Medical Practitioners Disciplinary Tribunal

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DECISION NO: 28/97/16D

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(1)(a) of the Act against **JOHN DANNEFAERD NEALIE** medical practitioner of Waimauku

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr R S J Gellatly, Dr J M McKenzie,

Dr L F Wilson, Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Date of Hearing: 20 February 1998 at Auckland

Date of Receipt of
Final Submissions: 27 March 1998

Date of Decision: 23 April 1998

APPEARANCES: Ms K G Davenport, Director of Proceedings.

Mr H Waalkens for Dr J D Nealie ("the respondent").

1. DECISION:

THE hearing of the charge against the respondent concluded with the making of a finding by the Tribunal that the admitted facts amounted to disgraceful conduct in a professional respect. It was ordered that the respondent's name be removed from the Register (Section 110 (1)(a) of the Act). In making that Order the Tribunal expressly refrained from exercising either or both of the powers reposed in it under Section 111 of the Act. It was also ordered that the respondent be censured. Leave was reserved for counsel to make submissions on monetary penalties. Those submissions have now been received, thus facilitating issue of this Decision.

2. THE CHARGE:

2.1 '**THE** Director of Proceedings pursuant to section 102 of the Medical Practitioners Act charges John Nealie of Auckland Medical Practitioner that between December 1996 and March 1997 his management and treatment of his patient A was inappropriate.

Namely:

1. That he is in breach of Rights 2, 4(2) and 4(5) of the Code of Health and Disability Services Consumers' Rights.

RIGHT 2

Right to Freedom from Discrimination, Coercion, Harassment,

and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

"Exploitation" includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence.

RIGHT 4

Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

And/Or Further

1. He entered into a sexual relationship with Mrs A, his patient, between November 1996 and March 1997.

2. The relationship between Mrs A and Dr Nealie was a form of sexual abuse in the patient doctor relationship and amounted to sexual violation as that term is defined in the New

Zealand Medical Council's Statement for the Profession on Sexual Abuse dated June 1994.

3. When attending Mrs A in response to her suicide attempts he did not, on 11 March 1997, provide her with appropriate medical services (namely psychiatric follow-up, further physical check-up and toxicology testing) or fully record his attendances in the notes.

4. On 11 March 1997 following Mrs A's second suicide attempt he failed to attend her, or advise her husband of any alternative available medical assistance, or to arrange any subsequent visit or call to assess her welfare.

Such conduct reflects adversely on the practitioner's fitness to practice medicine, being disgraceful conduct in a professional respect."

3. PRIVACY ORDER:

3.1 **IN** Decision Number 25/97/16D which issued on 16 February 1998 the Tribunal made an order (following application from Ms Davenport on behalf of Mrs A) pursuant to Section 106 (2)(d) of the Act prohibiting publication of the name of A, or any particulars of her affairs in any manner which may identify her.

4. UNDERTAKING NOT TO PRACTISE MEDICINE:

4.1 **THE** Director of Proceedings recommended to the Tribunal that pending determination of the charge, registration of the respondent be suspended pursuant to Section 104 of the Medical Practitioners Act 1995. In Decision Number 23/97/16D which issued on 24 December 1997 the Tribunal ordered, until the charge of disgraceful conduct in a professional respect against

the respondent had been heard and determined, that he not return to medical practice, in accordance with a written undertaking to that effect given by him to the Tribunal on 22 December 1997, with leave reserved to apply for any further or other orders. The written undertaking not to return to medical practice covers the interregnum between the date of hearing of the charge and its determination as evidenced by delivery of this Decision.

5. BACKGROUND:

5.1 **THE** respondent was the general practitioner for Mrs A for 15 years. He knew Mrs A and her family intimately. Late in 1996 Mrs A began to see the respondent regularly. He began to suggest that she meet him after hours for treatment of her leg. One day the respondent laid out food and drink and after some alcohol was consumed the respondent kissed Mrs A. At a later date a sexual relationship began. This relationship ended and Mrs A was so upset that she attempted suicide. She was treated by the respondent and his nurse. It is alleged that this treatment was not of an acceptable standard and that Mrs A's care was further jeopardised. She attempted suicide again that night. She later had a termination of the respondent's child.

6. EVIDENCE FOR THE DIRECTOR OF PROCEEDINGS:

A:

6.1 **SHE** is the person who complained to the Health and Disability Commissioner about the relationship she had with the respondent. Currently aged xx, she has xx children who are xx, xx and xx.

6.2 **QUITE** early in the doctor/patient relationship she had told him about personal circumstances of her own, about how she had been raped badly at 13 and how it was important for him to

be present for the delivery of her xx child, for which apparently he was not present, because the medical staff had not called him.

6.3 **A** growing relationship of trust and dependency grew between the respondent and Mrs A in 1995 and 1996. In January/February 1996 the respondent removed a pre-cancerous growth from her leg. She kept knocking it and the stitches kept re-opening and she kept having to go back to the respondent to have the wound re-stitched. He became a real friend to her, she felt. This was of some importance. She was feeling depressed as her husband, because of his work, was not there often for her.

6.4 **THE** respondent began to offer her appointments after hours as she worked shift and he would often come downstairs from his upper lounge on top of the practice with a drink in his hand.

6.5 **SHE** became very reliant upon seeing the respondent and him taking notice of her. She became so dependent upon the respondent that when her leg began to heal she started to rip the stitches open so that she would have a reason for going back to see him. When the relationship started with the respondent he confirmed he was distressed that she was doing this.

6.6 **ON** one occasion the respondent gave her a bottle of Port in a paper bag. He told her to put it in her car straight away so nobody could see what he was giving her because *"you know how people talk"*.

6.7 **THE** respondent telephoned her at work one Friday afternoon to come in for a leg dressing. When she arrived there were no other patients. He dressed her leg and then told her to put

it up. He then asked if she would like a gin. After about 4 or 5 gins she noticed the respondent was staring at her and she asked him what he was looking at. He said that she was the most relaxed he had ever seen her. She went to stand up and found it difficult to do so (she could hear her children who were in the waiting room). He then came around and put his arms around her and started kissing her. Mrs A said she had to go to her children. She could hardly walk and the respondent told her to take some deep breaths and that she could do it. She then drove home with her children in the car.

6.8 **THE** respondent telephoned her the next day and said he had been thinking about her and could not sleep. He said he could not believe what had happened. He said she was the only patient it had ever happened to. The respondent made her feel like someone so special. She said he told her how much they had in common.

6.9 **ON** the Monday she had to go in to have her leg dressed. It was just after Christmas. The respondent said to come in at 6.30 pm and he told her to park the car around the back. He had chips, avocado dip etc laid out on his desk. He locked the door. She had a lot of gin and was a bit intoxicated. He put his arms around her and started kissing her. He asked her what she wanted to happen and Mrs A said she was scared. She mentioned that she had heard gossip about another lady in the community and him (the respondent) having an affair, but he said he had only had an affair years ago. They then had sex on the floor of his office. When it was all over he unlocked the door and ushered her out. The sex she found was not very pleasant but he was so kind to her and gave her great attention.

6.10 **THE** respondent telephoned her at the beginning of January as she still had to have the leg looked at and they began to have sex on a regular basis. Mrs A said the respondent encouraged oral sex, which she found distasteful, but he wanted her to do it to him. She said *"I felt very degraded. I saw him two days later and I could hardly look at his face and told him how I felt. He said that was part of my hang up (I took that to mean the rape)"*. Mrs A said she continued on with the relationship with her feeling very gravely like it was not right. She said no form of contraception was used at all throughout the relationship.

6.11 **IN** the first week in March she went in and the respondent seemed very off-hand. He said *"that he was getting in way too deep and that would I just walk away"*. Mrs A continued *"I felt like a part of me had been ripped out, that it had just ended"*. There was no call from the respondent that night, although he said he would call her. Over the weekend she began to get worse. The respondent contacted her on the Saturday and asked how she was. Mrs A replied *"I told him I was like a sheet of glass ready to shatter"*. She said the respondent kept telling her he was sorry. Mrs A said *"Sorry was not helping me. He also knew my husband was away that weekend on a fishing trip"*.

6.12 **IN** describing her increasing feelings of depression Mrs A explained:

"After that I began to feel more and more depressed, like I was at the bottom of a pit. I didn't want to live. I sent a message on John Nealie's pager on the Tuesday morning thinking he could help me. I waited for nearly two hours for a reply from him. There was nothing. Then I just snapped. I got all the pills I could find in the house and kept on taking them. My husband arrived home unexpectedly. I was beginning to get dozy.

xx took me straight to the surgery. I don't remember a lot of what happened after that. xx eventually brought me home."

6.13 **MRS** A said that she told her sister about her relationship with the respondent. Her sister than contacted the respondent and told him she was aware of the situation. This was the same day as the overdose. The respondent called in that night and wanted to know what Mrs A had told her sister. Mrs A continued *"Then he said he would deny anything I said. He told me this twice."* The respondent then asked her if she had had a period and she said no. The respondent had said she had better come into the clinic for tests. She was very very depressed and she tried to commit suicide again that night after he left by taking a full bottle of nurofen. Although Mrs A's husband telephoned the respondent immediately his response was that a full bottle of nurofen would not hurt her and she said he did not come up to find out how she was or send her for any tests.

6.14 **MRS** A had become so depressed and down that she went to live with her mother the next day and began to have counselling at xx. She then began, after much counselling, to feel like she could recover and face the dreadful situation that she was in. She felt she was an emotional wreck. She had been given a pregnancy test kit which she took home and was told to test a week later, which she did and found out she was pregnant. Mrs A said she could not tell anyone and at that stage even her husband did not know about the respondent. Her husband had had a vasectomy eight years ago so she knew it was not his child. She said she was in a hell of a mess. She had a very close friend in whom she confided. Her friend knew of somebody who performed abortions, no questions asked. Mrs A went to that person and had it done. At the time she said she felt she had nothing to lose as she felt her life was over

anyway. She said she did not care whether she lived or died. She said she could not stand the humiliation by going through normal procedures and wanted nothing to do with any doctors after what she had been through with the respondent. It has taken her a long time and she still feels very humiliated, depressed and upset when she considers the whole episode and she does not think she will ever recover.

Mary Farrell:

6.15 **MARY** Farrell resides in Auckland and is an accredited counsellor and psychotherapist and a member of the New Zealand Association of Counsellors. Her qualifications are BA(Hons), PGCE Dip Counselling, BACAccred and an ACC approved counsellor and psychotherapist.

6.16 **MRS** A's first visit to her was on Wednesday 12 March 1997. She had been referred by her sister and was accompanied by her mother and was in a highly distressed and debilitated state.

6.17 **MRS** A recounted to her that she had been sexually involved with her GP, the respondent, and that he had ended their relationship in a dismissive manner and that she had taken two overdoses of tablets.

6.18 **ON** checking if Mrs A had been to hospital or had monitoring of her physical well-being following the overdoses, she was shocked to discover that she had had no other treatment but an emetic to induce vomiting and no other doctor had seen her but the respondent who had been the perpetrator of the sexual abuse.

6.19 **AS** she was concerned about Mrs A's physical safety first and foremost, she referred her to the xx Family Health Practice and made sure she was going to be seen by a female doctor. At this time Mrs A was complaining of severe lower back pain and had no idea whether or not she had taken any drugs containing paracetamol.

6.20 **AFTER** Mrs A had had the necessary tests to establish her physical health, weekly counselling sessions were begun and Ms Farrell lodged her report and claim for counselling fees with the ACC Sensitive Claims Unit.

6.21 **MS** Farrell assessed Mrs A as a "high impact" client and sees her as such. In other words, Ms Farrell considers that Mrs A suffers extreme trauma and is now suffering from complex post-traumatic stress as a result of the sexual abuse by the respondent.

6.22 **DURING** the counselling it has been clear that Mrs A has suffered the symptoms of repeated traumatic and intrusive flashbacks of the abuse, nightmares, intense anxiety and hypervigilance, obsessive and phobic thoughts of the perpetrator (fear of seeing the respondent) and extreme feelings of shame and worthlessness. These symptoms, in Ms Farrell's professional opinion, are a direct result of the sexual abuse by the respondent, seriously compounding Mrs A's earlier history of rape when she was a young teenager. Referring to her understanding of the respondent's knowledge of this dreadful experience and as a medical practitioner, Ms Farrell explained the respondent would have known that this incident would have increased the impact on Mrs A of any further exploitation or abuse.

6.23 **IN** Ms Farrell's opinion, the other compounding factor in this sad case is the fact that Mrs A had been a patient of the respondent for 15 years. The trust that had been built up during this time meant that Mrs A saw him as a figure of paternal and almost omnipotent beneficence.

6.24 **MS** Farrell explained Mrs A felt that the respondent certainly knew what he was doing and recommending to her, and contained in that would be a hypnotic element which would predispose Mrs A to follow his suggestions unquestioningly.

6.25 **IN** Ms Farrell's view Mrs A is a highly vulnerable woman who has suffered enormous psychological consequences as a result of the abuse and that she will only gradually heal with weekly counselling sessions. ACC have currently allotted 60 sessions under Sensitive Claims and will allocate more if necessary.

6.26 **MS** Farrell explained the post-traumatic stress disorder that Mrs A suffers from needs careful debriefing and gradual and painstaking rebuilding of her internal world and system of meanings. Needless to say, the effects of this last year have also taken a toll on Mrs A's family, especially her young sons, Ms Farrell concluded.

6.27 **UNDER** cross-examination by Mr Waalkens it was conceded by Ms Farrell that she did not have access to a psychological profile of Mrs A prior to her relationship with Dr Nealie. Nevertheless Ms Farrell maintained that most of the trauma Mrs A is suffering now is as a result of the recent abuse by Dr Nealie.

B:

6.28 **THERE** was no written brief of the evidence of the practice nurse, B, she having been subpoenaed to attend the hearing as a witness. Mrs B identified for Ms Davenport an entry she had made in the medical notes on 11 March 1997 recording Mrs A's blood pressure and her pulse. As well Mrs B indicated that she had checked Mrs A's pupils to determine her state of consciousness. Explaining that she had considerable experience in emergency nursing, Mrs B was critical of Dr Nealie for not sending Mrs A to hospital following the overdose.

7. EVIDENCE FOR THE RESPONDENT:

7.1 **IN** electing not to call any evidence from or on behalf of the respondent, Mr Waalkens confirmed admission of the charge as constituting disgraceful conduct in a professional respect. Nonetheless the Tribunal considers, quite independent of any admissions made by or on behalf of the respondent, that it has a responsibility to determine whether the facts alleged in the charge had been proved to the required standard. For this reason it was considered necessary to include in this Decision the substantial detail of the evidence of the witnesses called by the Director of Proceedings.

7.2 **ALTHOUGH** having engaged in minimum cross-examination of witnesses, and having called no evidence, Mr Waalkens asked for it to be recorded that the matrix of the evidence overall could be open to challenge in a number of minor respects. For example Mr Waalkens signalled that there were some reservations to the evidence given by Ms Farrell and in some minor respects Mrs A's interpretation of events did not accord with that of the respondent.

7.3 **BE** that as it may, it is to the respondent's credit that he has endeavoured to minimise Mrs A's ongoing suffering by choosing not to give evidence or to challenge the substance of the evidence for the Director of Proceedings.

7.4 **THE** facts having been established to the required standard, the Tribunal must now go on to determine whether the conduct established by the proven facts amounts to disgraceful conduct in a professional respect.

8. PROFESSIONAL GUIDELINES:

8.1 **ALTHOUGH** the Tribunal is a newly constituted body under the Medical Practitioners Act 1995, it has the resources of past statements of the governing bodies of the medical profession on which to draw when assessing professional standards. For example the Code of Ethics of the New Zealand Medical Association requires a medical practitioner to ensure that all conduct in the practice of the profession is above reproach and neither physical, emotional nor financial advantage is taken of any patient.

8.2 **IN** June 1994, well before the events to which these proceedings relate, the Medical Council of New Zealand issued a statement for the profession on sexual abuse in the doctor/patient relationship. The statement confirms that the doctor must ensure that every interaction with a patient is conducted in a sensitive and appropriate manner with full information and consent and that the Council condemns all forms of sexual abuse in the doctor/patient relationship for reasons set out in the statement. It points out that the onus is on the doctor to behave in a professional manner, that total integrity of doctors is the proper expectation of the community and of the profession, that the doctor is in a privileged position which may increase the risk of

boundaries being broken, that sexual misconduct by a doctor risks causing psychological damage, and that the doctor/patient relationship is not equal - in seeking assistance, guidance and treatment, the patient is vulnerable.

8.3 **THIS** is confirmed by a consideration of reports of a number of cases published in the New Zealand Medical Journal where the Council has found doctors guilty of sexual intimacies of various kinds. Ms Davenport provided the Tribunal with copies of several reports of this nature. Where the degree has been other than minor, the Council has consistently found the doctor guilty of disgraceful conduct, with the consequence that the doctor's name has been removed from the Register or the doctor has been suspended from practice.

9. THE FINDINGS:

9.1 **THE** Tribunal makes the following findings:

9.1.1 **THE** respondent entered into a sexual relationship with Mrs A, his patient between November 1996 and March 1997.

9.1.2 **THE** relationship between Mrs A and the respondent was a form of sexual abuse in the doctor/patient relationship and amounted to sexual violation as that term is defined in the New Zealand Medical Council's statement for the profession on sexual abuse dated 16 June 1994.

9.1.3 **WHEN** attending Mrs A in response to her suicide attempts the respondent did not, on 11 March 1997, provide her with appropriate medical services (namely psychiatric

follow-up, further physical check-up and toxicology testing) or fully record his attendances in the notes.

9.1.4 **ON** 11 March 1997 following Mrs A's second suicide attempt, the respondent failed to attend her, or advise her husband of any alternative available medical assistance, or to arrange any subsequent visit or call to assess her welfare.

9.2 **IN** all four respects the above conduct reflects adversely on the respondent's fitness to practise medicine, constituting disgraceful conduct in a professional respect.

9.3 **THE** obligation of the Tribunal is to make clear both its findings on each particular of the charge and its findings on any comprehensive charge. In the normal course of events it should also give a reasonably full explanation of its reasons. However in the present case that is not necessary given the fact that the respondent did not give evidence and the admission on his behalf by very experienced counsel in this jurisdiction that the particulars of the charge amount to disgraceful conduct in a professional respect.

9.4 **THE** Tribunal would add that the conduct complained of fell well short of the conduct to be expected of a reasonably competent general practitioner. This is clearly so. The Medical Council's statement on sexual relations with patients makes it clear that *"The Council will not tolerate sexual activity with a current patient by a doctor"*. Sexual violation is the most serious of the categories of offence identified by the Council. The failure to treat Mrs A properly or note her records compounded this breach.

9.5 **THE** relevant standards are set by the medical profession, it being represented on the Tribunal by three of its members together with a representative of consumers and a legal Chair. In *Faris v Medical Practitioners Disciplinary Committee* [1993] 1 NZLR 60 Gallen J posed the question and went on to make the following observations which are relevant:

".... whether the fixing of standards by the medical peers of persons subject to charges, refers to the disciplinary committee or to the wider body of practitioners. The answer to that I think is that the disciplinary committee is to be regarded as a representative body. It would be impracticable and undesirable to endeavour to set standards by some kind of referendum. Those standards must be fixed by the members of the committee themselves, but in doing so they must bear in mind that they act in a representative capacity and must endeavour to formulate standards which are themselves seen as representative, rather than an expression of their own personal views. The standards are professional in nature and need to be seen in that light. No doubt there are certain difficulties theoretically in arriving at and expressing such standards. However, this is the way in which professional bodies have always acted and in practical terms I think there would be little difficulty in determining those standards in an acceptable way. That view is in accordance with the comments in ***Ongley v Medical Council of New Zealand****".*

9.6 **FROM** decided cases and statements of the Medical Council it is clear that there is absolutely no tolerance of any form of sexual relationship, the reason of course being because of the imbalance of power in such a relationship and the abuse of trust which is so necessary for the doctor/patient relationship. This abuse is compounded if the relationship interferes with the proper care of the patient. This was clearly so when the respondent failed to properly treat

Mrs A's two attempted suicides. The Tribunal has no alternative but to find the respondent guilty of disgraceful conduct in a professional respect.

10. ORDERS:

THE Tribunal makes the following orders:

10.1 **THAT** Dr Nealie's name be removed from the Register pursuant to Section 110 (a) of the Medical Practitioners Act 1995. The Tribunal expressly refrains from making any order under Section 111 of the Act.

10.2 **THAT** the respondent be censured.

10.3 FINE:

THAT the respondent be fined $10,000.00.

10.4 COSTS:

THAT the respondent pay a contribution of $3,905.00 towards costs and expenses of and incidental to the following and apportioned as stated:

10.4.1 **INVESTIGATION** made by the Health and Disability Commissioner under the Health and Disability Commissioner Act 1994 in relation to the subject matter of the charge: $750.00.

10.4.2 **THE** prosecution of the charge by the Director of Proceedings: $3,155.00.

10.5 **THAT** the order made by the Tribunal in Decision No. 25/97/16D pursuant to Section 106(2)(d) of the Act prohibiting publication of the name of A, or any particulars of her affairs in any manner which may identify her, is continued.

10.6 **THAT** publication under Section 138 of the Act be made in the New Zealand Medical Journal.

11. REASONS FOR ORDERS:

11.1 REMOVAL FROM THE REGISTER:

11.1.1 **RECORDED** is Mr Waalkens' submission that removal from the Register is discretionary rather than mandatory, and that in this case suspension of Dr Nealie's registration as a medical practitioner for a period up to 12 months would be more appropriate than removal of name from the Register. For this submission reliance was placed on a report from Dr M D Eilenberg, a Specialist in Psychiatry, addressed to the Tribunal dated 17 February 1998. Dr Eilenberg spoke of seeing the respondent on some ten occasions, excluding the initial consultation, prescription of anti-depressants and involvement of him in psycho-therapy for his feelings of guilt, depressed mood, and suicidal ideation. Dr Eilenberg explained that the respondent had obviously had considerable traumas as a result of the present situation, involving coming to terms with the emotional impact on his family, withdrawing from medical practice and the sale of that practice as well as awaiting the outcome of the disciplinary proceedings.

11.1.2 **AFTER** addressing certain underlying psychological elements that may have partly contributed to the relationship that became the subject of the disciplinary proceedings,

Dr Eilenberg concluded his report by expressing the view that with ongoing psycho-therapy and with the resolution of present difficulties, whatever the outcome, that there was a very good chance that should, at some time in the future, Dr Nealie both be allowed and wish to practise medicine, that he would consider the prognosis good as to any further transgressions of professional boundaries. Dr Eilenberg explained he felt supported to some extent in this view, by the degree of Dr Nealie's remorse, his sense of having let himself down, his family, his profession and despite what had taken place, Dr Eilenberg's belief that Dr Nealie has a sense of conscience and responsibility which would support his hopes about changes in his future behaviour.

11.1.3 **ADDITIONALLY** Mr Waalkens supplied the Tribunal at the hearing with copies of very supportive testimonials from two sets of former patients.

11.1.4 **THE** Tribunal acknowledges that this is a very tragic case, not only from the point of view of Mrs A but also from the point of view of Dr Nealie. Both parties have suffered significantly. Responsibly Dr Nealie stopped practising medicine voluntarily. He should and is given credit for this. He has sold his practice. His life is seemingly in ruins. Although credit can be given for Dr Nealie's co-operation, and the fact that he has endeavoured to decrease Mrs A's ongoing suffering, the Tribunal considers the circumstances of this case to be so serious that any period of suspension, even were it to be of a maximum 12 months duration, would be seen to trivialise an enormous miscalculation of judgement. Dr Nealie abused the relationship of trust between doctor and patient and then aggravated that serious breach of trust by failing to provide appropriate medical services during two attempted suicides.

11.2 CENSURE:

A censure order ought to be made in this case, especially given the finding of disgraceful conduct.

11.3 FINE:

11.3.1 ASSESSING the level of the fine which ought to be imposed in this case is not straight forward. One of the criticisms levelled at the Medical Practitioners Act 1968 and the transitional period provisions was that the maximum fine of $1000.00 was so low as often to be out of keeping with the serious nature of the level of the offending, whether professional misconduct or disgraceful conduct in a professional respect.

11.3.2 IN this case the Tribunal has found the respondent guilty of the most serious of all of the offences, disgraceful conduct in a professional respect. The facts in this case need no further canvassing but they are serious. The admissions of misconduct are at the higher end of the scale. Ms Davenport submitted that the Tribunal must therefore award costs which are commensurate with a finding of disgraceful conduct. Accordingly Ms Davenport argued that the level of fine in this case ought to be in the vicinity of $17,000 - $20,000.

11.3.3 IN the circumstances, Mr Waalkens submitted it would be wrong to fine Dr Nealie towards the upper end of the scale as Ms Davenport seeks, a fine of $17,000 - $20,000 being wrong, harsh, excessive and unreasonable. In declining to recommend

to the Tribunal actual quantum of fine, Mr Waalkens argued against imposition of a fine for the following reasons:

(a) The offending in question was unacceptable and hence acceptance of the charge of disgraceful conduct. It was, however, a consensual relationship - albeit this not being offered as an excuse by Dr Nealie - rather than an explanation for what happened.

(b) To say that he has co-operated from the outset with the investigation and prosecution, is an understatement.

(c) Dr Nealie has suffered substantially. His professional life has been ruined. He has no present employment nor any immediate prospects of such. He and his family are living on capital. His practice was sold in circumstances amounting to a *"fire sale"* for which he received little. He received $6,000 for the goodwill and equipment of the practice (prior to this matter, he estimates he would have received $150,000 or thereabouts for the same assets). Additional to the sale of the practice, Dr Nealie has sold the land and buildings where his medical practice was situated. Dr Nealie and his family have been living on the capital from the sale of the practice land and buildings. He presently has $130,000 approximately left in the bank against a mortgage of $30,000, and combined overdraft of $80,000.

(d) The Nealie's family home is now on the market for sale. It is an exceedingly poor time to be selling property in the current economic climate, but they have little alternative.

(e) Part of the penalty that Dr Nealie had suffered of course is the Disciplinary Tribunal's decision to remove his name from the Register of Medical Practitioners. That for Dr Nealie was a substantial penalty.

(f) When the Tribunal comes to assess what fine to impose on Dr Nealie, consideration should be given to the reaction of the local community. (Copies of letters and testimonials filed by Mr Waalkens with the Tribunal indicate that the Nealie family has received widespread support from several quarters in the community).

11.3.4 **NOT** to impose any fine at all was not an option which was given serious consideration by the Tribunal.

11.3.5 **ON** the other hand the Tribunal has taken into account some of the mitigating factors put before it by Mr Waalkens in imposing a mid-level fine of $10,000. Particularly the Tribunal considers there is merit in the submission that part of the penalty is the Tribunal's decision to remove Dr Nealie's name from the Register of Medical Practitioners. Although it was necessary to make that order in the public interest and for reasons of public safety, the Tribunal acknowledges that removal from the Register was a substantial penalty for Dr Nealie.

11.4 COSTS:

11.4.1 **THE** Director of Proceedings submitted a schedule of the Commissioner's costs for both the investigation and the proceedings against Dr Nealie:

	Hours	Rate	Total
Cost of Investigation:	48 hours @	$75.00	3,600.00
Cost of Prosecution:			
Counsel's time - Director of Proceedings			
Preliminary Matters	3.5 hours @	$160.00	560.00
Preparation	13 hours @	$160.00	2,080.00
Attending at Hearing	7 hours @	$160.00	1,120.00
Office Administration Staff Preparation	40.5 hours @	$ 40.00	1,620.00
Photocopying			549.00
Witness Fees:			
Mary Farrell			1,095.83
B			333.33
			$10,958.16

11.4.2 **MR** Waalkens was critical of the HDC's schedule of costs in the following respects:

(a) 48 hours for investigation of the case is plainly unreasonable. Dr Nealie from the outset signalled that he accepted the substance of the complaint including the fact of the sexual relationship.

(b) An additional 16.5 hours as costs of the prosecution excepting the hearing itself is unreasonable. There is no dispute with the hearing attendance, but the office administration staff attendances of 40.5 hours is unacceptable as *"preparation"* in the circumstances of this matter.

(c) Although, of itself, a relatively minor item, $549.00 for photocopying cannot be justified.

(d) As to witness fees, there is no *"clear mandate in the statute"* (*K v Auckland District Law Society*, Auckland High Court, HC 74/97 (Justices Cartwright,

Giles and Barker), 4 November 1997) in Section 110(1)(f) of the MP Act justifying the claim of actual witnesses fees. Witnesses costs in accordance with The Witnesses And Interpreters Fees Regulations 1974 should apply.

(e) The HDC should also be unable to recover wasted expenditure on attendances. That includes the unreasonable application and attendances seeking interim suspension of Dr Nealie in late December 1997.

(f) A more reasonable and more accurate figure of costs claimable by the HDC, although unable to be accurately quantified by Counsel, would be estimated to be in the vicinity of $3,000 rather than $10,958.16.

11.4.3 **A** summary of the costs and expenses of the Tribunal follows:

Pre-Hearing, Hearing and Post-Hearing Expenses of Chair and Members	$8,520.32
Travel	2,269.44
Accommodation and Meals	751.21
Equipment/Room Hire	300.00
Advertising	90.25
Stenographers Fees	550.00
Telephone and Tolls	429.80
	$12,911.02

11.4.4 **IN** terms of the Tribunal making an assessment of an appropriate contribution to the costs of investigation and prosecution, some downwards adjustment has been made to the former, but none to the latter. Likewise adjustments have been made to office administration staff preparation and photocopying charges.

11.4.5 **THE** Tribunal will need to adopt a policy on fees for expert (or independent) opinions including reports, clinical assessments, attendances of such witnesses at hearings. The Tribunal should explain that a professional level of witnesses fees should be paid to ensure willing attendance.

11.4.6 **THE** Tribunal does not agree with Mr Waalkens that the application and attendances incidental to seeking interim suspension of Dr Nealie in late December 1997 were *"unreasonable"*. The same comment applies to the application to have the records of Ms Young produced.

11.4.7 **ARISING** out of the judgement of the High Court in *K v Auckland District Law Society* (supra), Mr Waalkens (letter of 15 April 1998 to the Secretariat) has challenged some of the items of Tribunal expenditure listed in paragraph 11.4.3. This aspect of costs is being further researched. So as not to further delay the issue of this Decision, the contribution payable by the respondent towards costs and expenses of the Tribunal will be addressed in a Supplementary Decision.

12. RELATIONSHIP BETWEEN MEDICAL PRACTITIONERS ACT 1995 AND THE HEALTH AND DISABILITY COMMISSIONER ACT 1994:

12.1 **THIS** is the first charge laid by the Director of Proceedings of the Health and Disability Commissioner before the Medical Practitioners Disciplinary Tribunal. In 1994 the first Health and Disability Commissioner was appointed. Her initial task was to prepare and have put into legislation a code of consumer rights. This Code, known as the Code of Health and Disability

Services Consumers' Rights ("the Code"), was passed into legislation by regulation and came into effect on 1 July 1996.

12.2 **IF** the Commissioner forms an opinion that there has been a breach of the Code, then the Commissioner can refer the matter to the Director of Proceedings. In this particular case the Commissioner formed the opinion that the doctor charged, the respondent, breached Rights 2, 4(2) and 4(5) of the Code. She referred the respondent to the Director of Proceedings and a charge was laid against him.

12.3 **MS** Davenport submitted:

".... a finding of a breach by the Commissioner itself creates a presumption of professional misconduct which can be the subject of disciplinary action by the Medical Practitioners Disciplinary Tribunal. Therefore it is submitted that the Medical Practitioners Disciplinary Tribunal itself does not have to re-examine the facts to determine whether there has been a breach. It is acknowledged that to do so would be outside the Tribunal's area of expertise and is solely a task for the Commissioner. However it is submitted that the Tribunal must take cognisance of the findings of the Commissioner and must give recognition to the legislative change and a new Code of consumer rights. For the Tribunal to find that a breach of the Code does <u>not</u> constitute professional misconduct would be to find that the Medical Practitioners Disciplinary Tribunal has a lesser standard than that envisaged by the Code, as new consumer protection legislation. Such a conclusion, it is submitted, would be entirely wrong. The focus of the Health and Disability Commissioner legislation is consumer protection and

the Medical Practitioners Act 1995 must be read in a way that is consistent with the new legislation."

12.4 **MS** Davenport is correct in arguing that the Health and Disability Commissioner legislation has a very strong consumer focus. This is amply borne out by the long title of the statute which commences by stating that it is:

"An Act to promote and protect the rights of health consumers and disability services consumers and, in particular, - ....."

12.5 **HOWEVER** the Tribunal does not agree with Ms Davenport that a finding of a breach by the Commissioner itself creates a presumption of professional misconduct. The first point the Tribunal needs to make is that Ms Davenport's use of the words *"finding of a breach by the Commissioner"* does not accord with the provisions of Section 45 of the Health and Disability Commissioner Act 1994 ("the HDC Act") which regulate the procedure to be adopted by the Commissioner after investigating a complaint under Part 4(IV) of the HDC Act. The language of Section 45 of the HDC Act is that the Commissioner may take all or any of six courses of action if she *"is of the opinion that any action that was the subject matter of the investigation was in breach of the code, ..."*

12.6 **THE** Concise Oxford Dictionary definition of a "finding" is *"a conclusion reached by an inquiry"*. In contrast the same dictionary definition of an "opinion" is *"a belief or assessment based on grounds short of proof"* or *"a view held as probable"*. Thus the Tribunal takes the view that the formulation by the Commissioner of an opinion that there has been a breach

of the Code permits her to cross a threshold and do all or any of the following (as listed in Section 45 of the HDC Act):

"(a) Report the Commissioner's opinion, with reasons, to the health care provider or, as the case requires, the disability services provider whose action was the subject matter of the investigation, and may make such recommendations as the Commissioner thinks fit, including a recommendation that disciplinary proceedings be taken against any officer or employee or member of the health care provider or, as the case requires, of the disability services provider:

(b) Report the Commissioner's opinion, with reasons, together with such recommendations (if any) as the Commissioner thinks fit, to all or any of the following:

(i) Any purchaser:

(ii) Any health professional body:

(iii) Any other person that the Commissioner considers appropriate:

(c) Make such report to the Minister as the Commissioner thinks fit:

(d) Make a complaint to any health professional body in respect of any person:

(e) Where any person wishes to make such a complaint, assist that person to do so:

(f) Refer the matter to the Director of Proceedings for the purpose of deciding whether any one or more of the following actions should be taken:

(i) Any of the actions contemplated by section 47 of this Act:

(ii) The institution of disciplinary proceedings."

12.7 **IT** is clear, then, particularly from an examination of Section 45 of the HDC Act, that the Commissioner may report her opinion with reasons and such recommendations as she thinks

fit, to a number of sources. Alternatively or additionally the Commissioner may report to the Minister, make a complaint to any health professional body, assist any person wishing to make such a complaint or refer the matter to the Director of Proceedings. It is then the preserve of the Director of Proceedings to decide whether any one or more of the three stipulated courses of action should be taken, including disciplinary proceedings.

12.8 **GIVEN** that Section 45 of the HDC Act regulates the procedure of the Commissioner after making an investigation, the submission that the Tribunal itself does not have to re-examine the facts is rejected. A re-examination of the facts is not necessary to determine whether there has been a breach of the Code, but rather to determine whether the Commissioner's opinion as to breach of the Code warrants disciplinary sanction by the appropriate health professional body, in this case the Medical Practitioners Disciplinary Tribunal.

12.9 **IT** seems to the Tribunal that in dealing with the rights of health and disability consumers and the corresponding duties of the providers of such services, that a clear and complete separation is intended between alleged breaches of the Code, on the one hand, and the disciplinary function for any such claimed breaches, on the other hand.

12.10 **INITIALLY** it is the function of the Commissioner to investigate any action of any health care or disability services provider where that action is, or appears to the Commissioner, to be in breach of the Code. Once the Commissioner has formed an opinion as to a breach of the Code, the way is clear for the institution of disciplinary action should the Director of Proceedings so decide. The Commissioner's opinion that there has been a breach of the Code becomes the evidential base of first instance to aid the Director of Proceedings into deciding,

pursuant to Section 49 of the HDC Act, whether to take proceedings against a medical practitioner under Part (VIII) of the Medical Practitioners Act ("the MP Act").

12.11 **THE** questions being considered by the Commissioner and the Tribunal are separate and to hold that the answer to one pre-determines the answer to the other would not give proper effect to the legislation.

12.12 **THE** functions of the Commissioner and the Tribunal are separate. These separate roles were acknowledged in parliamentary discussion of the relevant legislation (537 NZPD 17279 3 August 1993; 543 NZPD 4309 13 October 1994; 544 NZPD 5067 24 November 1994; 544 NZPD 5069 24 November 1994). The Commissioner must determine if there has been breach of the Code. The Tribunal's concern is with the discipline of the medical profession and it must decide whether certain conduct is disgraceful conduct or professional misconduct or conduct unbecoming of a medical practitioner. If certain conduct is determined to fall before within one of these prescribed categories the Tribunal may impose penalties.

12.13 **THE** effect of Ms Davenport's submissions, if accepted, would be that the Tribunal would be imposing punishment for breach of the Code. We consider this is not the Tribunal's legislative function.

12.14 **WHILST** it might seem artificial for the Tribunal to consider whether the medical profession's standards (as contained in the MP Act) have been breached after it has already been determined that the Code has been breached, these are nonetheless two separate issues and they require separate consideration.

12.15 **THE** exercise by the Tribunal of its role does not therefore involve a questioning of the Commissioner's decision. The Tribunal is considering a separate issue and is making a separate decision.

12.16 **IN** this context it should also be noted that the original Medical Practitioners Bill proposed a new, single disciplinary ground. By the time the Bill was made law, the current disciplinary grounds, which existed under the previous law subject to one modification, had been reinstated. It appears the change was made so that the Tribunal would have the benefit of case law when making determinations under the Act. If breach of the Code were automatically to be a ground for disciplinary action, this change would have been entirely unnecessary.

12.17 **ANOTHER** consideration in our view is that the principles of natural justice would be offended if the Tribunal agreed that breach of the Code necessarily means that a practitioner is guilty of professional misconduct/disgraceful conduct/conduct unbecoming. This is particularly so when it is accepted that the questions being considered by the Commissioner and the Tribunal are separate.

12.18 **THE** basic principles of natural justice, which have been approved by the Privy Council are: *"That the person accused should know the nature of the accusation made; secondly, that he should be given an opportunity to state his case; and thirdly of course that the Tribunal should act in good faith."* (*University of Ceylon v Fernando* [1960] 1 WLR 223 at 232).

12.19 **LEGISLATION** may choose to exclude natural justice but there is a presumption that natural justice applies. We do not think the language of the relevant Acts (discussed previously) imply any sort of intention to exclude the principles of natural justice. On the contrary, the languages presumes a hearing will take place.

12.20 **MS** Davenport is arguing that the Tribunal should deal with a practitioner on the grounds that the Commissioner has determined that that practitioner has breached the Code, and that therefore the Tribunal does not need to re-examine the facts. In effect, if this argument were accepted, the Tribunal would not consider the facts of a case at all. This implication seems to be borne out by the way the charge has been formulated in this case. The facts have been offered only in the alternative. This cannot be right. Fortunately Ms Davenport provided a summary of facts and evidence on which, with the admissions made, the Tribunal was able to base its findings.

12.21 **THE** Tribunal's response to Ms Davenport's final closing submission is that its findings are made pursuant to its own legislation, and not pursuant to the Code of Health and Disability Services Consumers' Rights.

12.22 **CONTINUING** on the subject of the relationship between the MP Act and the HDC Act, Ms Davenport made the following further submissions:

1. All health professional disciplinary provisions are subject to the provisions of the HDC Act. See Section 49 (3) of the HDC Act and Section 86 of the MP Act.

2. The Medical Practitioners Disciplinary Tribunal's ability to act on complaints of "professional misconduct" is suspended. The sole right to act upon these allegations vests in the Health and Disability Commissioner under Section 86 and 102 of the MP Act.
3. The Director of Proceedings is the only person who can charge a doctor with professional misconduct, and then only when a breach of the Code of Health and Disability Services Consumers' Rights has been determined.
4. It is the breach of the Code of Health and Disability Services Consumers' Rights which creates entry into the MP Act, and there needs to be a breach of the Code before any action can be taken before the disciplinary body (except transitional provisions).

12.23 **THE** Tribunal is in little doubt that the HDC legislation, including the Code, has brought about significant changes in the way in which complaints are investigated and disciplinary proceedings are brought against registered health professionals. However because the particular submissions which Ms Davenport addressed were not fully argued, the Tribunal is not in a position of being able to respond to those submissions. No doubt there will be another occasion when this aspect of the interface between the HDC Act and the MP Act can be examined.

13. EVIDENTIAL RULING:

13.1 **MS** Davenport sought to have the Health and Disability Commissioner's opinion included in the agreed bundle of documents as part of the record. Mr Waalkens objected. He explained there was no dispute as to the existence of the Commissioner's opinion. But that, Mr Waalkens argued, should be the end of the matter. Mr Waalkens submitted that the opinion of the Commissioner is no more than an opinion, that it is merely a triggering mechanism for

activating the charging process, and that it would be wrong to permit the Commissioner's opinion to be elevated to *"agreed bundle of documents"* status.

13.2 **THE** position taken by Ms Davenport in seeking admissibility in evidence of the Commissioner's opinion is partly explained in her opening submissions. Some of those submissions had been discussed already in context of the relationship between the MP Act and the HDC Act.

13.3 **IN** ruling at the commencement of the hearing against admissibility of the Commissioner's opinion, the Tribunal emphasised first that the document is only an opinion and that the Commissioner was not present to answer any questions relating to it. Secondly the Tribunal indicated that even were the Commissioner to have been present as a witness, that it was unlikely to have permitted her opinion to be given in evidence.

13.4 **THE** legal position relating to opinion evidence is explained in Cross On Evidence. In so far as it is possible for them to do so, Courts and Tribunals set themselves against receiving evidence from any witnesses as to the very matter which the Court or Tribunal must decide. This is because parties to a dispute are entitled to have the matter settled by the Court or Tribunal and not by the statement of witnesses. If witnesses are too readily allowed to give their opinion on ultimate issues, there could be a danger that the arbiter, in this case the Tribunal, will be unduly influenced. It was principally for this reason that the Tribunal ruled, on this occasion, against admissibility of the Commissioner's opinion.

13.5 **HOWEVER** the Tribunal wishes to indicate that it would be prepared to hear further argument generally on admissibility of the Commissioner's opinions. Having ruled that Tribunal findings are made pursuant to its own legislation and not pursuant to the Code, it may be that any perception of undue influence is more imaginary than real. Under Clause 6 of the First Schedule of the MP Act, the Tribunal *"may receive as evidence any statement, document, information, or matter that may in its opinion assist it to deal effectively with the matters before it, whether or not it would be admissible in a Court of Law"*. There may be an argument that the opinions of the Commissioner be admissible as evidence within the spirit of Clause 6 of the First Schedule of the MP Act.

DATED at Auckland this 23rd day of April 1998

.....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal