MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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**DECISION NO:** 317/04/123D

**IN THE MATTER** of the Medical Practitioners Act 1995

-AND-

**IN THE MATTER** of a charge laid by the Director of Proceedings designated under the Health & Disability Commissioner Act 1994 against **JOHN ANGUS MARKS** medical practitioner of Gisborne but formerly of Wellington.

**BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL**

**TRIBUNAL:** Miss S M Moran (Chair)

Dr I D S Civil, Dr M Honeyman, Dr A D Stewart, Mrs H White (Members)

Ms K L Davies (Hearing Officer)

Ms H Hoffman (Stenographer)

Hearing held at Wellington on Monday 6 through to and including Thursday 9 December 2004

**APPEARANCES:** Ms K P McDonald QC and Mr J Tamm for the Director of Proceedings

Mr C J Hodson QC and Ms R Scott for Dr J A Marks

**Supplementary decision on penalty**

1. In its decision 308/04/123D dated 20 April 2005 (the substantive decision) the Tribunal found Dr Marks guilty of professional misconduct in seven respects. In accordance with normal practice, this decision should be read in conjunction with the substantive decision.

2. The finding of professional misconduct was made by the Tribunal following the hearing of a charge laid by the Director of Proceedings. The charge arose in the context of Dr Marks' management and treatment of the late AB (A) during the period 11 August to 8 October 1999. A's name was permanently suppressed.

3. At the hearing, Dr Marks defended the charge in all its particulars and denied that he had been guilty of professional misconduct.

**Findings on Charge**

Particular 1.1

4. The Tribunal found that Dr Marks failed to undertake or document an adequate clinical assessment of A on or about 11 August 1999 or at any time thereafter.

5. The Tribunal found that given the scant records that Dr Marks made, the inadequacy of his notes and, importantly, the nature of the content of the notes, the only

reasonable inference was that Dr Marks failed to undertake adequate clinical assessments from 11 August 1999 onwards.

6. The Tribunal was also able to reach this view having carefully observed Dr Marks give his evidence, having heard his answers under cross-examination, having perused the medical notes which he made of the consultations, having perused the other written material, and having carefully considered the evidence of the witnesses.

7. It rejected Dr Marks' claim that he undertook adequate assessments but did not record them in writing.

Particular 1.2

8. The Tribunal found that on or about 11 August 1999 or at any time thereafter Dr Marks failed to undertake or document an adequate risk assessment.

9. The Tribunal found that despite what Dr Marks said about A presenting as a very high risk of suicide, Dr Marks' conduct was inconsistent with that understanding and that he failed to communicate A's high risk to others which was borne out in the "Risk Assessment Form" completed by A's care manager on 1 October 1999.

10. The Tribunal further found that Dr Marks failed to communicate adequately the levels of A's risk to his parents and did not tell them at any time that he was a suicide risk.

11. A's treatment and assessment of his risk needed to be assessed against the background of his multiple suicide attempts and the other evidence which had been provided to the Tribunal. Dr Marks' notes were entirely silent on the issue of suicidation.

Particular 1.3

12. The Tribunal found that on or about 11 August 1999 or at any time thereafter, Dr Marks failed to develop or document an adequate treatment plan.

13. There was no evidence that Dr Marks discussed or developed a comprehensive plan of treatment for A; and there was nothing in Dr Marks' notes other than some bare references to what he had prescribed or that A was to be seen by the care manager that could ever be thought to resemble *"a treatment plan"*.

Particular 2.1

14. The Tribunal found that on or about 10 September 1999 or at any time thereafter, Dr Marks failed to undertake or document a thorough and systematic review of A's mental status.

15. Dr Marks' evidence was that A's condition would have been obvious to any other clinician perusing the records. The Tribunal found that Dr Marks' position seemed to be that A's mental state could have been worked out by looking at the various entries in the notes and piecing together an assessment of A based on the scant notes that were recorded. It was the Tribunal's view that this piecemeal approach fell well short of what was accepted practice from a consultant psychiatrist.

16. By way of example, with regard to Dr Marks' notes for the 10 September 1999 consultation, there was no recording of A's thought form or content, any abnormal perceptions, mood state or affect; and nor was there a recorded assessment or formulation of A's presenting situation and clinical state at that time as viewed in the context of his past history (including his risk to himself and others). Dr Marks had recorded that A was *"scared"* but there was no explanation of what A was scared about or any indication of the presence or absence of psychotic symptoms. When questioned at the hearing about what *"scared"* meant, Dr Marks proffered an explanation. However, it was readily apparent to the Tribunal that Dr Marks was not sure at all what the reference to *"scared"* meant and found his answers to this particular issue opportunistic.

Particular 2.2

17. The Tribunal found that on or about 10 September 1999 or at any time thereafter, Dr Marks failed to adequately formulate or document a diagnosis.

18. Despite Dr Marks' claim that he had made the diagnosis of cycloid psychosis, there was no record in the notes when or how he came to that conclusion, and there was no record of such a diagnosis or of a diagnosis of psychotic depression.

19. The Tribunal found that having reached that diagnosis it was incumbent on Dr Marks to make a note of it for the benefit of other clinicians.

20. The Tribunal specifically rejected Dr Marks' explanation that he was prevented from making any such recording as a result of a letter from his employers and found that he was not prevented from making a record of his diagnosis as a result of his employment situation.

21. At no time in his notes did Dr Marks record the onset of A's psychotic depression. While he claimed he was aware of the emergence of psychotic features in a depressive phase he failed to make a record of that at any stage. It was of critical importance that A's emerging psychotic symptoms were appreciated but there was no evidence to suggest that Dr Marks ever appreciated the significance of the emerging psychosis despite the fact that he told the Tribunal that A was suffering from a psychotic depression.

Particular 3

22. The Tribunal found that on or about 17 September 1999 or at any time thereafter Dr Marks failed to undertake an adequate review and/or adjustment of A's medication plan in the light of his presentation.

23. The Tribunal found there was ample evidence to support this particular. It specifically found aspects of Dr Marks' explanation as not being credible.

Particular 4

24. On or about 8 October 1999 Dr Marks failed to communicate adequately with A, and/or his partner Ms E, and/or his parents regarding the advantages and/or disadvantages of admission to hospital.

25. The Tribunal found that A's parents would have been very receptive to the idea of admission and that while A may not have wanted to go to hospital it was clear that his parents were confident they could have convinced him to do so. They had done so previously.

26. At the consultation of 8 October 1999, A was not in a position to make rational decisions in relation to his care and in those circumstances his attitude should not have been considered an overriding factor in Dr Marks' decision whether to discuss the issue of hospitalisation.

27. A's parents were heavily involved in his care from the outset and it was equally clear that A relied on them and they were able to influence compliance both in general terms and more particularly as it related to the issue of hospitalisation. This was known to Dr Marks.

28. Dr Marks had an obligation to discuss the issue of hospitalisation in a way which the family could understand.

29. Further, in earlier correspondence with the Health & Disability Commissioner, when he (the Commissioner) was investigating the parents' complaint, Dr Marks had written that the family opposed admission and that A had become comparatively estranged from his family. The Tribunal found that neither of these statements were true and Dr Marks accepted, before the Tribunal, that the statements were not correct.

30. The true position was that A's parents were undoubtedly deeply concerned for the welfare of their son at all times and, at this last consultation, had Dr Marks raised the issue of hospital admission and had he put forward its advantages and had he made it clear to the parents that A was a high suicide risk (as he made clear subsequently to both the Coroner at the inquest and before this Tribunal) it is beyond question that A's parents would have done all that they could to persuade A to enter hospital where he could have been appropriately observed and monitored.

**Submissions on Penalty**

Submissions by the Director of Proceedings

31. On behalf of the Director, Ms McDonald submitted that the registration of Dr Marks should be suspended; that upon resumption of practice he should be required to practise subject to conditions, that is, under strict supervision and monitoring; that reports be made to the Medical Council at regular intervals on his progress and supervision and that he undertake training focusing on mental health assessment, management and documentation. The Director also submitted that Dr Marks be censured, be fined and be ordered to pay costs.

32. The Director referred to what she described as *"aggravating features"*.

33. These features included the Tribunal unanimously upholding all the particulars to the charge the totality of which called for a significant penalty to protect the public, set appropriate standards, and punish the doctor.

34. The Director submitted that Dr Marks failed to undertake fundamental assessments well within the expected competence of a consultant psychiatrist in his position, and that in the face of A's history of high suicide risk Dr Marks took a particularly cavalier approach to A's management.

35. While the Director accepted that Dr Marks was entitled to put the prosecution to proof, his not guilty plea needed to be assessed in the context of the Tribunal's findings particularly as to his credibility.

36. Additionally, the Director submitted that the misconduct in question was not a "one off" incident but covered a period of over nine weeks and amounted to an ongoing and serious abrogation of Dr Marks' responsibilities as a consultant psychiatrist.

37. With regard to registration, the Director submitted that an appropriate penalty would be suspension from practice. In this regard the Director referred to the unwavering view Dr Marks expressed as to the validity of the management options despite his views being well out of step with those of the experts called on behalf of the prosecution and that Dr Marks' views must be of grave concern to the Tribunal.

38. With regard to conditions, the Director submitted that specifically the failings as found by the Tribunal were fundamental; that Dr Marks showed significant deficiencies in his understanding of the clinical issues involved in A's care; and Dr Marks' lack of insight into his shortcomings.

Submissions by Counsel for Dr Marks

39. Mr Hodson on behalf of Dr Marks described Dr Marks' career, before arriving in New Zealand in 1998, as distinguished. He referred to the fact that the events under review took place almost six years ago and that this tragic event constituted the sole blot on an otherwise successful career.

40. He opposed suspension as being manifestly oppressive and provided documentation in support of his submission.

41. With regard to conditions on Dr Marks' practice, Mr Hodson submitted that had the present enquiry taken place in the year 2000 there may well have been an argument for imposing conditions, but that period was long past and the Medical Council had satisfied itself both by conducting a competence review and by granting Dr Marks full registration. He added that there was nothing which would make conditions on Dr Marks' practice appropriate at the present time in the context of his continued employment in Gisborne Hospital.

42. He stated that there was no evidential and/or current basis on which to act on the Director's request for conditions to be imposed and commented that the Director, while asking for conditions, had made no suggestions as to what would be appropriate.

43. Mr Hodson accepted that the reality is that the Tribunal would want to impose a censure. While he thought that sometimes members of the public thought this was an empty gesture for a doctor, it was not so and that every doctor could appreciate the weight of a formal reproof of this nature administered by the doctor's profession.

44. Mr Hodson submitted that the Tribunal may impose a fine but asked the Tribunal to take into account Dr Marks' means.

45. Dr Marks' domestic and financial arrangements were made available to the Tribunal by way of documentation and an affidavit from Dr Marks.

46. Mr Hodson accepted that it is inevitable, having regard to past precedent, that the Tribunal would make an order requiring Dr Marks to pay a proportion of the costs incurred.

47. Dr Marks' counsel referred to the lengthy history of events which followed the death of A which included an internal enquiry at Capital Coast Health which produced a lengthy report in February 2000 and which recommended supervision for two aspects of Dr Marks' practice which was put into effect at the time.

48. This was followed by the Coroner's inquest which commenced in May 2001 until delivery of the Coroner's verdict on 15 October 2002.

49. There was also an enquiry by the Health & Disability Commissioner following a complaint made by A's parents in 2000 with the Commissioner's final opinion being available in March 2004.

50. Mr Hodson submitted that these events by themselves had constituted a substantial punishment for Dr Marks.

51. He added that since the Tribunal had made its findings there had been media reporting which was to be expected but which caused considerable comment to be made in Gisborne where the doctor now practises.

52. Mr Hodson referred to a report made on the supervision and a resolution of the Medical Council in June 2001 approving Dr Marks ceasing to be under a competence programme.

53. Mr Hodson concluded that on the basis of 30 years good practice before the present event, and five years good practise since, and the comments in the supervision report, it appeared clear that the present episode was an uncharacteristic tragedy in an otherwise reputable career stemming from incompatible employment circumstances in a foreign environment.

**Simpson/Carncross Report**

54. In his submissions on behalf of Dr Marks, Mr Hodson referred to an internal enquiry at Capital Coast Health which followed A's death. Mr Hodson stated that this produced in February 2000 a lengthy report authored by Dr Simpson and Ms Carncross who recommended supervision for two aspects of Dr Marks' practice which recommendation was put into effect at the time.

55. As Mr Hodson had made specific reference to this report, the Tribunal considered it appropriate that it should see it and accordingly asked for it to be produced.

56. Mr Hodson replied in further written submissions that the fact of there having been a lengthy review report authored by Dr Simpson and Ms Carncross was a matter of public record as it was discussed in the Coroner's Court at the commencement of the inquest. He stated that the contents of the report itself were not a matter of public record because the Coroner did not take it into account and proceeded on the evidence before him. Dr Simpson, but not Ms Carncross, gave evidence at the inquest. He stated that the report was commissioned by Capital Coast Health which was the owner of it and if the Tribunal required a copy of it then consent should be obtained from Capital Coast Health. He added that the purpose of mentioning it in his earlier submission was to indicate that there had been a recommendation for supervision. He stated that he had never seen any report on the supervision emanating from Capital Coast Health because the Medical Council took over the supervision when Dr Marks changed employment.

57. Capital Coast Health provided a copy of the report to the Tribunal, all members of which read it.

58. Mr Hodson objected to the Tribunal seeing it, arguing that it was both irrelevant and prejudicial and drew to the Tribunal's attention additional matters relating to it. Mr Hodson concluded that if all members of the Tribunal had read it then they must endeavour to put the content of most of it out of their minds and that a simple statement that they had done so would hardly be satisfactory.

59. Having read it, all members of the Tribunal were of the view that it did not in any way affect or influence the thinking of the Tribunal with regard to its decision on penalty. In any event, much of the material in it was already in evidence before the Tribunal.

**Medical Council Competence Review**

60. In his submissions, Mr Hodson stated that the Medical Council established a Competence Review Committee in November 1999 as a result of concerns expressed by Capital Coast Health.

61. A document entitled *"Competence Review on Dr John Angus Marks for the Medical Council of New Zealand in accordance with section 60-62 of the Medical Practitioners Act 1995"* was produced. While it is undated, it appears to have been concluded some time between 10 May 2001 and the Medical Council meeting in June 2001.

62. The scope of the review was to review Dr Marks' competence to practise medicine as a psychiatrist under section 60(1)(b) of the Act including the following:

(a) General clinical assessment and management
(b) Record keeping
(c) Communication and ability to work within a multi-disciplinary team.

63. The Committee concluded that Dr Marks had an acceptable level of competence following a competence programme but made the following suggestions to him:

(a) That he communicates the rationale for his diagnostic and management decisions clearly to the team with whom he works.
(b) That he clearly documents this rationale, documenting both negative and positive findings.
(c) That he finds out about and follows guidelines of his employers on clinical risk assessment and management.
(d) That he engages in ongoing supervision to assist with the above issues and to gain further understanding of the local New Zealand environment.

**Decision**

64. Having carefully reviewed the evidence and its substantive decision and having taken into account all of the matters submitted on behalf of both the Director of Proceedings and Dr Marks (not all of which detail has been set out in detail above), the Tribunal has concluded that the following penalty should be imposed:

(A) Dr Marks is censured.

(B) Dr Marks is fined $5,000.

(C) Dr Marks may, for a period not exceeding three years, practise medicine subject to the following condition:

(i) That Dr Marks be supervised and work in accordance with a supervision plan approved by the Medical Council of New Zealand.

(ii) That Dr Marks be responsible for the costs of and associated with the supervision.

(D) Dr Marks is required to pay 30% of the costs and expenses of the investigation by the Health & Disability Commissioner and prosecution of the charge by the Director of Proceedings (which amounted to $24,712.26), and 50% of the hearing of the Tribunal (which amounted to $19,192.26). The Secretary of the Tribunal will forward a schedule to Dr Marks setting out how these amounts have been calculated and the amount he is required to pay in accordance with this decision. The total amount of costs Dr Marks is therefore required to pay is $43,904.52.

65. The Tribunal recommends that the Medical Council of New Zealand consider a further competence review of Dr Marks. Given the concerns of the Tribunal, should the Medical Council undertake a further competence review, then it is of the view that it should be in regard to the competency and safety of Dr Marks' practice focusing on mental health assessment, management and documentation, and including:

(a) management of patients with chronic psychosis;

(b) clear communication of the rationale for his diagnostic and management decisions to the team with whom he works;

(c) clear documentation of the rationale recording both negative and positive findings;

(d) ascertaining and following the guidelines of his employer on clinical risk assessment and management.

While it is not the Tribunal's function to state how the Medical Council should carry out a competence review, should the Medical Council undertake a further review regarding Dr Marks then it is the Tribunal's view that any audit it may make of Dr Marks' files be randomly selected and not ones which Dr Marks selects.

66. The Secretary of the Tribunal shall cause a notice under section 138(2) of the Act to be published in the New Zealand Medical Journal.

**Reasons**

67. Although the Director of Proceedings submitted that suspension of Dr Marks' practice was appropriate, the Tribunal was not persuaded that this was an appropriate course to take.

68. With regard to conditions as to practice, Mr Hodson submitted that had the enquiry before the Tribunal taken place in the year 2000 there could well have been an argument for imposing conditions on Dr Marks' practice. However, as that period was long past and that the Medical Council had satisfied itself both by conducting the competence review and by granting full registration, there was nothing in the case before the Tribunal which would make conditions on Dr Marks' practice appropriate at the present time in the context of his continued employment at Gisborne Hospital. He added that there could be little objection, notwithstanding his submission above, to the imposition of conditions were there some evidence that they were presently necessary and appropriate to the Tribunal's findings. He commented that it was notable that while the Director asked for conditions, she made no suggestion as to what conditions would be appropriate; and that the inferences of the Tribunal, while being empowered by statute to impose conditions, had no evidential and/or current basis on which to act on the Director's request.

69. The Tribunal does not agree with Mr Hodson's submissions regarding the imposition of conditions. While A died in 1999 and the competence review was

completed in 2001, the hearing before this Tribunal took place in 2004 at which time the Tribunal had the opportunity to hear and observe Dr Marks.

70. It would be fair to say that having heard and observed Dr Marks give his evidence in chief and in cross-examination, all members of the Tribunal were left with significant disquiet and with serious concerns as to the competency and safety of Dr Marks' practice.

71. Overall the Tribunal did not find Dr Marks a credible witness and thought that his answers often showed a significant lack of insight.

72. The principal purpose of the Medical Practitioners Act is to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine. The Tribunal would have some measure of comfort in knowing that the Medical Council were putting in place a plan of supervision regarding Dr Marks given the particulars of the charge and the deficiencies highlighted during the hearing and the findings of the Tribunal in relation to those particulars.

73. With regard to the fine imposed, while the Tribunal can impose one to the level of $20,000 it took into account Dr Marks' personal domestic situation and his straightened financial circumstances.

74. Notwithstanding the penalty imposed on Dr Marks, the principal concern of the Tribunal is to ensure that the health and safety of members of the public are protected and that Dr Marks is safe to continue practising in his chosen specialty. The Tribunal's emphasis is on a constructive approach.

**DATED** at Wellington this 1st day of September 2005

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Sandra Moran

Senior Deputy Chair

Medical Practitioners Disciplinary Tribunal