MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 304/04/122C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against Dr A medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Dr F E Bennett, Dr R W Jones, Dr J M McKenzie,

Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at xx on Monday 11 October 2004

APPEARANCES: Ms K P McDonald QC and Ms J Hughson for a Complaints Assessment Committee ("the CAC")

Mr A Lewis for Dr A.

Introduction

1. Doctor A is a psychiatrist. On 28 June 2004 a Complaints Assessment Committee ("CAC") laid a charge of professional misconduct against Dr A. The charge was laid pursuant to s.93(1)(b) of the Medical Practitioners Act 1995 ("the Act"). The details of the charge are explained in paragraph 5 of this decision.

2. The charge was heard on 11 October 2004. At the commencement of the hearing Mr Lewis advised Dr A wished to admit the charge. The Tribunal heard submissions from both counsel and after a short adjournment advised the parties that it found the charge proven and that Dr A was guilty of professional misconduct. The Tribunal then heard submissions on:

   2.1 An application from Dr A for permanent name suppression;

   2.2 An application from Dr A for orders suppressing aspects of the evidence;

   2.3 The penalty which the Tribunal should impose.

3. In this decision the Tribunal explains:

   3.1 Its reasons for finding the charge proven;

   3.2 Why Dr A should now have the benefit of permanent name suppression;

3.3 Its reasons for suppressing part of the evidence; and

3.4 Its reasons for imposing the following penalties on Dr A:

- An order that if Dr A is deemed able to resume practising medicine by the Medical Council of New Zealand he only do so subject to the supervision of a vocational registered psychiatrist who is available on site to ensure Dr A is closely supervised (S.110(1)(c) of the Act). This order is for a period of three years from the date of this decision.

- An order that he pay $12,448.23 being 25% of the costs and expenses of the CAC and the Tribunal (s.110(1)(f)(ii)and (iv) of the Act).

4. Dr A engaged counsel a matter of days before the hearing. The Tribunal was concerned both Dr A and the complainant would have been severely disadvantaged if Dr A continued to represent himself at the hearing. To address some of these concerns the Tribunal appointed Mr B Corkill as *amicus* to the Tribunal. Mr Corkill spoke to Dr A and persuaded him to engage a lawyer. The Tribunal is grateful to Mr Corkill and to Mr Lewis who accepted instructions at extremely short notice.

The Charge

5. The CAC alleged that during the course of his clinical management and treatment of the complainant between October 2001 and April 2002 Dr A:

> "*1. Made frequent inappropriate telephone contacts with [the complainant], outside normal office hours and for reasons unrelated to her clinical need; and/or*
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> *2. During the course of the telephone contacts particularised in paragraph 1 and on other occasions, made inappropriate repeated references to the use of the provisions of the Mental Health Act such that [the complainant] felt she was being threatened with being re-admitted to hospital under the provisions of the Mental Health Act; and/or*
>
> *3. During the course of the telephone contacts particularised in paragraph 1 attempted to develop a personal relationship with [the complainant] by inviting her, during those telephone contacts with her, to lunch and dinner; and/or*

> *4. During a professional consultation with [the complainant], offered her work as his housekeeper and then, when she was at his home, tried to embrace her; and/or*
>
> *5. In professional consultations with [the complainant] and contrary to the therapeutic relationship, began to disclose to her his personal problems and issues".*

The charge alleged that when viewed singularly, or cumulatively, the particulars of the charge constituted professional misconduct.

Legal Principles

Onus and Burden of Proof

6. The allegations levelled against Dr A are serious. Because the charge is serious the onus on the CAC requires a high standard of proof.

7. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[1] where the High Court adopted the following passage from *Re Evatt: ex parte New South Wales Bar Association*[2]*:*

> *"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*[3]*. 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."*

8. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[4] where it was explained 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*[5]:

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

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1 (1984) 4 NZAR 369
2 (1967) 1 NSWLR 609
3 [1966] ALR 270
4 [1989] 1 NZLR 139 at 163
5 Unreported HC Wellington M238/87, 11 October 1990

9. In *Cullen v The Medical Council of New Zealand*[6] Blanchard J adopted the directions given by the legal assessor to the Medical Practitioners Disciplinary Committee on the standard of proof 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 or not, you have got to be sure in your own minds, satisfied that the evidence establishes the facts."*

10. In this case the CAC had little difficulty in satisfying the requisite standard of proof. The CAC readily established that Dr A's conduct amounted to professional misconduct in a professional respect.

Professional Misconduct

11. It is not necessary to traverse in detail the development of the concept of professional misconduct in this country. Suffice to say there now appears to be complete acceptance of the way the Tribunal has described the test in its recent decisions as being a two stage evaluation.[7]

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

> *"Has the doctor so behaved in a professional capacity that the established act/or omissions under scrutiny would be reasonably regarded by the doctors colleagues and representatives of the community as constituting professional misconduct?"*

The second limb of the test requires an answer to the following question:

> *"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*

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6 Unreported HC Auckland 68/95, 20 March 1996

7 See for example, *McKenzie v MPDT*, unreported, HC Auckland, CIV2002-404-153-02, 12 June 2003, Venning J; *F v MPDT*, HC Auckland, AP 113/02, 20 November 2003, Frater J

professional standards and/or punishing the doctor?"

13. The words "representatives of the community" are additional to the test of professional misconduct articulated by Jefferies J in *Ongley v Medical Council of New Zealand.*[8] The words "representatives of the community" have been added by the Tribunal because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative, and a chairperson who must be a lawyer. The composition of the Tribunal has altered since Jefferies J delivered his seminal decision in *Ongley*. The new 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 communities expectations may require the Tribunal to be critical of the usual standards of the profession.[9]

14. The second limb of the test of professional misconduct recognises the observations in *Pillai v Messiter [No.2];*[10] *B v Medical Council;*[11] *Staite v Psychologists Board*[12] and *Tan v Accident Rehabilitation Insurance Commission*[13] that not all acts or omissions which constitute a failure to adhere to the standard expected of a doctor will in themselves constitute professional misconduct.

Conduct Unbecoming a Medical Practitioner

15. Neither counsel suggested this was a case in which the Tribunal should consider finding Dr A guilty of conduct unbecoming a medical practitioner pursuant to s.109(1)(c) of the Act. The approach taken by counsel was entirely appropriate. Doctor's A conduct in this case could never be objectively considered as conduct unbecoming a medical practitioner.

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8 Supra

9 *B v MPDT*, unreported, HC Auckland, HC11/96, 8 July 1996, Elias J; *Lake v Medical Council of New Zealand*, unreported, HC Auckland, 123/96, 23 July 1998, Smellie J

10 (1989) 16 NSW LR197

11 Supra

12 (1998) 18 FRNZ 19

13 (1999) NZAR 369

Tribunal's Reasons For Finding Dr A Guilty of Professional Misconduct

Findings of Fact

16. The Tribunal received and considered statements of evidence from:

16.1 The complainant;

16.2 The complainant's solicitor;

16.3 Doctor A.

The Tribunal also had the benefit of an expert opinion provided by Dr Graham Mellsop, a senior and highly respected psychiatrist.

17. It is not necessary to traverse all of the evidence set out in the statements received by the Tribunal. It is however, appropriate to summarise the Tribunal's findings which are substantially based upon the complainant's unchallenged evidence.

18. The complainant had received treatment from public mental health services for a number of years. She suffered a bi-polar affective disorder. The complainant's first exposure to mental health services was in 1978 when she was 20 years old. From 1984 to 2002 she had several admissions to her local public hospital's acute mental health unit.

19. The complainant first came under Dr A's care in late 1999 when she was admitted to her local hospital's mental health ward suffering a hypomanic episode. The complainant's admission on this occasion was from 26 December 1999 to 12 January 2000. The complainant had a further admission to the same psychiatric unit 12 months later. On this occasion the complainant was initially thought to be in a hypomanic state but this was revised to an assessment she was in a manic phase. The complainant was under Dr A's care during her admission on this occasion from 28 December 2000 to 3 January 2001. The complainant had a good therapeutic relationship with Dr A during these admissions.

20. The complainant was re-admitted to the acute unit of her local hospital from 8 to 16 July 2001. This admission followed the sudden death of the complainant's mother. The complainant was again under the care of Dr A. At this time the complainant's relationship with her husband began to deteriorate. The complainant's marriage had been one of long

duration and the complainant suffered stress and turmoil as she tried to maintain her marriage, look after herself, and support her recently widowed father.

21. The complainant was re-admitted to the same psychiatric unit from 25 September to 15 October 2001. During part of this time the complainant was again under the care of Dr A.

22. In mid November 2001 the complainant's marriage continued to deteriorate.

23. Doctor A saw the complainant in an outpatient's facility on 7 December 2001. By this time the complainant's husband was not staying at their home. The complainant was very distressed and confided to Dr A her feelings and concerns about her marital problems. A further outpatient's consultation occurred on 13 December 2001. Again the complainant talked to Dr A about the breakup of her marriage.

24. From 28 December 2001 to early April 2002 the complainant regularly saw Dr A, primarily to discuss her marital problems. These consultations occurred almost every week.

25. On the evening of 6 February 2002 Dr A telephoned the complainant at her home. The complainant felt slightly uncomfortable about Dr A contacting her but she was reassured when he explained he was concerned about her. During the course of this telephone call Dr A invited the complainant to "come for a cuppa". The complainant noted this call in her journal. She also noted the telephone call was for "three hours or so".

26. The complainant's evidence was that Dr A telephoned her at home on approximately 4 or 5 occasions after 6 February 2002. Two of these telephone calls were noted by the complainant in her journal (8 and 10 March 2002). The complainant found it difficult to terminate the telephone calls. She thought Dr A had been drinking on occasions. The complainant's entry in her journal for 10 March 2002 indicated the complainant was feeing very uneasy by Dr A's telephone calls. In addition, the complainant thought the calls were threatening. She said that on three occasions Dr A said words to the effect that he did not want to have to put her back in the ward. The complainant thought these comments meant Dr A was threatening to use the mental health legislation to have the complainant re-admitted to hospital.

27. The complainant was at this time suffering financial stress as a result of her marriage breakup. Doctor A was aware of the financial pressures the complainant was under. The complainant told Dr A that she would like to do some housework, or similar activities to try and improve her financial position.

28. During a consultation with Dr A on 25 January 2002 the complainant raised the possibility of her doing some of Dr A's housework. Subsequently Dr A asked the complainant if she would go to his home to iron his shirts. Arrangements were then put in place for the complainant to go to Dr A's home. The complainant thought this probably occurred on 7 March 2002.

29. When the complainant went to Dr A's house she noticed it was "neglected and dishevelled". Doctor A and the complainant discussed the possibility of the complainant working for Dr A on a regular basis at his home. It was during the course of this discussion Dr A placed his hands on the complainant's shoulders and then kissed her.

30. After this incident the complainant resolved not to return to Dr A's house.

31. On 8 March 2002 Dr A telephoned the complainant at her home. During this call Dr A invited the complainant to dinner at a restaurant. When this offer was declined Dr A invited the complainant to lunch. The complainant also declined this invitation. The complainant's notes of the conversation on 8 March 2002 record she declined Dr A's invitations because they were "not appropriate".

32. The complainant was by this time becoming increasingly uneasy. She knew Dr A was breaking doctor/patient boundaries. The complainant's unease was highlighted by the fact she had disclosed a considerable amount of personal and intimate information about herself to Dr A.

33. On 11 March 2002 the complainant spoke to her lawyer and explained her concerns about Dr A. The complainant advised her lawyer that she did not want her lawyer to take matters further, that she believed she could deal with the situation herself. The complainant said she simply wanted her lawyer to be aware of the situation.

34. The complainant said that at the next consultation with Dr A he asked her on two occasions why she had not accepted his invitation to go to dinner or lunch. The complainant told Dr A that she thought going to dinner or lunch would be inappropriate because of their doctor/patient relationship. At this consultation the complainant told Dr A she would not be returning to his home to do his housekeeping. The complainant explained that after 15 March she received two further telephone calls from Dr A asking for the name and telephone of another person who might do his housekeeping.

35. There were two further consultations between the complainant and Dr A after which she was transferred to the care of another clinician.

Findings in Relation to Each Particular of the Charge

First Particular: "*[Dr A] made frequent inappropriate telephone contacts with [the complainant], outside normal office hours and for reasons unrelated to her clinical needs*".

36. There is no doubt Dr A made a number of evening telephone calls to the complainant at her home. The complainant's unchallenged evidence is that at times she found it difficult to terminate the phone calls and that on occasions she thought Dr A had been drinking.

37. There are occasions when it is necessary for a psychiatrist to make contact with a patient at their home and outside of normal working hours. Occasions of that kind are rare and only arise out of clinical necessity. None of the telephone calls which Dr A made to the complainant during the time in question were based upon clinical need. On the contrary, the telephone calls were motivated by Dr A's needs and had nothing to do with the complainant's clinical circumstances.

38. It is totally inappropriate for a psychiatrist to communicate with a patient in the circumstances disclosed in this case. Doctor A's conduct when telephoning the complainant at her home, after hours, and talking to her for long periods of time about matters unrelated to the complainant's clinical needs constituted a serious departure from the standards ordinarily expected of a psychiatrist in Dr A's circumstances. Doctor A's conduct was so serious a disciplinary finding is justified for the purposes of:

38.1 Maintaining professional standards; and/or

38.2 Protecting the public.

Second Particular: *"During the course of the telephone contacts [referred to in particular 1 of the charge] and on other occasions, [Dr A] made inappropriate repeated references to the use of the provisions of the Mental Health Act such that [the complainant] felt that she was being threatened with being re-admitted to hospital under the provisions of the Mental Health Act".*

39. The Tribunal was very satisfied Dr A did make comments to the complainant which led her to believe she was being threatened with being re-admitted to hospital under the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

40. There is no evidence in the complainant's medical records to suggest it was likely to be necessary to re-admit her to hospital during the time that Dr A was telephoning her in the evenings (January to April 2002 inclusive).

41. It is not appropriate for a psychiatrist to threaten a patient with admission to hospital under the mental health legislation unless there are sound clinical reasons for doing so. There is no evidence the complainant was displaying any signs or symptoms which would have justified Dr A raising the possibility of the complainant being re-admitted to hospital during the time in question.

42. Doctor A failed to adhere to the standards ordinarily expected of a psychiatrist in his position when he raised with the complainant the possibility of her being re-admitted to hospital during the period January to April 2002. Doctor A's breaches of his professional responsibilities in this regard were serious and justify a disciplinary finding in order to:

42.1 Maintain professional standards; and/or

42.2 Protect the public.

Third Particular: *"During the course of the telephone contacts [referred to in the First Particular of the Charge Dr A] attempted to develop a personal relationship with the complainant by inviting her … to lunch and dinner".*

43. It is a cardinal principle that a psychiatrist should not indulge in social interaction with a patient. This point was emphasised by the Court of Appeal of England in *Landau v*

Werner[14]. In that case a psychiatrist agreed to have a series of social meetings with a patient to try and "wean her" [the patient] from their therapeutic relationship. The Court of Appeal held that social contacts, although intended to be therapeutic amounted to a clear departure from accepted psychiatric practise The psychiatrist in that case was held liable for professional negligence.

44. When Dr A invited the complainant to dinner, and then to lunch on 8 March 2002 he committed a serious breach of the standards ordinarily expected of a psychiatrist. Those breaches were very serious and justify a disciplinary finding against Dr A for the purposes of:

44.1 Maintaining professional standards; and/or

44.2 Protecting the public.

Fourth Particular: *"During a professional consultation with [the complainant Dr A] offered her work as his housekeeper, and then when she was at his home, tried to embrace her".*

45. It is totally inappropriate for a medical practitioner to employ a patient to undertake domestic duties. It is particularly dangerous for non therapeutic factors to be introduced to the special relationship which exists between a psychiatrist and their patient.

46. When Dr A embraced his patient he breached a fundamental tenet of the doctor/patient relationship. When a psychiatrist kisses a patient he commits a serious breach of the boundaries of the doctor/patient relationship. Doctor A's conduct was particularly dangerous because:

46.1 He breached the trust which the complainant had developed in him. The complainant trusted Dr A to discharge his professional responsibilities in an objective and professional way. That trust was breached when Dr A endeavoured to embrace the complainant;

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[14] (1961) 105 Sol J 1008

46.2 By trying to develop a personal relationship with the complainant Dr A compromised his ability to objectively discharge his clinical responsibilities to his patient;

46.3 The complainant was clearly a vulnerable person, highly susceptible to suffering significant harm if she had allowed herself to succumb to Dr A's attentions. It is only due to the complainant's intelligence and exercise of her common sense that the possibility of serious harm was avoided in this particular case.

47. Doctor A's activities when employing the complainant to carry out domestic tasks for him, and his kissing the complainant on one occasion constituted a significant serious breach of Dr A's professional responsibilities. Doctor A's actions justify a disciplinary finding for the purposes of:

47.1 Maintaining professional standards;

47.2 Protecting the public.

Particular Five: "*In professional consultations with [the complainant] and contrary to the therapeutic relationship [Dr A] began to disclose [to the complainant] his personal problems and issues"*.

48. The complainant's evidence was that during both formal consultations and during the course of his telephone calls to the complainant, Dr A told her various things about his personal life. Doctor A told the complainant about the time when he lived in another country, and how his wife and children had left him and were now living in the United Kingdom. The complainant said she did not feel uncomfortable listening to Dr A tell her about these aspects of his personal life, but that she did believe that at times Dr A's conversations were becoming "possibly too familiar".

49. Doctor Mellsop told the Tribunal *"It is generally considered to be a foolish practise, and almost invariably an unhelpful one, for a doctor to disclose their personal problems or circumstances, to a patient"*. The Tribunal agrees. It was not appropriate for Dr A to use the complainant as a "sounding board" for his personal problems. Doctor A's breaches of his professional responsibilities in this regard were unacceptable and merit disciplinary findings for the purposes of:

49.1 Maintaining professional standards; and/or

49.2 Protecting the public.

Conclusion

50. The Tribunal had little hesitation in concluding on 11 October the allegations in each of the particulars of the charge were proven. When viewed singularly or cumulatively, the established particulars constitute professional misconduct.

Name Suppression

51. On 6 September 2004 the Tribunal issued a decision in which it:

51.1 Made an order suppressing publication of the name and any features which could identify the complainant;

51.2 Declined an application from Dr A for an interim order suppressing publication of his name and any identifying features.

52. It is not necessary to re-iterate the Tribunal's reasons for granting the complainant's request that the Tribunal order nothing be published which named or otherwise identified her. Suffice to say that decision was based on the following points:

52.1 There was no compelling public interest in allowing publication of the complainant's name;

52.2 Section 106(2) of the Act requires the Tribunal to have regard to a complainant's privacy which is described as being "without limitation";

52.3 The complainant's evidence was of an intimate and distressing nature and as such she was entitled to the special protections for complainants set out in s.107 of the Act. The Tribunal reasoned that the combined effects of s.106(2) and s.107 suggest that in the absence of compelling public interest considerations it would be unusual to decline a complainant's request for name suppression when their evidence is subject to the protections contained in s.107 of the Act.

53. The Tribunal declined Dr A's request for interim name suppression because it was not supported by any persuasive evidence. The Tribunal concluded that it was not desirable to suppress publication of Dr A's name having regard to his interests and the public interest. Mr Lewis suggested the Tribunal's decision of 6 September was entirely appropriate in light of the fact Dr A's application was not supported by any meaningful evidence.

54. Doctor A did not appeal the Tribunal's decision of 6 September. The time to appeal that decision lapsed on 5 October 2004.

55. Mr Lewis correctly submitted the Tribunal's decision of 6 September was in relation to an application for interim name suppression. Ordinarily orders relating to applications for interim name suppression are re-visited once the Tribunal reaches a decision on whether or not the doctor is guilty of a disciplinary offence. Normally this occurs when a doctor has been granted an interim order granting suppression of their name and identifying features.

56. The fact that in this case Dr A's application for interim name suppression was declined by the Tribunal does not prevent the Tribunal from considering an application for permanent name suppression after finding the charge of professional misconduct proven. An application for permanent name suppression in these circumstances does not constitute a "re-application" for interim name suppression, and as such does not offend the principle of issue estopple.[15]

57. Mr Lewis was able to ensure the Tribunal had access to significant information which Dr A did not disclose to the Tribunal when he made his application for interim name suppression. The information supplied to the Tribunal by Mr Lewis was extremely important and is likely to have caused the Tribunal to have reached a different conclusion had the same information been presented to the Tribunal when it considered Dr A's application for interim name suppression.

58. Much of the information now made available to the Tribunal is very personal medical information concerning Dr A. It is not necessary to explain that information in great depth. Suffice to say:

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[15] "The rule is that, once a issue has been raised and distinctly determined between the parties, then, as a

58.1 Doctor A has not worked as a medical practitioner since December 2002;

58.2 Doctor A is an alcoholic. He has abstained from consuming alcohol for 20 months but it is apparent from the extensive reports made available to the Tribunal that at the time of his offending Dr A was abusing alcohol on a serious scale.

58.3 Doctor A suffers significant neurological impairment. His cognitive functions have been seriously compromised. This tragic state of affairs is due to Dr A's abuse of alcohol.

58.4 It is uncertain if Dr A will ever recover sufficiently to be able to practise medicine again.

58.5 Doctor A is being carefully monitored by the Health Committee of the Medical Council of New Zealand. Doctor A appears to have responded well to the measures put in place by the Health Committee.

59. The Tribunal also learned Dr A's wife and children left him in 2000. Doctor A found it very difficult to cope with his wife and children living in the United Kingdom. He did not respond well to the stress he suffered when his marriage effectively ended and he resorted to abusing alcohol at this time.

60. The Tribunal has had the benefit of two very comprehensive neuro-psychological reports which carefully detail Dr A's medical condition. Those reports explain why it is inappropriate for Dr A to currently practise medicine.

61. The Tribunal also now has had the benefit of evidence from a counsellor who has expressed genuine fear that if Dr A's name is published he may suffer a relapse and that all of the efforts which have been made in the past 20 months to rehabilitate Dr A may be frustrated.

62. The CAC and the complainant properly opposed Dr A's application for interim name suppression. However, the CAC and the complainant do not oppose Dr A's application for permanent name suppression. No doubt the CAC and the complainant's revised position is

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general rule, neither party can be allowed to fight that issue all over again". *Fidelitis Shipping Co Ltd v V/O*

entirely attributable to the fact they have now had access to the evidence which has only come to light since Mr Lewis agreed to act for Dr A.

63. The starting point when considering the principles applicable to name suppression in the medical disciplinary arena is section 106 of the Act. Subsections 106(1) and (2) provide:

> *"(1) Except as provided in this section and in section 107 of this Act, every hearing of the Tribunal shall be held in public;*
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> *(2) Where the Tribunal is satisfied that it is desirable to do so, after having regard to the interests of any person (including (again without limitation) the privacy of the complainant (if any)) and to the public interest, it may make any one or more of the following orders: …*
>
> *(d) … an order prohibiting the publication of the name, or any particulars of the affairs, of any person".*

64. Subsection 106(1) of the Act places emphasis on the Tribunal's hearings being held in public unless the Tribunal, in its discretion applies the powers conferred on the Tribunal by section 106(2) of the Act.

65. Whereas section 106(1) of the Act contains a presumption that the Tribunal's hearing shall be held in public, there is no presumption in section 106(2) of the Act. When the Tribunal considers an application to suppress the name of any person appearing before the Tribunal, the Tribunal is required to consider whether it is desirable to prohibit publication of the name of the applicant after considering:

65.1 The interests of any person (including the unlimited right of the complainant to privacy); and

65.2 The public interest.

<u>Public Interest</u>

66. The following public interest considerations have been evaluated by the Tribunal when considering Dr A's application for permanent name suppression.

Exportchieb [1965] 2 All ER 4, at 9.

66.1 The public interest in knowing the identity of a doctor found guilty of a serious disciplinary offence;

66.2 Accountability and transparency of the disciplinary process;

66.3 The importance of freedom of speech and the right enshrined in s.14 New Zealand Bill of Rights Act 1990;

66.4 The extent to which other doctors may be unfair impugned if Dr A is not named.

67. Each of these considerations will now be examined by reference to Dr A's application for permanent name suppression. In focusing on these public interest considerations the Tribunal notes no specific submissions were received relating to the complainant's interests in this case. The interests of the complainant were merged with the position taken by the CAC in relation to Dr A's application for permanent name suppression.

Public Interest in Knowing the Name of a Doctor Found Guilty of a Serious Disciplinary Offence

68. In its decision of 6 September the Tribunal referred to the well known authorities which emphasise the importance of openness in judicial proceedings.[16] It is not necessary to repeat what the Tribunal said about those cases in its earlier decision. Suffice to say the Tribunal adopts the following passage from *Director of Proceedings v I*[17].

> *"The presumption in s.106(2) of the Act, in fair and public hearings makes it clear that, as in proceedings before the Civil and Criminal Courts, the starting position in any consideration of the procedure to be followed in medical disciplinary proceedings must also be the principle of open justice".*

69. The principle of open justice weighs very heavily against Dr A's application for permanent name suppression. The Tribunal has now found Dr A guilty of a serious disciplinary offence. It was noted in *F v Medical Practitioners Disciplinary Tribunal*[18] a doctor found guilty of a disciplinary offence can normally expect to have their name published.

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[16] *M v Police* (1991) CRNZ 14; *R v Liddell* [1995] 1 NZLR 538; *Lewis v Wilson & Horton* [2000] 3 NZLR 546; *Re X* [2002] NZAR 938

[17] Unreported, HC Auckland, CIV 2003 – 438-2180, 20 February 2004 Frater J.

[18] Unreported HC Auckland, AP21-SWO1, 5 December 2001, Laurenson J

Accountability and Transparency of the Disciplinary Process

70. The Tribunal noted in its decision of 6 September that a major criticism of the disciplinary regime under the Medical Practitioners Act 1968 was that disciplinary hearings were not heard in public and that the identity of doctors who appeared before the disciplinary body was often suppressed. This led to claims that the disciplinary process was neither transparent nor accountable. It is also apparent from an examination of the Hansard records concerning the introduction of the Medical Practitioners Act 1995 that those who promoted the legislation wanted the present disciplinary process to be transparent and accountable.[19]

71. The Tribunal repeats that it fully accepts there is considerable public interest in maintaining accountability and transparency in the disciplinary process and that this factor also weighs against Dr A's application for permanent name suppression.

The Importance of Freedom of Speech and the Right Enshrined in s.14 New Zealand Bill of Rights Act 1990

72. The public interest in preserving freedom of speech and the ability of the media "as surrogates of the public" to report the Tribunal's proceedings has been emphasised on numerous occasions by the Tribunal and Courts.[20]

73. To date the media does not appear to have shown interest in Dr A's case. Regardless of whether or not there is media interest in the case, the Tribunal reiterates its comments in its decision of 6 September that if the media wishes to publish the Tribunal's proceedings and identify Dr A then the importance of freedom of speech enshrined in s.14 New Zealand Bill of Rights Act 1990 is a further factor which weighs against suppression of publication of Dr A's name.

Unfairly Impugning Other Doctors

74. When the Tribunal declined Dr A's application for interim name suppression it was concerned that suppressing Dr A's name might result in other doctors being unfairly impugned.

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[19] See for example Hon J Shipley, New Zealand Parliamentary Debates Volume 544 p.5065

[20] See for example *R v Liddell*, and *Lewis v Wilson & Horton* (supra)

75. The Tribunal did not appreciate at the time that it made its decision declining Dr A's request for interim name suppression that he in fact had not been practising medicine for close to two years. This information only came to light when Mr Lewis became counsel for Dr A. The likelihood of other doctors being unfairly impugned is reduced if the public are told that Dr A has not practised medicine since December 2002.

Dr A's Interests

76. The factor which has weighed heavily in favour of Dr A's request for permanent name suppression is the state of his health. The fact Dr A is an alcoholic, and that he was suffering from cognitive impairment at the time of his offending are not in themselves persuasive factors. What is influential is the fact that Dr A's efforts at rehabilitation may be seriously jeopardised if he is required to cope with the stress of publicity. The Tribunal is very concerned Dr A's circumstances are such that if his name is published he may again resort to alcohol and the progress which has been made over the past 20 months in trying to rehabilitate him will be substantially undone.

77. The Tribunal has been influenced by its desire to assist Dr A's rehabilitation. The Tribunal is satisfied on the evidence placed before it that if Dr A's name is published there is a serious risk of his relapsing and suffering significant medical harm as a consequence.

Conclusion

78. The Tribunal has concluded that Dr A's personal circumstances outweigh by a very narrow margin the public interest considerations identified and considered in paragraphs 66 to 75 of this decision. Accordingly the Tribunal orders nothing should be published which names or otherwise identifies Dr A. For the sake of completeness the Tribunal also records that it was influenced in reaching its decision by the stance taken by the CAC and the complainant in this case. The Tribunal also notes that there are some similarities between its conclusion in relation to name suppression in this case and its decision to grant permanent name suppression in *Re D*[21] in which the Tribunal granted permanent name suppression to a

[21] 235/02/97C

retired doctor found guilty of professional misconduct who was suffering serious health problems.

Suppression of Evidence

79. Mr Lewis also sought orders suppressing publication of evidence relating to Dr A's "health history". That application was made pursuant to s.106(2)(d) of the Act.

80. The fact Dr A's name will not be published substantially negates the need for an order suppressing details of Dr A's medical history. Nevertheless, the Tribunal has had made available to it detailed information about Dr A's medical history and has summarised that information in general terms in this decision. The Tribunal believes that the public interest is served by directing that none of the details of Dr A's medical history may be published other than the general information set out in this decision.

Penalty

81. The CAC suggested Dr A's registration as a medical practitioner should be suspended pursuant to s.110(1)(b) of the Act. There is merit in that suggestion.

82. The fact Dr A acknowledged his errors and admitted the charge (albeit only after receiving legal advice) has influenced the Tribunal in reaching a decision that it can impose a penalty less onerous than suspension.

83. The Tribunal believes that the public interest is best served by ensuring that if the Medical Council of New Zealand decides Dr A can return to practising medicine in the next three years he will only do so under strict and close supervision. For this reason the Tribunal orders that Dr A can only practise medicine during the next three years under the supervision of a vocationally registered psychiatrist who is available on site to ensure Dr A is closely supervised. This order is made pursuant to s.110(1)(c) of the Act.

Costs

84. The High Court has said that in relation to the costs incurred by the Tribunal and the CAC:

> *"… the choice is between the [doctor] who was … found guilty … and the medical profession as a whole"*[22]

These observations arise from the fact that the costs of running the Tribunal and the CAC are met in the first instance by the entire profession.

85. 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 person to pay 50% of the costs incurred by the professional disciplinary body.[23] Of course, before making any award of costs the Tribunal must take account of the total amounts involved in the doctor's ability to pay costs.

86. In this case, Dr A gave evidence about his financial circumstances. It is apparent that he is impecunious and that any award of costs will be difficult to pay if Dr A is required to pay them without resource to assistance from other quarters.

87. In making an award of costs against Dr A the Tribunal has paid particular attention to the following:

87.1 Dr A has been found guilty of a serious disciplinary offence;

87.2 Dr A pleaded guilty and thereby reducing the length of the hearing and avoided the need for the complainant to give evidence;

87.3 Dr A is presently impecunious.

88. Having taken all these factors into account the Tribunal orders Dr A pay $12,448.23 being 25% of the costs and expenses of the hearing of the Tribunal and the CAC.

Publication

89. The Tribunal orders publication of its orders in the New Zealand Medical Journal pursuant to s.138 of the Medical Practitioners Act 1995 in a way which does not name or identify Dr A or the complainant.

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[22] *Vasan v The Medical Council of New Zealand*, unreported, High Court Wellington, AP43/91, 18 December 1991, Jefferies J

[23] See for example, *Neuberger v Veterinary Surgeons Board*, unreported, High Court Wellington, AP103/94, 7 April 1995, Doogue J

Summary

90. The Tribunal finds Dr A's acts and omissions constitute professional misconduct and that he is:

90.1 Ordered not to practise medicine for a period of three years except under the supervision of a vocationally registered psychiatrist who is available on site to ensure that he is closely monitored;

90.2 Ordered to pay costs in the sum of $12,448.23.

91. Nothing may be published which names or otherwise identifies the complainant and Dr A.

DATED at Wellington this 28th day of October 2004

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal