr Crowley as part of a routine follow up at 2115 hrs. When Dr Cooke saw Mr Crowley at 2345 hrs he noted that the patient had been restless during the evening and was complaining of pain in his shoulder and abdomen. Mr Crowley's respiratory rate had risen from 16 to close to 20 per minute and the pulse rate was up to 120. Mr Crowley also had profuse diarrhoea via his rectum. Dr Cooke thought that Mr Crowley's symptoms were related to spasm of the gut or that there might be a gut ischaemia. Dr Cooke remained with the patient for 45 minutes. He took a sample of arterial blood to the laboratory and tested it but the tests did not show acidosis. Dr Cooke was telephoned by nursing staff at 0430 hrs because Mr Crowley's blood pressure had started to fall. It was down to 75 systolic. Dr Cooke asked that the epidural infusion be turned off because an epidural infusion can lower a patient's blood pressure. This was done as a temporary measure. The records show Mr Crowley's temperature peaked at 38.3°C overnight.

25. Dr Breeze visited Mr Crowley and other patients at 0700 hrs before going to Tauranga Hospital to perform two operations. There is no record of any clinical observations or assessments made by Dr Breeze at 0700 hrs. The records do however show Dr Breeze prescribed some medication including further antibiotics (Flagyl and Gentamicin).

26. Dr Cooke was contacted at 0840 hrs because of recurrence of hypotension (75 systolic). After ascertaining that Dr Breeze had visited Mr Crowley at 0700 hrs Dr Cooke gave

instructions to stop the infusion again.

27. At approximately 1115 hrs Dr Breeze was telephoned by a nurse at Southern Cross Hospital concerning Mr Crowley's laboratory blood test results. Dr Breeze was ending an operation at this stage at Tauranga Hospital. The laboratory reported that the blood tests "*showed a very toxic looking picture – needs triple antibiotic cover and can go down very quickly*". The white blood cell count had fallen dramatically to 2.4 with a *"marked left shift and marked neutrophil toxic changes"*. Dr Cooke was told of these developments at 1120 hrs. Dr Breeze telephoned Southern Cross Hospital at 1150 hrs. The nursing notes record:

> *""1150. Mr Breeze phoned in. Aware of lab results and that [blood pressure] has been low. Says [patient's] bowel prep wasn't very good so likely contamination … He will ring in later".*

28. Dr Cooke visited Mr Crowley at 1250 hrs and was told there could be faecal material in the pelvic drain. Dr Cooke assessed Mr Crowley's condition and determined an immediate transfer to the ICU at Tauranga Hospital was necessary.

29. Dr Cooke telephoned Dr Breeze at approximately 1330 hrs. There is no doubt Dr Breeze agreed that Mr Crowley needed to be transferred to the ICU at Tauranga Hospital. Dr Cooke stressed to Dr Breeze that his patient was *"very sick, much sicker than outward appearances suggested"*[7]. Dr Breeze explained he wished to follow a *"conservative"* approach in treating Mr Crowley, that is to say, he did not want to re-operate but chose instead to deal with the infection by drainage and antibiotics. Dr Cooke agreed to arrange the transfer of Mr Crowley to Tauranga Hospital's ICU. In relation to the topic of re-operation, Dr Breeze said in his evidence in chief:

> *"Had [Dr Cooke] considered a laparotomy was indicated, I would have consented".*[8]

In his evidence in chief Dr Cooke responded to these comments. He said:

> *"… this gives entirely the wrong emphasis to the conversation I had with Mr Breeze. And it makes me feel as I was being made responsible re the decision for laparotomy. In my opinion the crux of*

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7 Paragraph 27 Cooke

8 Paragraph 30, I Breeze

> *my message to Mr Breeze was that this man is sick and that he needs intensive care … I'm not saying that operation wasn't mentioned, it was, but it was Mr Breeze that raised the matter and in my mind that was a surgical decision primarily and the first priority for me was to have the patient transferred to[the] Intensive Care where the treatment could be provided more easily."*[9]

30. Dr Cooke telephoned Dr Jackson the intensivist on call at Tauranga Hospital and arranged for Mr Crowley's transfer to the Tauranga Hospital ICU.

31. Mr Crowley was transferred to the Tauranga Hospital ICU at approximately 1500 hrs on 17 December. Dr Jackson summarized Mr Crowley's critically ill status on arrival at the ICU in the following way:

> *"post-op sepsis with multi organ failure: resp. failure, renal dysfunction, shock."*

Mr Crowley's admission note for ICU records:

> *"… drainage of faecal material from redivac 500mls in less than 1 hour"*

The intensive care nurse recorded a total of 1100mls of dark brownish red fluid from the redicav drain within a short period.

32. The admission diagnosis at Tauranga ICU was:

> *"Generalised faecal peritonitis secondary to anastomotic leak, severe sepsis secondary to faecal peritonitis,*
> *multi-organ dysfunction syndrome secondary to sepsis"*

Following this assessment Dr Jackson telephoned Dr Breeze who by this stage had left Tauranga Hospital and gone to Pro Med House where his rooms and an operating facility are located. Pro Med House is approximately 10 minutes drive from Tauranga Hospital. Dr Breeze was performing an operation at Pro Med House that afternoon. Dr Jackson believes he telephoned Dr Breeze at approximately 1530 to 1545hrs. Dr Breeze initially thought this telephone call was at about 1700hrs but acknowledged it was likely to have been earlier than he initially thought.

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[9] Paragraph 35 l.15-23

33. Dr Jackson told the Tribunal that when he spoke to Dr Breeze he told Dr Breeze of his assessment and diagnosis. Dr Jackson was in no doubt Dr Breeze was made aware of Mr Crowley's deteriorating condition and in particular:

- The profound septic shock that would necessitate inotropic support,
- That respiratory failure would likely require artificial ventilation in the near future,
- The depressed white blood cell count, and
- The extreme (500mls) faecal material that had been drained.

Dr Jackson said he *"asked Mr Breeze about an exploratory laparotomy and washout"* but was told *"this was definitely not indicated"*[10]

During the course of this telephone conversation Dr Breeze indicated he would visit Mr Crowley the next day and that he would contact the surgical registrar on call who in turn would be expected to contact Dr Breeze if there was any deterioration in Mr Crowley's condition.

34. Dr Jackson summarized Mr Crowley's deterioration over the next 1 to 2 hours by telling the Tribunal:

> *"The patient's clinical condition continued to deteriorate. Increasing doses of inotropic drugs were required to support the [patient's] unstable cardiovascular system. Anaesthesia was commenced with the patient being placed on artificial ventilation at 4.40pm. 100% oxygen was required to maintain adequate oxygenation. Faecal drainage through the redivac continued with a total of 1,000mls over two hours."*[11]

35. Dr Breeze telephoned Dr Jackson at approximately 1700hrs. Dr Breeze was in his rooms at Pro Med House at this time dictating notes. Dr Jackson recalls:

> *"I advised him of the patient's critical status with now a total of 1,000mls faecal loss through the redivac over a two hour period and rapid clinical deterioration. He was advised the patient was now anaesthetized and ventilated, had profound hypotension on large and increasing doses of dopamine and nor-adrenaline and my*

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[10] Paragraph 8, D Jackson
[11] Paragraph 9, D Jackson

> *expectation that renal failure was highly likely to occur. He advised that he would review the patient personally the next day."*[12]

36. Dr Breeze believes he telephoned the acute general surgical registrar on call, Dr Martin and that together they *"planned to trial conservative management"*. Dr Martin gave evidence before the Tribunal. He was adamant Dr Breeze did not contact him. Dr Martin relied on the fact that there is no record in the clinical notes of his speaking to Dr Breeze and he is certain that he would have made an entry in the notes if he had been asked to participate in Mr Crowley's management.

37. Dr Breeze went home soon after 1700 hrs. He went to an end of year function that evening.

38. During the night of 17 December Mr Crowley's condition continued to deteriorate. He suffered multi-organ failure and he required large quantities of nor-adrenalin to sustain his blood pressure. At 0245hrs on 18 December Mr Crowley's blood pressure dropped significantly when his nor-adrenalin syringe was being changed. Mr Crowley was resuscitated but his condition was so bad that Dr Jackson decided no further resuscitation attempts would be made.

39. Dr Breeze visited Mr Crowley on 18 December. He believes his visit was at approximately 0900 hrs. Dr Jackson confirms Dr Breeze went to the ICU some time between 0900 and 1100hrs on 18 December. Mrs Crowley was certain that the visit did not occur until after lunch on 18 December. It is not necessary to resolve that issue. As will be seen later in this decision the Tribunal is very critical of Dr Breeze for not attending his patient on 17 December (after 0700 hrs) to discuss management options with the patient and/or his family.

40. By the time Dr Breeze saw his patient on 18 December Mr Crowley's fate was sealed. He had by this stage reached the point where he required maximum respiratory and cardiovascular support and was developing acute renal failure. Mr Crowley's life was maintained in the Tauranga ICU until the morning of 21 December when he passed away.

41. A post mortem was carried out on 22 December. The pathologist's report noted that:

> *"In the region of the rectum, there is an 18mm defect, which has surrounding staples. There are fibrous adhesions in the lower*

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[12] Paragraph 10, D Jackson

> *abdominal cavity. Approximately 150mls of brown stained fluid and admixed faecal material are present in the abdominal cavity."*

The pathologist also noted Mr Crowley had an enlarged heart and narrowing of three coronary arteries.

Summary of the Director of Proceedings Case

42. The Director of Proceedings called two expert witnesses, namely Dr M Neill and Dr S Packer.

43. Dr Neill is a very experienced colorectal and general surgeon in Auckland. Dr Neill obtained his basic medical qualifications in 1968. He was a senior registrar and research fellow for Sir Alan Parks at St Marks and Royal London Hospitals. Dr Neill has practised as a consultant colorectal surgeon in Auckland since 1984.

44. Dr Neill first became involved in this matter when he was asked by the Southern Cross Hospital Audit Review Committee to provide an opinion on the care Dr Breeze provided Mr Crowley. Dr Breeze apparently agreed to Dr Neill undertaking his assessment. Dr Neill interviewed Dr Breeze in May 2000 before finalizing his report.

45. Dr Neill told the Tribunal Dr Breeze had a duty to ensure that Mr Crowley's bowel was adequately prepared for the intended surgery. Dr Neill said it was particularly important that Dr Breeze recognized and discharged his responsibility in this regard when it became apparent to Dr Breeze that Mr Crowley had eaten prior to surgery. In discharging his duty Dr Breeze needed to ensure that appropriate bowel preparation was given. Dr Neill was certain that a Microlax enema was not appropriate because it was not likely to clear the entire colon. Dr Neill told the Tribunal that Dr Breeze should have ensured that Mr Crowley had a further dose of oral bowel preparation such as oral Fleet in order to ensure as much faecal material as possible was evacuated from the colon before surgery commenced. Failure to ensure an appropriate bowel preparation was administered meant that there was loose stool present when the resection was performed. The defunctioning ileostomy, which was placed proximal to the colon, would have had no impact in evacuating faecal material from the colon below the ileostomy.

46. Dr Neill was of the opinion that at the time Dr Breeze visited his patient at 0700hrs on 17 December Mr Crowley was already suffering systemic inflammatory response syndrome. The factors which Dr Neill pointed to which he said should have alerted Dr Breeze to this possibility included:

- The inadequacy of the bowel preparation
- The questions about the integrity of one of the "donuts"
- By 0700hrs Mr Crowley had had abdominal tenderness and pain
- Mr Crowley's urinary output at 0500hrs was low (10mls per hour)
- Mr Crowley was tachycardic
- At 0430hrs Mr Crowley's oxygen saturation was reported to have been down to 87%
- Mr Crowley's blood pressure had not responded significantly to interrupting the epidural.

47. Dr Neill was in no doubt that by 0700hrs

> *"It was … imperative for Mr Breeze to undertake a full assessment and further investigations to determine the cause of [Mr Crowley's] infection."*[13]

48. Dr Neill advised the Tribunal that as Dr Breeze excluded pneumonia as a cause of infection in Mr Crowley's case then,

> *"… anastamotic leak was the only other likely source. There is only one course of action that can be followed in such an instance; surgical intervention with either an attempt to repair the leak, or, preferably, disruption of the anastamosis and [the] proximal colon brought out as a colostomy".*[14]

49. Dr Neill was even more certain Dr Breeze should have initiated surgical intervention when the very low white blood cell count was brought to Dr Breeze's attention later in the morning of 17 December. In Dr Neill's opinion surgical intervention became even more imperative

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[13] Paragraph 25, M Neill
[14] Paragraph 27, M Neill

when the presence of faecal material in the silastic drain clearly indicated an anastamotic leak and that the abdominal cavity was contaminated.

50. Dr Neill's evidence was that by the time Mr Crowley was transferred to Tauranga Hospital's ICU he was starting to show signs of multi organ dysfunction and that because of the continuing leakage in the pelvis, causing sepsis, Mr Crowley continued to deteriorate and subsequently died. Dr Neill told the Tribunal:

> *"Re-operation remained the only treatment option up to the time when the intensivists were of the view Mr Crowley's multi organ failure had deteriorated to the point where he could not be revived."*[15]

Dr Neill thought the window of opportunity to re-operate had closed by 0800hrs on 18 December.

51. Dr Neill was:

> *"… particularly concerned that despite Mr Breeze's own misgivings about the adequacy of the bowel preparation, and Mr Crowley's clinical presentation from 10pm onwards on 16 December 1999, Mr Breeze failed to regularly monitor Mr Crowley's progress and then failed to take the requisite steps to rectify the situation".*[16]

52. Dr Neill was of the:

> *"…view that as the surgeon, Mr Breeze had a responsibility to personally assess and monitor the patient's progress, at least on a three hourly basis. This [was] especially so, given [Dr Breeze's] decision to conservatively manage Mr Crowley's deteriorating condition. In the event that Mr Breeze was unable to personally assess the patient it [was Dr Neill's] view that he was under an obligation to discuss the case with another surgeon and arrange for that surgeon to take over Mr Crowley's management. This is because ultimately it is a surgical decision as to whether re-operation is necessary."*[17]

53. Dr Neill criticised Dr Breeze's records and pointed out that the brief handwritten operation record did not refer to the state of the "donuts" or testing of the anastamosis. Dr Neill noted

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[15] Paragraph 34, M Neill
[16] Paragraph 36, M Neill
[17] Paragraph 37, M Neill

that there was no record by Dr Breeze of his assessment made at 0700hrs on 17 December. When Dr Neill examined the medical files in April and May 2000 there was no typed operation note on file. When Dr Neill interviewed Dr Breeze in May 2000 it appeared Dr Breeze had a copy of his typed operation note on a computer file. Dr Neill said Dr Breeze declined to make a copy of that report available to Dr Neill at that time.

54. Dr Neill summarized his opinion by stating that the attention given to Mr Crowley by Dr Breeze was not up to the standard expected of a consultant surgeon. In particular Dr Neill said he was most critical of the lack of supervision of the patient in the post operative period and the failure to re-operate between 0700hrs on 17 December and 0800hrs on 18 December 1999.

55. Dr Packer was the second expert called by the Director of Proceedings. Dr Packer is a consultant surgeon at Dunedin Hospital and the clinical reader in surgery at the Dunedin School of Medicine. Dr Packer is a very experienced and senior consultant general surgeon. He obtained his MBChB from Otago University in 1966 and became a Fellow of the Royal Australasian College of Surgeons in 1971. Dr Packer has chaired the New Zealand Committee of the Royal Australasian College of Surgeons and has been an examiner in general surgery for the College since 1999.

56. Dr Packer told the Tribunal that when Dr Breeze learned that Mr Crowley had broken his fast, oral Fleet or a Fleet enema should have been prescribed by Dr Breeze. Dr Packer said that oral Fleet preparation or a Fleet enema would have been more effective at clearing the bowel rather than a micro enema, such as Microlax.

57. Dr Packer was concerned by the fact that when Dr Breeze was telephoned by nursing staff at 1010hrs on 16 December he did not personally go and assess his patient. At that juncture Dr Packer believes Dr Breeze should have been anxious about the nurses' reports that Mr Crowley had excessive pain, despite adequate epidural block and his shivering. Dr Packer also pointed out that at this juncture there had been intensive bowel activity post operatively with 500mls of effluent passing into the ileostomy bag while Mr Crowley was in the recovery room. Dr Cooke had noted *"profuse diarrhoea"* during the evening after surgery. Dr Packer believed these observations should have raised a concern about the strain on the staple line both from bowel contractions and from the liquid faecal load.

58. Dr Packer noted that by the time Dr Breeze visited Mr Crowley at 0700hrs on 17 December his patient had had two episodes of marked hypotension and had remained febrile despite having had intraoperative antibiotics. Dr Packer said that by 0700hrs:

> *"the possibility/probability of faecal leakage from the anastamosis causing sepsis should have been considered … Further measures to confirm or refute the diagnosis of possible anastamotic leak were required. Digital rectal examination may well have confirmed the defect in the anastamosis shown later to have been 18mm in diameter."*[18]

59. Dr Packer's evidence to the Tribunal was that:

> *"On becoming aware of the 'toxic looking' blood picture between 11:15 and 11:50 it is my opinion that Mr Breeze should personally have assessed the patient with a view to determining the cause of the sepsis. If the diagnosis of anastamotic leak was considered unlikely then other causes of infection needed to be excluded. The patient required physical examination … microscopy of urine, and consideration of an abdominal cause for infection (and digital rectal examination to exclude anastamotic leak)".*[19]

60. Dr Packer was in no doubt that by the time the faecal material was discovered in the silicone drain when Mr Crowley was still at Southern Cross Hospital it should have been obvious that there was an anastamotic leak. Dr Packer said:

> *"re-operation to deal with the leak and to clear the contamination was the key to salvaging the patient from this major septic complication".*[20]

61. Dr Packer informed the Tribunal that there was a limited opportunity in which to re-operate on Mr Crowley. Dr Packer thought:

> *"This opportunity probably did not extend beyond the midnight of the first post operative day (ie 17 December) and that the critical time for surgical intervention was missed. The longer the delay before intervening, the less likely it would be that a good outcome of survival could be obtained. It is unlikely that surgical intervention after the first 24 hours in intensive care could have prevented a fatal outcome. In my view as an examiner for the final*

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[18] Paragraph 52, S Packer
[19] Paragraph 54, S Packer
[20] Paragraph 55, S Packer

> *examination for fellowship of RACS, if a candidate were to advocate treatment with antibiotics and other supportive measures but without operation to deal with the source of continuing contamination for such a complication after bowel resection then he/she would most certainly fail the examination."*[21]

62. Dr Packer criticized Dr Breeze's failure to see his patient from 0700hrs on 17 December to some point during the morning of 18 December and his failure to make arrangements to transfer care to the duty surgical consultant at Tauranga Hospital. Dr Packer said:

> *"If Mr Breeze was not to be continuing to provide surgical input/care in conjunction with the intensive care specialist then he should have ensured that some other general surgeon was available and accepted such responsibility".*[22]

63. The handwritten record of the operation was described as being "*extremely brief*" by Dr Packer. Dr Packer also criticized Dr Breeze's clinical records which he described as "*inadequate*".

64. Dr Packer's evidence was summarized in the following way:

> *"… in the absence of transferring care to another surgeon, Mr Breeze's failure to visit and personally assess Mr Crowley between 7am on 17 December and midday on 18 December was seriously inadequate especially when Mr Crowley was clearly critically ill.*
>
> *It is my opinion that Mr Breeze has failed in his duty of care to his patient, the late Mr Crowley. The accumulation of a number of errors or omissions were compounded by his failure to respond to indications of the development of a significant and potentially lethal complication, by his decision not to undertake the corrective action of laparotomy and decontamination of the peritoneal cavity, and by his abrogation of clinical responsibility for the continuing care of his patient.*
>
> *… It is my opinion that there has been a serious breach of acceptable professional standards."*[23]

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21 Paragraph 58, S Packer
22 Paragraph 59, S Packer
23 Paragraphs 61, 62 and 63, S Packer

Summary of Dr Breeze's case

65. Dr Breeze told the Tribunal that he graduated MBChB in 1973 and became a fellow of the Royal Australasian College of Surgeons in 1982. He undertakes a broad range of general surgery. In the past five years he has performed 184 major colorectal resections. Dr Breeze estimates that since commencing work in Tauranga in 1985 he has carried out about 600 major colorectal resections.

66. Dr Breeze recalls that on the morning of 16 December 1999 his receptionist relayed a message to him that Mr Crowley had broken his fast. Dr Breeze was certain he told his receptionist that Mr Crowley was to have a Fleet enema as it is a rapid acting colonic laxative. Dr Breeze did not favour using oral Fleet because it is comparatively slow acting (often in excess of 6 hours) and requires the patient to drink one and a half glasses of water. Dr Breeze did not appear to appreciate that the nursing notes recorded Mr Crowley had a Microlax enema on the day of his surgery.

67. Dr Breeze said it was not evident during surgery that Mr Crowley's bowel had been poorly prepared. Dr Breeze fashioned a temporary loop ileostomy and inserted two pelvic drains from the anastamosis in case there was post operative leakage from the anastamosis. Dr Breeze told the Tribunal that he could see both "donuts" and observed they were intact "… *although one of these, the distal one, was thin at one point."*[24] Dr Breeze also said that he performed a gentle digital rectal examination which confirmed in his mind that the anastamosis was intact. While examining the anastamosis in this way Dr Breeze did detect faecal matter which he said indicated that the bowel had not been prepared as well as it should have for this type of surgery.

68. Dr Breeze confirmed that he was telephoned by nursing staff at 2200hrs and told of their concerns about Mr Crowley. Dr Breeze suggested Mr Crowley be monitored closely.

69. When Dr Breeze saw Mr Crowley at 0700hrs on 17 December he believed his patient's condition had improved. Specifically, Dr Breeze said he noted:

- Mr Crowley's temperature was no longer elevated

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[24] Paragraph 17, I Breeze

- Mr Crowley's abdomen was soft and not tender in all areas peripheral to the incision
- The patient's blood pressure was 105/45
- Mr Crowley's pulse was about 100/min
- The patient's blood glucose had improved
- Mr Crowley's urinary output had improved; and
- There was no evidence of acidosis.

In these circumstances Dr Breeze thought Mr Crowley's hypotension/tachycardia may have been secondary to the epidural. However, in case Mr Crowley may have been developing infection Dr Breeze prescribed further broad spectrum antibiotics (Gentamicin and Metronidazole).

70. After seeing Mr Crowley and other patients Dr Breeze went to Tauranga Hospital where he was scheduled to perform two operations, namely a bowel resection for rectal cancer and removal of a gall bladder.

71. Dr Breeze remembers that at some time between 1100 and 1150 hrs he was telephoned by a nurse at Southern Cross Hospital and told about Mr Crowley's latest blood test results. Dr Breeze inquired about Mr Crowley's general condition. The information he received caused him to be *"… concerned, but not alarmed about Mr Crowley's condition"*.[25] Dr Breeze thought by this stage Mr Crowley must have developed infection which was *"related to sub optimal bowel preparation"*.[26]

72. Dr Breeze did not believe it was possible for him to visit Mr Crowley at this stage because of his surgery commitments. Dr Breeze knew Dr Cooke was intending to assess Mr Crowley. Dr Breeze asked the Southern Cross nurse to have Dr Cooke telephone Dr Breeze with his assessment. Dr Breeze telephoned Southern Cross at 1250 hrs to see if Dr Cooke was there. Dr Cooke had not visited Mr Crowley at this time. From what Dr Breeze understood about Mr Crowley's condition, he did not consider it necessary to cancel or postpone the second operation he was about to commence at Tauranga Hospital.

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[25] Paragraph 24, I Breeze
[26] Paragraph 24, I Breeze

73. Dr Breeze confirmed he received a telephone call from Dr Cooke at approximately 1330 hrs. Dr Breeze said: *"The crux of Dr Cooke's message was that he did not consider Mr Crowley needed a laparotomy",*[27] but that he needed to be transferred to Tauranga Hospital's ICU. Dr Breeze believes that if Dr Cooke had conveyed to Dr Breeze the need for Mr Crowley to undergo further surgery he would have expected Mr Crowley to be kept at Southern Cross Hospital.

74. Dr Breeze recalled that he received a telephone call from Dr Jackson after Mr Crowley had been assessed at Tauranga Hospital's ICU. Initially Dr Breeze thought this telephone call was at about 1700hrs although he later acknowledged it could have been earlier. At the time he first spoke to Dr Jackson, Dr Breeze was at Pro Med House where he was performing minor surgery. Dr Breeze was confident Dr Jackson gave him a detailed account of Mr Crowley's condition. Dr Breeze considered that Mr Crowley must have suffered an anastamotic leak. He also believed that the best course of action was to rely on the ileostomy and drains from the anastamosis to control fluid leaking from the anastamosis. Dr Breeze told the Tribunal that his assessment at this time was reinforced by an experience he had during his training in the UK when *" a virtually identical case to Mr Crowley… was treated without re-operation and made a full recovery".*[28]

75. Dr Breeze said Dr Jackson agreed with the conservative (ie non operative) approach which Dr Breeze wished to follow. This suggestion was refuted by Dr Jackson who said that the way Dr Breeze conveyed his views to Dr Jackson left Dr Jackson in no doubt that re-operation was not an option.

76. Dr Breeze believes that he then telephoned the acute general surgical registrar on call, Dr Martin, and discussed Mr Growley's case with him and that they *"…planned to trial conservative treatment"*. Dr Martin is adamant he did not speak to Dr Breeze about Mr Crowley.

77. Dr Breeze told the Tribunal that at about 1900hrs he spoke again to Dr Jackson. During his oral evidence Dr Breeze thought this telephone call may have been made about 1700hrs when he was in his rooms at Pro Med House. He believes the information he received from

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[27] Paragraph 29, I Breeze
[28] Paragraph 39, I Breeze

Dr Jackson suggested Mr Crowley was responding to conservative treatment and *"… that his deterioration had been reversed"* and that his condition was *".. either stable or improving".*[29]

78. Dr Breeze went home after this telephone call and later that evening attended an end of year function. The following morning he learned that Mr Crowley's condition had deteriorated further overnight. He went to the ICU and saw Mr Crowley at about 0900 hrs. The medical records show Dr Breeze requested that an additional antibiotic, Primaxin be administered. This was done at 1100hrs indicating Dr Breeze must have seen Mr Crowley before that time.

79. Dr Breeze spoke to Mrs Crowley on the 18th December and continued to monitor his patient until his death on 21 December.

80. Dr Breeze believes Mr Crowley suffered myocardial infarcts on 18 and 20 December, a suggestion which Dr Jackson refuted. Dr Breeze also referred to the autopsy findings concerning Mr Crowley's cardiac condition and suggested his patient's ability to cope with severe sepsis was limited. In his opinion *"… this was a significant determinant of the outcome,"*[30]

81. In summary, Dr Breeze:

- Denied he failed to ensure adequate corrective bowel preparation was administered to Mr Crowley
- Did not consider that his care of his patient post operatively was inadequate or that the failure to assess Mr Crowley in person between 0700 hrs on 17 December and 0900 hrs on 18 December contributed to his patient's death
- Did not accept that re-operation was indicated between 0700 hrs and 2400 hrs on 17 December
- Did not initiate a referral to an appropriately qualified consultant surgeon prior to 0700 hrs on 18 December because he thought his patient's condition was improving
- Believed the typed surgical report concerning his operation on Mr Crowley was dictated on the evening of 16 December and would have been placed in Mr Crowley's clinical files on 20 December.

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[29] Paragraph 43, I Breeze
[30] Paragraph 53, I Breeze

82. Dr Breeze called one expert witness, namely Professor F Frizelle. Professor Frizelle is a colorectal surgeon at the Colorectal Unit of Christchurch Hospital. He is also a professor of colorectal surgery at the Christchurch School of Health Sciences. Professor Frizelle qualified MBChB in 1985. He became a fellow of the Royal College of Surgeons in 1992.

83. Professor Frizelle thought it was appropriate for Dr Breeze to prescribe a Fleet enema when he learnt that Mr Crowley had broken his fast. Professor Frizelle confirmed that Oral Fleet would have taken longer to work than an enema and that therefore, the decision to prescribe a Fleet enema was appropriate. Professor Frizelle dealt with the suggestion that Dr Breeze had erred in failing to appreciate that Mr Crowley had a Microlax enema by saying that there was no valid scientific evidence that established that bowel preparation affected the outcome of colorectal surgery. Professor Frizelle did acknowledge however that in 1999 it was standard practice among colorectal surgeons to ensure their patients had adequate bowel preparation before undertaking the type of surgery performed on Mr Crowley on 16 December 1999.

84. Professor Frizelle acknowledged that:

> *"… if a patient is having problems [post operatively] it is normal practice that they be seen and reviewed by the surgeon".*[31]

Professor Frizelle was willing to suggest that in this case there was communication between Dr Breeze, Dr Cooke and Dr Jackson and that it was not unreasonable for Dr Breeze to draw the conclusions he did about Mr Crowley's condition between 0700 hrs on 17 December and 0900 hrs on 18 December.

85. Professor Frizelle's opinion concerning Dr Breeze's decision to adopt a conservative method of management on 17 December was summarized in the following way by Professor Frizelle:

> *"The issue of whether one operates with an anastamotic leak or treats a leak conservatively is a matter of clinical decision making. If the patient is otherwise well, then it is not unreasonable to manage them conservatively."*[32]

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[31] Paragraph 16, F Frizelle

[32] Paragraph 19, F Frizelle

86. Professor Frizelle's testimony in relation to Dr Breeze's failure to transfer the care of Mr Crowley to an appropriately qualified specialist surgeon was that the decision to transfer or not is a matter of clinical judgment. Professor Frizelle told the Tribunal:

> *"The decision not to formally transfer Mr Crowley's care to another surgeon was a matter of Dr Breeze's judgment based on the information he was provided by his colleagues. Plainly he considered he had sufficient information to order conservative management."*[33]

87. In relation to Dr Breeze's clinical records Professor Frizelle said Dr Breeze could not be blamed if his typed surgical report was not on the patient's file and if it had been lost or misplaced by others.

88. Professor Frizelle's testimony was summarized by his expressing the view that Dr Breeze:

> *"… provided a reasonable standard of care with regard to his management of Mr Crowley."*[34]

Evaluation of Evidence

89. The Tribunal has very carefully evaluated the evidence presented to it and taken into account the helpful submissions made by counsel.

90. In assessing the evidence the Tribunal has accepted that the contemporaneous handwritten records reflect the events recorded in those documents. The Tribunal also accepts the autopsy report is a faithful record of the pathologist's findings.

91. When assessing the accuracy of the memories of witnesses of fact the Tribunal is mindful that the events under scrutiny occurred in December 1999. It is natural that with the passage of time memories fade and recollections can become distorted.

92. In assessing the credibility of witnesses of fact, and in particular their contested evidence, the Tribunal has carefully focused upon their demeanour and the way in which they have responded to careful and thorough cross examination from experienced counsel, as well as their responses to the questions put by members of the Tribunal. As is often the case where

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[33] Paragraph 24, F Frizelle
[34] Paragraph 33, F Frizelle

issues of credibility become important the Tribunal has concluded that not all witnesses have accurately recalled events. In those instances where the Tribunal has rejected the evidence of a witness it has done so on the basis that the witness' recollection is inaccurate and not because the witness concerned has deliberately tried to mislead the Tribunal.

93. The Tribunal's findings in relation to the crucial questions of fact are explained by the Tribunal later in this decision when analysing the particulars of the charge. It is however convenient to summarise in general terms the Tribunal's assessment of the evidence given by the witnesses.

Mrs Crowley

94. The Tribunal thought Mrs Crowley was an honest, intelligent and objective witness. The Tribunal is not able to resolve the factual dispute between Mrs Crowley and Dr Breeze over when he met her on 18 December. If Mrs Crowley has erred in her recollection that is entirely understandable given the enormous stress she was suffering on 18 December.

Lois Redaway

95. The Tribunal accepted Ms Redaway's evidence, most of which was confirmed by a note she wrote in Mr Crowley's medical records on 20 December 1999.

Karen Russell

96. The Tribunal accepted Ms Russell's evidence which was also substantially confirmed by entries written in Mr Crowley's notes at the time.

Dr Cooke

97. Dr Cooke conveyed to the Tribunal that he is an honest and reliable witness. He did not attempt to avoid responsibility and impressed as being a dedicated and caring anaesthetist who did all he reasonably could for Mr Crowley.

Dr Jackson

98. Dr Jackson also gave honest and reliable evidence to the Tribunal. Most of Dr Jackson's evidence was supported by contemporaneous notes. Dr Jackson also impressed as being a dedicated doctor who did all he could for Mr Crowley.

Dr Martin

99. On balance the Tribunal accepts Dr Breeze did not communicate with Dr Martin in the detailed way suggested by Dr Breeze. The Tribunal believes Dr Martin would have had some recollection of such an important conversation if it had occurred.

Mrs Breeze

100. The Tribunal has accepted Mrs Breeze unchallenged evidence that her husband left their home at about 0800hrs on 18 December to visit patients at Southern Cross and Tauranga Hospitals.

Dr Breeze

101. The Tribunal has accepted some, but not all of Dr Breeze's evidence. Where the Tribunal has rejected Dr Breeze's evidence it has done so because:

101.1 Dr Breeze's recollections are not consistent with contemporaneous written records, and/or

101.2 Dr Breeze's recollections do not accord with the recollections of witnesses whose testimony the Tribunal has accepted. In this regard the Tribunal records that it believes Dr Breeze has endeavoured to reconstruct some of the facts in a way which casts him in the best possible light. The Tribunal believes Dr Breeze has now convinced himself about certain events which do not accord with the recollections of other more reliable and objective witnesses.

102. An example of Dr Breeze's evidence not being able to be reconciled with the clinical records can be found in Dr Breeze's assertion in his evidence in chief that by the early evening of 17 December:

> *"Mr Crowley appeared to be responding to the conservative treatment, in that it seemed that his deterioration had been reversed, as his parameters were either stable or improving".*[35]

Dr Breeze partially based this claim on information he said he obtained at about 1700 hrs from Dr Jackson that Mr Crowley's urine output had improved up to 150mls per hour and

that the ICU notes corroborated this. In fact, the clinical records show Mr Crowley's urinary output did not reach 150mls per hour until 2100hrs. Dr Breeze was obliged to concede this point when cross examined.[36]

103. An example of Dr Breeze's evidence on critical matters conflicting with the more reliable and objective evidence of other witnesses concerned the decision to manage Mr Crowley conservatively after his admission to the Tauranga ICU. In his evidence Dr Breeze maintained that Dr Jackson "concurred" with the decision not to re-operate on Mr Crowley.[37] The Tribunal however is very satisfied that Dr Jackson's recollection on this topic is accurate. Dr Jackson was certain that the decision to treat Mr Crowley conservatively was Dr Breeze's decision and that so far as Dr Jackson was concerned re-operation was simply not an option because Dr Breeze was not willing to consider proactive treatment.[38]

The Expert Witnesses

104. The Tribunal was very grateful for the expert testimony provided by Dr Neill, Dr Packer and Professor Frizelle. There are some aspects of the evidence of each of their evidence which the Tribunal accepts, and some which it rejects. The Tribunal has endeavoured to explain what parts of the experts' opinions it has accepted when explaining its decision in relation to each particular of the charge.

Standard of Proof

105. The allegations leveled against Dr Breeze are very serious. Accordingly the onus placed upon the Director of Proceedings to establish the charge requires a high standard of proof.

106. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[39] where the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[40]

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35 Paragraph 43, I Breeze
36 Transcript p.204, l.7
37 Transcript p.206 l.6
38 Transcript p.69, l. 2-9
39 (1984) 4 NZAR 369
40 (1967) 1 NSWLR 609

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy.*[41] *Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

107. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[42] where it was emphasized that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*[43]:

> *"The onus and standard of proof is upon the[respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge".*

In *Cullen v The Medical Council of New Zealand*[44] Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall correctly described it in the directions which he gave the Committee:*
>
> > *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts".*

108. In this case where the Tribunal has made findings adverse to Dr Breeze it has done so because the evidence satisfies the test as to the onus of proof set out in paragraphs 106 and 107 of this decision. Indeed, in relation to the three particulars where the Tribunal finds Dr Breeze's conduct constitutes professional misconduct the Tribunal (or in the case of

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41 [1966] ALR 270
42 [1989] 1 NZLR 139 at 163
43 Unreported HC Wellington M 239/87 11 October 1990
44 Unreported HC Auckland 68/95, 20 March 1996

particular 4, the majority of the Tribunal) believes the evidence against Dr Breeze is very compelling.

Disgraceful Conduct in a Professional Respect

109. The Director of Proceedings urged the Tribunal to find Dr Breeze guilty of disgraceful conduct. A charge of "disgraceful conduct in a professional respect" is reserved for the most serious instances of professional disciplinary offending. Doctors found guilty of disgraceful conduct in a professional respect are at risk of having their name removed from the register of medical practitioners. In *Duncan v Medical Practitioners Disciplinary Committee*[45] the Court of Appeal said:

> *"A charge of disgraceful conduct in a professional respect has been described by the Privy Council as alleging conduct deserving of the most serious reprobation.*[46]

This observation succinctly conveys the seriousness of a charge of disgraceful conduct in a professional respect.

110. Mr Waalkens accepted that clinical acts and omissions by a doctor can amount to disgraceful conduct. That concession was appropriate in light of the High Court's decision in *Director of Proceedings v Parry*[47] in which Paterson J said that:

> *"…serious negligence of a non deliberate nature can in appropriate cases constitute disgraceful conduct,"* and
>
> *"… under the definition of 'disgraceful conduct' as I find it to be, a practitioner can commit an offence by one act of gross negligence if that act, although not deliberate, is an abuse of the privileges which accompany registration as a medical practitioner".*

111. In relation to the three particulars which the Tribunal finds proven the Tribunal is satisfied Dr Breeze's acts and omissions fall short of disgraceful conduct. The Tribunal records however that in relation to the second particular Dr Breeze's failings were very serious and have come close to constituting disgraceful conduct. In making this assessment the Tribunal has carefully evaluated its findings and compared Dr Breeze's errors to other doctors found

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45 [1986] 1 NZLR 513

46 Citing *Felix v General Dental Council* [1960] AC 704; *McEniff v General Dental Council* [1980] 1 All ER 461.

47 Unreported, High Court, Auckland, AP61-SWO1, 15 October 2001

guilty of disgraceful conduct.

112. Mr Waalkens alluded to the possibility of the Tribunal considering a finding of conduct unbecoming a medical practitioner pursuant to s.109(1)(c) of the Act. Even if, as a matter of law, such a finding were possible the Tribunal believes Dr Breeze's errors and omissions could never be objectively regarded as conduct unbecoming a medical practitioner.

Professional Misconduct

113. In recent years, those attempting to define professional misconduct have invariably commenced their analysis by reference to the judgment of Jefferies J in *Ongley v Medical Council of New Zealand*[48]. In that case his Honour formulated the test as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

114. In *Pillai v Messiter* [No.2][49] the New South Wales Court of Appeal signalled a slightly different approach to judging professional misconduct from the test articulated in *Ongley*. In that case the President of the New South Wales Court of Appeal considered the use of the word "misconduct" in the context of the phrase "misconduct in a professional respect". In his view, the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

> *"The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

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48 supra.

49 (1989) 16 NSWLR 197.

115. In *B v The Medical Council*[50] Elias J said in relation to a charge of "conduct unbecoming" that:

> *"… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice, but patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

116. In *Staite v Psychologists Board*[51] Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

117. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

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[50] Unreported HC Auckland , HC11/96, 8 July 1996

[51] (1998) 18 FRNZ 18.

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care that would reasonably be expected of the practitioner in the circumstances – that is in relation to the preparation of Family Court Reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of Section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances …".*

118. In *Tan v Accident Rehabilitation Insurance Commission*[52] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand*. Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

119. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

120. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J. delivered his judgment in *Ongley*. In the Tribunal's view the following are the crucial considerations when determining whether or not conduct constitutes professional misconduct:

- The first portion of the test involves an objective evaluation of the evidence and answer to the following question:

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[52] (1999) NZAR 369

Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

- If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards, and/or punishing the doctor?

121. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his seminal decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession.[53]

122. This second limb to the test recognises the observations in *Pillai v Messiter, B v Medical Council, Staite v Psychologists Board* and *Tan v ARIC* that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

123. In the recent High Court case of *McKenzie v MPDT*[54] Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. The same judgment of the High Court cautioned against reliance in this country upon the recent judgment of the Privy Council in *Silver v General Medical Council*[55]

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53 *B v Medical Practitioners Disciplinary Tribunal* (supra); *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) In which it was said: "If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in *B* goes beyond usual practice to take into account patient interests and community expectations".

54 Unreported, High Court Auckland, CIV 2002-404-153-02, 12 June 2003

55 [2003] UK, PC33

124. The Tribunal has assessed Dr Breeze's conduct by answering the questions posed in paragraph 120 in relation to each particular allegation in the amended notice of charge.

Tribunal's Findings in Relation to Each Particularised Allegation of the Charge

First Particularised Allegation:

On or about 16 December 1999 Dr Breeze failed to ensure the adequate preparation of Mr Crowley's bowel prior to surgery by not ensuring adequate corrective bowel preparation agents were administered to Mr Crowley when Dr Breeze became aware his patient had broken his fast.

125. The Tribunal is not satisfied this particular of the charge has been proven to the requisite standard.

126. The Tribunal is satisfied that Dr Breeze was justified in asking that Mr Crowley be given a Fleet enema after he learned his patient had broken his fast. The Tribunal accepts Dr Breeze exercised reasonable judgment in not directing Mr Crowley be given oral Fleet because of the length of time it would take for oral Fleet to clear Mr Crowley's bowel.

127. The Tribunal was concerned Dr Breeze appears not to have appreciated Mr Crowley was in fact administered a Microlax enema. It would appear Dr Breeze did not read or properly read the nurses notes before operating on his patient. The Tribunal is of the view that this oversight does not in itself justify a disciplinary finding against Dr Breeze.

128. The Tribunal acknowledges that there are now valid scientific questions about the efficacy of bowel preparations in colorectal surgery and that Professor Frizelle's research, and the research of others cast some doubt on the conventional wisdom concerning bowel preparation.

129. In the final analysis it is the Tribunal's considered view that the Director of Proceedings has not proved to the requisite standard the first particular of the charge.

Second Particularised Allegation:

Dr Breeze failed to adequately assess Mr Crowley post operatively before 1200hrs on 18 December 1999

130. The Tribunal is very satisfied Dr Breeze failed to adequately assess Mr Crowley post operatively and that he should have done so between 0700hrs on 17 December and well before 1200hrs on 18 December.

131. The Tribunal's decision that Dr Breeze failed to adequately assess Mr Crowley is based on the following findings:

131.1 Dr Breeze should have personally attended upon and assessed Mr Crowley well before he visited his patient on the morning of 18 December. Whilst the Tribunal can understand Dr Breeze's reluctance to postpone or cancel other surgical commitments he had no pressing engagements after 1700hrs on 17 December. At that time Dr Breeze was in his rooms dictating operation notes. He then went home and later went to an end of year function. The Tribunal was very concerned Dr Breeze gave priority to an end of year function over attending to his critically ill patient. The Tribunal is unimpressed by the fact Dr Breeze failed to attend upon Mr Crowley for at least 26 hours during which time his patient deteriorated to the point where death became inevitable.

131.2 Whilst Dr Breeze was entitled to rely to some extent on the information he received from Dr Jackson when Mr Crowley was in the Tauranga Hospital ICU, he nevertheless needed to personally assess his patient. The Tribunal fully agrees with the evidence of Drs Packer and Neill when they said Dr Breeze had a responsibility to personally assess and monitor his patient's progress, particularly as Dr Breeze had resolved to pursue a conservative course of management. Ultimately the decision as to whether or not more proactive treatment was required needed to be made by a surgeon after carefully assessing and examining the patient. The Tribunal is in no doubt Dr Jackson conveyed accurate information to Dr Breeze concerning Mr Crowley's deteriorating condition after his admission to the Tauranga Hospital ICU. Dr Breeze should have attended upon, examined and carefully assessed his patient as soon as his operation commitments finished on 17 December 1999.

131.3 The Tribunal does not believe Dr Breeze spoke to the surgical registrar on call on 17 December in the detailed way he now suggests. Even if he did, Dr Breeze

needed to fully assess and monitor his patient's condition. As will be seen later, if Dr Breeze could not discharge his responsibilities in this way, he needed to ensure his patient's care was properly transferred to a consultant surgeon.

131.4 The Tribunal was concerned that during the course of 17 December Dr Breeze seemed determined to optimistically interpret all information he received about his patient and not critically assess his own judgment. Dr Breeze should have been aware as early as 0700hrs on 17 December that there were danger signs that needed to be read and carefully considered. Those signs were:

- Dr Breeze knew Mr Crowley's bowel preparation had been inadequate
- Dr Breeze knew Dr Cooke had raised questions about the integrity of the "donuts"
- Mr Crowley had had abdominal tenderness and pain
- Mr Crowley's urine output had been very low at 0500hrs
- Mr Crowley was tachycardic
- At 0430hrs Mr Crowley's oxygen saturation was reported as being 87%
- Mr Crowley's blood pressure had not responded significantly to interrupting the epidural.
- Mr Crowley's temperature had fluctuated during the night.

131.5 Even if Dr Breeze was satisfied in allowing others to monitor his patient after 0700hrs on 17 December he needed to make every effort to personally assess and evaluate the management of his patient when it became apparent that Mr Crowley's condition was rapidly deteriorating in the Tauranga Hospital ICU. Ideally Dr Breeze should have attended Mr Crowley after the low white blood cell count was reported to him, although, as stated earlier, the Tribunal understands why Dr Breeze was reluctant to cancel or postpone other operations. Nevertheless, there was no justification for Dr Breeze to continue to

rely on the observations of others once his surgical commitments were over on the 17th December. Dr Breeze continued to optimistically interpret the information he received about Mr Crowley and not take account of the fact that any 'positive' signs concerning Mr Crowley's condition were attributable to the extreme life saving measures taken by staff in the ICU. Had Dr Breeze attended upon his patient and critically assessed his own judgment at 1700hrs on 17 December then it is possible proactive and potentially life saving measures could have been taken.

131.6 The Tribunal is very concerned Dr Breeze continues to justify his failure to personally assess and monitor his patient's condition by attempting to shield himself behind others. The decision to embark on conservative management of Mr Crowley was Dr Breeze's decision, and his alone. The Tribunal fully accepts Drs Cooke and Jackson played no role in determining the course of management followed in this case. The Tribunal is also satisfied Dr Martin played no role in Dr Breeze's decision not to take more proactive steps to treat his patient.

132. The Tribunal believes Dr Breeze's failure to personally attend and assess his patient for at least 26 hours from 0700hrs on 17 December was a serious abrogation of his duties. The Director of Proceedings has clearly established Dr Breeze's acts and omissions in not adequately assessing Mr Crowley from 0700hrs onwards on 17 December constituted a serious departure from professional standards and amounts to professional misconduct. The Tribunal is also satisfied Dr Breeze's breaches of his duty were so serious that a disciplinary finding is required in order to:

- Protect the public, and/or
- Maintain professional standards, and/or
- Punish Dr Breeze

Third Particularised Allegation:

Dr Breeze failed to adequately and appropriately respond to Mr Crowley's clinical presentation in that he failed to re-operate any time after 0700hrs and before 2400hrs on 17 December 1999.

133. The Tribunal is in no doubt that Dr Breeze failed to adequately and appropriately respond to Mr Crowley's clinical presentation between 0700hrs and 2400hrs on 17 December 1999.

134. The Tribunal has explained in relation to other particulars of the charge the necessity for Dr Breeze to have:

- Attended and personally assessed Mr Crowley after 0700hrs and before 2400hrs on 17 December
- Critically evaluated the wisdom of the conservative course of management he initiated
- Consult with, and or refer Mr Crowley to a consultant surgeon

Dr Breeze's failure to take these measures meant he also failed to adequately and appropriately respond to his patient's clinical condition.

135. The third particular of the charge is based on the belief that re-operation was mandatory between 0700hrs and 2400hrs on 17 December. Whilst the Tribunal strongly suspects that re-operation was necessary, the Tribunal also accepts the force of Professor Frizelle's opinion that ultimately the decision to re-operate or not had to be a clinical judgment and that accordingly the Tribunal should not conclude re-operation was mandatory. Dr Breeze's critical error was he failed to give adequate consideration to re-operating, not that he failed to re-operate. In these circumstances the Tribunal can not make an adverse finding against Dr Breeze in relation to the third particular. The Tribunal believes however that Dr Breeze's major shortcomings are adequately addressed in the second and fourth particulars of the charge.

Fourth Particularised Allegation

Between 1100hrs on 17 December and 1200hrs on 18 December 1999 Dr Breeze failed to consult with, and/or transfer care of Mr Crowley to an appropriately qualified specialist surgeon in a timely manner.

136. The Tribunal is in no doubt Dr Breeze failed to consult with, and/or transfer the care of Mr Crowley to an appropriately qualified specialist surgeon. The Tribunal has no hesitation in concluding that if Dr Breeze was unable to attend to and personally assess his patient then he

had a duty to ensure Mr Crowley's care was transferred to another consultant surgeon.

137. Dr Breeze endeavoured to minimize his culpability by suggesting from 0700hrs onwards on 17 December he was relying on the observations of nurses, and information he received from Drs, Cooke and Jackson. He also suggested that he was reliant on Dr Martin contacting him.

The Tribunal reiterates that Dr Breeze was entitled to rely to some extent on the clinical information he received from Dr Cooke and later Dr Jackson. However, Dr Breeze needs to appreciate that Mr Crowley was his patient. Mr Crowley rapidly deteriorated during the 17th December because of complications arising from the surgery which Dr Breeze performed. Judgments on Mr Crowley's care and management needed to be made by a surgeon. Dr Breeze could not sidestep his responsibilities by simply relying on the clinical information provided by others.

138. Having carefully evaluated the evidence given by Dr Martin and Dr Breeze and the way they presented to the Tribunal, the Tribunal is confident Dr Breeze did not have the detailed conversation he claims to have had with Dr Martin. Dr Martin did not take responsibility for the "trial [of] conservative treatment", nor did he undertake to make contact with Dr Breeze on the evening of 17 December.

139. The Tribunal is unanimous in its findings that the Director of Proceedings has established Dr Breeze failed to consult with and/or transfer the care of Mr Crowley to an appropriately qualified specialist when he should have done so.

140. The Tribunal is not however unanimous in its finding that Dr Breeze's breaches of duty as established in the fourth particular of the charge justified a disciplinary finding against him.

141. Three members of the Tribunal (the Chairperson, Dr Jones and Ms Courtney) are very satisfied that Dr Breeze's shortcomings as established in relation to the fourth particular of the charge justify a disciplinary finding. They believe it is necessary to impose a disciplinary sanction against Dr Breeze in relation to this aspect of the charge because the Tribunal needs to ensure public safety is not compromised and to maintain appropriate professional standards.

142. Two members of the Tribunal acknowledge that the Director of Proceedings has proven the factual elements of the fourth particular of the charge. However they do not think a disciplinary finding is necessary in relation to the fourth particular because at all relevant times Mr Crowley was receiving care and treatment from highly qualified medical personnel (albeit not surgeons) and that to some extent Dr Breeze was falsely assured by the fact his patient was in the Tauranga ICU from 1500hrs on 17 December.

143. The decision of the Tribunal, by a majority of 3 to 2 is that the fourth particular of the charge has been established and that in relation to that particular Dr Breeze is guilty of professional misconduct.

Fifth Particularised Allegation:

Dr Breeze failed to adequately and in a timely fashion document in the clinical notes his operation and/or post operative care in relation to Mr Crowley.

144. The Tribunal cannot determine when, or if, the typewritten surgical note was placed in the patient's file. Furthermore, the Tribunal cannot attribute blame to Dr Breeze if the typed surgical report was either not placed on the patient's file or was misplaced by others.

145. The Tribunal agrees with Dr Packer and Dr Neill when they criticized the inadequacy of Dr Breeze's handwritten operation note. It is extremely brief and very uninformative.

146. Dr Breeze failed to document any of his post operative assessments and care of his patient in the clinical notes.

147. Dr Breeze's failure to write anything at all in his patient's clinical notes after 16 December reflects a very casual and unprofessional attitude. Dr Breeze should require no reminding of the need for a surgeon to maintain full and informative records so that others charged with caring for the patient can understand the surgeon's thoughts and implement his instructions.

148. The Tribunal is unanimously of the view that the fifth particular of the charge has been established. Dr Breeze's records (such as they were) can be accurately characterized as being grossly inadequate. Dr Breeze's lack of professionalism in this regard justifies a finding of professional misconduct for the purposes of:

- Maintaining professional standards, and/or
- Punishing Dr Breeze

Cumulative Charge

149. The Tribunal has carefully considered whether the cumulative effect of its findings in relation to the second, fourth and fifth particulars of the charge constituted disgraceful conduct in a professional respect. For the reasons set out in paragraphs 109 – 111 of this decision the Tribunal has concluded that Dr Breeze's shortcomings, even when viewed cumulatively, fall short of disgraceful conduct in a professional respect.

Penalty

150. When the Tribunal announced its decision on 27 August it indicated it wished to learn about Dr Breeze's financial circumstances. The Tribunal provisionally had in mind the imposition of a fine pursuant to s110(1)(e) of the Act as well as an order for costs pursuant to s100(1)(f).

151. The Director of Proceedings has now filed submissions seeking, inter alia, the imposition of conditions on Dr Breeze's ability to practice (s110(10(c) of the Act). The Director of Proceedings has raised valid issues which the Tribunal has carefully considered. The Director of Proceedings has emphasized that one of the principal purposes of the Act under which the Tribunal functions is "… to ensure that medical practitioners are competent to practise medicine."[56] The Director of Proceedings points to Dr Breeze's serious shortcomings established in this case and suggests that public safety considerations warrant the imposition of conditions on Dr Breeze's ability to practise medicine.

152. The Tribunal has resolved that in this instance Dr Breeze should be fined. This decision is primarily based on the ground that so far as the Tribunal is aware, the events focused upon in this case are a "one off series of events". That is to say, the Tribunal has been required to consider Dr Breeze's conduct in relation to his management of one patient over a relatively short time frame. The Tribunal's decision to impose a fine, and no other penalty, has also been influenced by the fact the events focused upon occurred almost four years ago. There have been significant delays incurred in this case. Those delays are not attributable to the Tribunal. Delays generate stress which in itself can be a significant punishment.

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[56] Section 3(1) of the Act.

153. In imposing a fine the Tribunal has carefully considered Dr Breeze's financial circumstances. Dr Breeze has asked that his personal financial situation not be publicly disclosed. The Tribunal is willing to accede to that request but records that it has carefully considered the information supplied by Dr Breeze in his counsel's submissions dated 9 September 2003. In particular the Tribunal appreciates that the consequences of Dr Breeze's management of Mr Crowley's case have had a severe impact upon his income. Dr Breeze has told the Tribunal that he is *"…. in a position to pay a fine but it will create a burden on his depleting finances"*.[57]

154. After balancing the Tribunal's assessment of the gravity of Dr Breeze's conduct, the range of financial penalties available under s110(1)(e) of the Act and Dr Breeze's financial circumstances the Tribunal has determined Dr Breeze should pay a fine of $12,500. In reaching this decision the Tribunal has applied the principles referred to by Paterson J in *Parry v MPDT*[58].

Costs

155. Section 110(1)(f) of the Act confers on the Tribunal jurisdiction to order a medical practitioner to pay part or all of the costs and expenses of and incidental to:

155.1 The investigation made by the Health and Disability Commissioner in relation to the subject matter of the charge.

155.2 The prosecution of the charge by the Director of Proceedings.

155.3 The hearing by the Tribunal.

156. In this case:

156.1	The Director of Proceedings has only sought costs pursuant to s110(1)(f)(iii) and not s110(1)(f)(i). The costs of the Director of Proceedings were:	$37,807.95
156.2	The costs of the hearing by the Tribunal were:	$45,405.52

[57] Paragraph 36, I Breeze submissions, 9 September 2003.
[58] supra

157. The Tribunal believes a distinction can be drawn when assessing the costs Dr Breeze should pay in relation to the costs incurred by the Health and Disability Commissioner/Director of Proceedings and the costs incurred by the Tribunal.

158. The High Court has said that in relation to the costs incurred by the Tribunal "*… the choice is between the [Dr] who was …found guilty … and the medical profession as a whole"*.[59] These observations arise from the fact that the costs of running the Tribunal are met in the first instance by the entire medical profession.

159. In balancing the circumstances of a doctor found guilty of a disciplinary offence against the interests of the "medical profession as a whole" the High Court has said that it is not unreasonable to require a professional to pay 50% of the costs incurred by the professional disciplinary body.[60] Of course, before making any award of costs the Tribunal must take account of the total amounts involved and the doctor's ability to pay costs.

160. Dr Breeze has not questioned the Tribunal's costs. The Tribunal has weighed all relevant factors and determined that Dr Breeze should pay 50% of the costs of the Tribunal in this case ($22,702.76).

161. The offices of the Health and Disability Commissioner and Director of Proceedings are funded by the State. In assessing the costs incurred by these offices it is not necessary to take account of the interests of "the medical profession as a whole". When assessing the amount of costs Dr Breeze should pay the Health and Disability Commissioner and the Director of Proceedings in relation to the subject matter of the charge, the Tribunal derives some guidance from the key principles which apply to awards in High Court civil proceedings, namely:

    161.1 A doctor found guilty of a disciplinary hearing should expect to pay costs to the Health and Disability Commissioner and Director of Proceedings. The extent to

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[59] *Vasan v The Medical Council of New Zealand*, unreported, High Court Wellington, AP No.43/91, 18 December 1991, Jeffries J.

[60] See for example *Neuberger v Veterinary Surgeons Board*, unreported, High Court Wellington, AP No. 103/94, 7 April 1995, Doogue J.

which a prosecution succeeds is a relevant factor for the Tribunal to take account under this heading.

161.2 Costs awards should reflect the complexity and significance of the proceeding.

161.3 Costs should reflect a fair and reasonable rate being applied to the time taken to investigate the complaint as well as preparing for and conducting the prosecution. The emphasis is on reasonable as opposed to actual costs.

162. In this case Dr Breeze has challenged the amount of costs claimed by the Director of Proceedings and argues too much time was incurred in investigating and preparing the prosecution's case.

163. The Tribunal has carefully assessed:

163.1 The reasonableness of the costs incurred by the Director of Proceedings;

163.2 Dr Breeze's financial circumstances;

163.3 The fact Dr Breeze has been found guilty of professional misconduct in relation to three particulars of the charge,

and the other matters urged upon the Tribunal by counsel. The Tribunal has determined the Director of Proceedings is entitled to $15,123.18 being 40% of the amount claimed.

Name Suppression

164. Dr Breeze has sought an order that his name be permanently suppressed by the Tribunal. As part of that application Dr Breeze also seeks a permanent order suppressing any publication of any matter that could identify him as a Tauranga practitioner.

165. Applications have also been received to suppress the identity of Norfolk Community Hospital, Southern Cross Hospital and Tauranga Hospital as well as the names of employees of those organizations who gave evidence to the Tribunal.

166. In its decision dated 15 July 2003 the Tribunal granted Dr Breeze interim name suppression (and anything which could identify him as a Tauranga practitioner). That decision was made

by a majority of three to two members of the Tribunal. The order was made *"…until the commencement of the hearing of the charge … scheduled to occur on 25 August 2003"*.

167. The Director of Proceedings appealed the Tribunal's order granting interim name suppression. That appeal was heard on 18 August 2003. During that hearing Dr Breeze sought an extension of the Tribunal's order through to the time when the Tribunal determined the charge. On 21 August the District Court dismissed the Director of Proceeding's appeal and declined to extend the Tribunal's order saying:

> *"It would be reasonable to continue the order until the decision of the Tribunal but that is a matter [which] should be left in the hands of the Tribunal"*.

168. It is not appropriate for the Tribunal to comment on its earlier order, or the judgment of the District Court. Suffice to say. In their decision of 15 July the minority members of the Tribunal set out the principles applicable to determining a name suppression application. Those principles have been referred to and relied upon by the entire Tribunal when considering Dr Breeze's application for permanent name suppression. The Tribunal's earlier decision should be read in conjunction with this decision in relation to name suppression.

169. Prior to the commencement of the hearing on 25 August the Tribunal heard and considered submissions on whether or not it should extend its earlier order until it had determined the outcome of the charge. By a majority of three to two the Tribunal extended the effect of its earlier decision until it had determined the charge. The majority members were Drs Dame N. Restieaux J. Cullen and R. Jones. The Tribunal took account of the additional evidence which Dr Breeze had filed in the District Court concerning the health of one of his daughters. When the Tribunal reconsidered name suppression on 25 August Dr Cullen's reasons for continuing interim name suppression were the same as those previously favoured by Drs Dame N Restieaux and R Jones, namely that Dr Breeze's personal circumstances justified continuation of interim name suppression.

170. The Tribunal has carefully considered the submissions advanced by Dr Breeze in support of his application for continued name suppression. The Tribunal has unanimously concluded it can no longer grant Dr Breeze suppression of his name. The Tribunal's reasons for reaching this conclusion can be succinctly stated.

Dr Breeze's personal circumstances

171. The Tribunal accepts that there will be some harm caused to Dr Breeze's reputation if Dr Breeze's name is published in connection with the Tribunal's findings. The Tribunal appreciates that the inquiries which have occurred since Mr Crowley's death have had a considerable impact on Dr Breeze's standing in the hospitals referred to in this decision. The Tribunal also appreciates that Dr Breeze no longer performs colo-rectal surgery.

172. The Tribunal believes that concerns about Dr Breeze's reputation can not outweigh the public interest considerations referred to in paragraphs 178 to 181 of this decision. Dr Breeze has now been found guilty of professional misconduct. Dr Breeze's shortcomings, identified in relation to the Tribunal's findings in respect of the second particular of the case were that his acts and omissions were very serious.

173. When Dr Breeze sought interim name suppression he placed emphasis on the fact that his application was for an interim period and made in circumstances where he was entitled to the presumption of innocence. It is axiomatic that those considerations are no longer relevant. Dr Breeze has been found guilty of professional misconduct in circumstances where his conduct has been considered to be a serious breach of his professional responsibilities.

174. The Tribunal has taken account of the implications of its decision on Dr Breeze's employment at Tauranga Hospital. However, the Tribunal believes its responsibilities to the public significantly outweigh Dr Breeze's concerns about what might happen to his employment at Tauranga Hospital and that the public interest considerably outweigh Dr Breeze's employment issues.

175. Dr Breeze has asked the Tribunal not to disclose some of the details of his personal circumstances he relies upon in support of his name suppression application. The Tribunal has refrained from mentioning those matters in its decision but places on record that it has carefully considered the matters referred to by Dr Breeze.

Dr Breeze's family circumstances

176. The Tribunal acknowledges and accepts Mrs Breeze and the children of Dr and Mrs Breeze will suffer distress if Dr Breeze's name is published as a result of the Tribunal's findings. However, the Tribunal is very satisfied that the public interest considerations referred to later in this decision outweigh the interests of Mrs Breeze and other members of Dr Breeze's family. The Tribunal repeats its earlier finding that its decision should have no impact on Mrs Breeze's role as a trustee of a School Board.

Dr Breeze's patients

177. The Tribunal accepts that some of Dr Breeze's patients may be upset and concerned if he receives adverse publicity as a result of this decision. The fact Dr Breeze no longer performs the type of surgery carried out on Mr Crowley is a factor which should substantially allay any fears and concerns of Dr Breeze's current patients.

Public Interest in Knowing the Name of a Doctor Found Guilty of a Disciplinary Charge.

178. In the interim decision of the minority members of the Tribunal it was said that when Parliament passed s.106 of the Act it wanted to ensure hearings of the Tribunal would be held in public. All members of the Tribunal maintain that closely interwoven with Parliament's objective of public hearings is the clear intention that the public would normally be entitled to know the identify of a doctor found guilty of a disciplinary offence by the Tribunal. The public's interest in knowing the identity of a doctor found guilty by the Tribunal is a very powerful consideration in cases such as this where the doctor has been found to have seriously failed in their duty to a patient.

179. The public interest in knowing the identity of a doctor found guilty of a serious disciplinary offence is reinforced in this case because of publicity given to Dr Breeze and his role as surgeon for Mr Crowley when the Coroner in Tauranga conducted an inquest into Mr Crowley's death. The inquest took place in August 2000. In his submissions filed on 9 September 2003 counsel for Dr Breeze referred to the earlier publicity in the following way:

> *"The Coroner's hearing took place on 11 August 2000. It received a lot of publicity in the local media at the time including front page articles in the local newspaper where Ian Breeze was named and identified as the surgeon who*

was said to have caused the death of Mr Crowley. This was a damaging series of media articles which did adversely impact upon Mr Breeze's practice."

The Tribunal believes the fact that Dr Breeze's role in managing Mr Crowley has already been the subject of media attention (albeit three years ago) weighs in favour of the Director of Proceedings' submission that name suppression can no longer continue.

Accountability and Transparency of the Disciplinary Process

180. A major criticism of the disciplinary regime under the Medical Practitioners Act 1968 was that disciplinary hearings were not heard in public. This in turn led to claims that the disciplinary process was neither transparent nor accountable. It is not necessary to debate that view in this decision. Suffice to say the profession's and public's confidence in the disciplinary process should not be put at risk by suppressing the name of a doctor found guilty of a disciplinary offence unless there are compelling reasons for doing so. Both the profession and public should derive assurance about the transparency and accountability of the disciplinary process. Assurance of this kind is enhanced through knowing those who are found wanting by the Tribunal are likely to have their names published. Part of the rationale for this proposition can be found in the judgments of the House of Lords in *Scott v Scott*[61] and *Home Office v Harman*[62] where Lords Shaw and Diplock explained the reasons why civil proceedings are invariably heard in open Court, and why the identity of parties in civil action is rarely suppressed. Their Lordships referred to Bentham's statement that "*publicity is the very soul of justice*". Bentham's comments have been interpreted to mean that transparency and openness are essential in judicial and quasi judicial proceedings in order to ensure Judges and Tribunals are kept "up to the mark" (to quote Lord Diplock in *Home Office v Harman*).

181. The Tribunal believes that it is essential to decline Dr Breeze's application in order to uphold the principles of accountability and transparency in the medical disciplinary process. The Tribunal has unanimously reached this conclusion notwithstanding that publicity will undoubtedly have an adverse impact upon Dr Breeze and his family.

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61 [1913] AC 47

62 [1982] 1 All ER 532

Importance of Freedom of Speech and s.14 New Zealand Bill of Rights Act 1990

182. The Court of Appeal in *R v Liddell*[63] and *Lewis v Wilson & Horton Limited*[64] stressed:

> *"The importance in a democracy of freedom of speech, open judicial proceedings and the right of the media to report [proceedings] fairly and accurately as "surrogates of the public"*

as an important factor which weighs against suppressing of the name of an accused in criminal proceedings. This same consideration applies to a doctor found guilty of a disciplinary offence before the Tribunal. The Tribunal believes that if the media wish to publish the Tribunal's decision then it would be unreasonable to constrain the media from identifying Dr Breeze.

Hospitals and their Employees

183. The application made to suppress the identity of Norfolk Community Hospital, Southern Cross Hospital and Tauranga Hospital, and the names of the employees of those institutions was made without the benefit of the hospitals and employees being aware of the Tribunal's reasons for the decision it has reached in this case. It will now be apparent that the Tribunal is not in the least bit critical of the three hospitals or the employees of those hospitals who gave evidence to the Tribunal (other than Dr Breeze).

184. When she gave her evidence to the Tribunal Mrs Crowley graciously said that she believed the nurses and other staff at Southern Cross Hospital and Tauranga Hospital did all they possibly could for her late husband. Having heard the evidence and observed the employees of those hospitals most directly associated with Mr Crowley's care, the Tribunal fully endorses Mrs Crowley's observations.

185. The Tribunal believes that the three hospitals in question, and their employees who gave evidence to the Tribunal have nothing to fear from any publicity associated with the Tribunal's decision. On the contrary, they can take considerable satisfaction from the fact that the Tribunal compliments them for what they did for the late Mr Crowley.

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63 [1995] 1 NZLR 538
64 [2000] 3 NZLR 546

186. In these circumstances, the Tribunal believes that principles of openness and transparency significantly outweigh any lingering concerns which the hospitals and their employees may have about publicity associated with this case. For these reasons the Tribunal has declined to make any order suppressing the identity of Norfolk Community Hospital, Southern Cross Hospital or Tauranga Hospital and the names of the employees of those institutions who gave evidence to the Tribunal.

Summary

187. The Tribunal has found Dr Breeze guilty of professional misconduct in relation to the second, fourth and fifth particulars of the notice of charge.

188. The Tribunal orders Dr Breeze pay $12,500 by way of a fine pursuant to s110(1)(e) of the Act.

189. The Tribunal orders Dr Breeze pay $37,825.94 by way of costs pursuant to s.110(1)(f)(iii) and (iv) of the Act.

190. The Tribunal declines Dr Breeze's application for an order permanently suppressing his name. The Tribunal also declines the applications for suppression of the names of Norfolk Community Hospital, Southern Cross Hospital and Tauranga Hospital as well as the names of the employees of those institutions who gave evidence to the Tribunal.

191. The Tribunal directs the secretary of the Tribunal to publish a summary of the Tribunal's findings in the New Zealand Medical Journal. That order is made pursuant to s.138(2) of the Act.

192. The Tribunal is aware Dr Breeze may wish to appeal its decision concerning Dr Breeze's application for name suppression. In order to accommodate Dr Breeze the Tribunal will direct the Tribunal's order declining Dr Breeze's name suppression application (and its orders declining the suppression of the identities of the three hospitals and their employees) will not take effect until the expiration of 5 working days from the date of this decision.

DATED at Wellington this 22nd day of September 2003

……
D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal