Protecting the Public and Maintaining Professional Standards: A Comparison of Disciplinary Tribunal Action Concerning Legal and Medical Practitioners

Alice Selby

A dissertation submitted in partial fulfillment of the degree of Bachelor of Laws (Honours).

University of Otago

12 October 2012

Acknowledgments

I would like to thank Peter Skegg for his invaluable guidance and support that has made this dissertation possible.
It was a privilege to have you as my supervisor and I will be forever grateful.

To Mum, Dad, Tim, Kate and Jamie for being there every step of the way.
Thank you all so very much.

For

E. W. Hammond

“Whenever a doctor cannot do good, he must be kept from doing harm” – Hippocrates.

Table of Contents

List of Abbreviations

DP – Director of Proceedings

HDC – Health and Disability Commissioner

HDCA – Health and Disability Commissioner Act 1994

HPCAA – Health Practitioners Competence Assurance Act 2004

HPDT – Health Practitioners Disciplinary Tribunal

LPA – Law Practitioners Act 1982

LCA – Lawyers and Conveyancers Act 2006

LCA Regulations – Lawyers and Conveyancers Act (Disciplinary Tribunal) Regulations 2008

LCDT – Lawyers and Conveyancers Disciplinary Tribunal

LCRO – Legal Complaints Review Officer

NZLS – New Zealand Law Society

PCC – Professional Conduct Committee of the New Zealand Medical Council

SC – Standards Committee

Preface

In writing this paper I have received invaluable insights into the professional discipline of medical and legal practitioners from conversations held with a number of particularly well-placed sources, who by virtue of their office wish to remain anonymous. Wherever the contributions of these sources have been relied upon is duly noted throughout this paper.

The basis of my research included a comparison of decisions made by the Health Practitioners Disciplinary Tribunal ("HPDT"), and Lawyers and Conveyancers Disciplinary Tribunal ("LCDT") over a recent three year period. The sample comprised all substantive judgments and any related penalty determinations, delivered between 22 April 2009 and 1 August 2012. The starting point for the sample is the date on which the first decision of the LCDT was delivered. No decisions of the previous Law Practitioners Disciplinary Tribunal are publically available and thus considering disciplinary cases regarding legal practitioners prior to 22 April 2009 was not a possibility. The sample period end date of 1 August 2012 was selected as it provided enough time for decisions that had been made to be published, analysed, and incorporated into my research. In total the sample period contained 31 LCDT cases in comparison to only 24 HPDT cases. The difference between the number of cases analysed from each tribunal was taken into account during analysis to prevent any methodologically unsound conclusions being drawn. Furthermore, whilst the sample size was not extensive it was sufficient to highlight similarities and differences between the two tribunals and comment accordingly.

Decisions of the High Court, and the courts above, were commonly relied upon to assess certain aspects of the HPDT and LCDT's operation. However, given the word limitation, a substantive comparison of the appeals process for challenging HPDT and LCDT decisions was not considered in this paper. This limitation is noted as an area for future research, as a comparison of the appeals process and how this process is relied upon, could offer further insight into the professional discipline of medical and legal practitioners.

Introduction

Between July 2005 and April 2009 Dr Suresh Vatsyayann, a general practitioner from Hamilton, enrolled 44 "patients" in his clinic without their consent or approval, some of whom had never been to the clinic, and some of whom were deceased. Dr Vatsyayann failed to adequately protect the privacy of numerous patients by examining multiple patients in the same room. He also allowed his wife who was unqualified and unregistered to carry out cervical smears, remove intrauterine devices, administer vaccinations and give injections.[1]

To practise law or medicine is a privilege that is accompanied by great responsibility. However, as demonstrated by Dr Vatsyayann, not all professionals adequately discharge their responsibilities.[2] The privileged position of medical and legal practitioners does not come with an immunity to the frailties of the human condition. The role of professional discipline is therefore vital to protect the public, and maintain proper professional standards in medicine and law.

This paper explores the grave end of professional discipline where medical and legal practitioners are charged with serious professional offending and are tried before the HPDT, or LCDT.[3] A comparison of the decisions made by the two tribunals is used to demonstrate that despite each tribunals' commitment to protecting the public and maintaining professional standards, some changes are required if consumers of medical and legal services are to be properly protected.[4]

[1] *Professional Conduct Committee of the Medical Council of New Zealand v Vatsyayann* 355/Med10/152P.
[2] The term "medical practitioner" is used in this paper to refer to registered doctors, and has the same meaning as in s 6 of the Health Practitioners Competence Assurance Act 2004 ["HPCAA"]. The term "legal practitioner" is used to refer to a person who is a barrister or solicitor of the High Court, and has the same meaning as "lawyer" in s 6 of the Lawyers and Conveyancers Act 2006 ["LCA"].
[3] The HPDT is responsible for the most serious professional discipline of medical practitioners. Whilst the HPDT also disciplines a number of other health professionals, it is the discipline of medical practitioners that is the focus of this research (see chapter one for further explanation). The LCDT is responsible for the most serious professional discipline of legal practitioners.
[4] The phrase "consumers" is used in this paper to refer to any member of the public seeking the professional services of medical or legal practitioners.

Chapter One
Why Compare Medical and Legal Practitioners?

Classically law, medicine, and the church were viewed as the only three real professions. Whilst this view has changed, simultaneous references to "doctors" and "lawyers" is still commonly relied upon to exemplify the very idea of professionalism. One can only speculate whether continued use of these two particular occupations as the poster children for professionalism is a result of the unparalleled level of trust and responsibility placed in doctors and lawyers to take care of people's most important and intimate matters. Whilst the identification of doctors and lawyers with the very concept of professionalism makes them an obvious choice for a study of professional discipline, there is an additional factor that makes the comparison both worthwhile and interesting. The focus of regulation in both contexts has undergone a consumer-centric shift in recent decades, placing consumers at the centre of the relevant legislation and ensuring that protection of the public is the foremost consideration of both tribunals.

1.1 The Consumer Focus of Regulation in the Medical Profession

With medical practitioners it is easy to trace the course of the consumer-centric shift. Acting as a dramatic starting point, the Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital published in 1988 ("Cartwright Report") can be seen as the major catalyst for many consumer-focused developments within the regulation of health practitioners in New Zealand.[5] The Cartwright Report was that of a "committee of inquiry" into unauthorised experimental research that had taken place at the National Women's Hospital. The "unfortunate experiment" in question involved the study of the natural course of carcinoma in situ of the cervix by the withholding of treatment.[6] As a result of the Cartwright Report, the Health and Disability Commissioner Act 1994

[5] DB Collins and CA Brown "The impact of the Cartwright Report upon the regulation, discipline and accountability of medical practitioners in New Zealand (2009) 16(4) JLM 595 at 596; and PDG Skegg "A Fortunate Experiment? New Zealand's Experience With A Legislated Code of Patients Rights" (2011) 19(2) Med L Rev 235 at 235. In regard to the report itself see Silvia Cartwright *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (July 1988).

[6] See generally Charlotte Paul "The New Zealand cervical cancer study: Could it happen again" (1988) 297 BMJ 533 at 533.

("HDCA") was enacted.[7] It provides for the appointment of a Health and Disability Commissioner ("HDC") and a readily available statement of patient rights in the form of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("Code of Rights").[8]

The consumer-centered philosophy of the Code of Rights is evidenced in the heading to clause 1 of the Code: "Consumers have rights and providers have duties".[9] Alongside its wide dissemination, the Code of Rights' success is attributed to its plain language and simplicity.[10] As was predicted in the Cartwright Report, these attributes have led to the rise of increasingly informed consumers eager to enforce their rights and to ensure their expectations are met.[11] This is crucial for the effective operation of any disciplinary regime. The Code is also legally enforceable, unlike many overseas counterparts.[12] It is a far cry from the "National Women's Hospital Code of Rights and Obligations of Patient and Staff" that was tucked away inside wardrobe doors at National Women's.[13]

Nonetheless, the provision of a Commissioner and Code was merely the beginning. The increasing recognition of consumer rights and informed consumers can be seen to have played a part in the development and enactment of the Health Practitioners Competence Assurance Act 2004 ("HPCAA") that now regulates the conduct of medical practitioners. Enacted as a piece of legislation focused on patients and their safety rather than on health professionals,[14] the HPCAA is a further iteration of the consumer-focus shift and ensures that the HPDT, for which it provides, operates in a consumer-orientated manner.[15]

---

[7] See Skegg, above n 5, at 236; and the Cartwright Report, above n 5, at 176.
[8] The HDCA provides for the appointment of the HDC in s 8. Section 74 of the HDCA permits the Governor-General to make regulations prescribing a Code of Rights.
[9] Skegg, above n 5, at 237.
[10] See Health and Disability Commissioner *A Review of the Health and Disability Commissioner Act 2004 and the Code of Health and Disability Services Consumer Rights* (November 2008), at 4.
[11] See Cartwright Report, above n 5, at 174.
[12] Health and Disability Commissioner, above n 10, at 4.
[13] See generally Cartwright Report, above n 5, at 159.
[14] Susan Rogers "Culling bad apples, blowing whistles and the Health Practitioners Competence Assurance Act 2003 (NZ)" (2004) 12(1) JLM 119 at 133.
[15] HPCAA, s 84.

1.2 The Consumer Focus of Regulation in the Legal Profession

The importance placed upon informed clients, aware of their rights as consumers of legal services, can also be seen in the Lawyers and Conveyancers Act 2006 ("LCA"), and related regulations. Albeit more recent and less controversial in its inception than the consumer shift in medicine, the LCA is nonetheless recognised as having a distinct consumer-protection focus that was not apparent in the earlier Law Practitioners Act 1982 ("LPA").[16] As a necessary part of this focus, the Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care Rules) 2008 ("Conduct Rules") provide for the protection of consumers, and ensure that consumers are informed of the obligations owed to them by practitioners.[17]

There are numerous features of the Conduct Rules that can be seen to assist and educate consumers that were not present in the previous Rules of Professional Conduct for Barristers and Solicitors (7th Edition) 2004. Firstly, a notable addition is the prescription of proper conduct for client relationships,[18] reflected in the title of the Conduct Rules as well as being explicit within the preface which provides 10 easy-to-understand obligations lawyers owe clients.[19] Secondly, the addition of rule 3.5(a) requires that lawyers provide clients with a written copy of client care and service information prior to undertaking significant work under a retainer.[20] This helps to ensure that consumers know exactly what standards they can expect and places them in a position to complain should practitioners fail to discharge their obligations.

1.3 Chapter One Summary

The catalyst for the consumer focus that has infiltrated the regulation of medical and legal practitioners may have occurred at different times and in different circumstances. Nonetheless, the end result common to both regimes is that the HPDT and LCDT both sit in highly consumer-orientated contexts. The legislation that governs each tribunal's

---

[16] Duncan Webb "The Lawyers and Conveyancers Act: catching up with consumerism" (2007) NZLJ 13 at 14.
[17] Sections 94(e) and 95 of the LCA dictate that the New Zealand Law Society ["NZLS"] must provide conduct and client care rules for lawyers, including the duties owed by lawyers to their clients.
[18] See Donna Buckingham "Disciplining Lawyers in New Zealand: Repining the Badge of 'Professionalism'" (2012) 15(1) JLE 58 at 62.
[19] See the preface of the Conduct Rules.
[20] See Conduct Rules, r 3.5(a).

operation specifically states that protecting the public and upholding confidence in professional standards are the principal purposes of regulation.[21] To compare how the two tribunals go about protecting the public and maintaining professional standards by disciplining those professionals that exemplify the very idea of professionalism, provides an interesting and worthwhile research opportunity.

[21] HPCAA, ss 3(1) and 84; and LCA, ss 3(1) and 226.

Chapter Two

The Substantive Decision: A Comparison of How the Statutory Offence Provisions are Laid, Heard, and Determined Before the HPDT and LCDT.

This chapter explores the substantive element of HPDT and LCDT determinations, namely, whether the charges alleged against medical and legal practitioners are established. Firstly, the disciplinary offences provided by statute are discussed to demonstrate the similarity of conduct, both in nature and in seriousness, with which the tribunals are concerned. The reality of how charges are laid and determined is then explored to highlight any patterns that reflect on each tribunal's ability to effectively discipline errant practitioners, protect the public, and maintain professional standards.

2.1 The Statutory Offences Subject to Discipline by the HPDT and LCDT

The HPCAA and LCA each provide a number of statutory offences that are subject to disciplinary action by the HPDT and LCDT. When looking past the labels and considering the nature of the professional improprieties aimed at, it becomes clear that both tribunals are concerned with essentially the same sorts of acts and omissions when they discipline medical and legal practitioners.[22]

2.1.1 Professional misconduct

Section 100(1)(a) of the HPCAA provides that professional misconduct by virtue of malpractice or negligence is a disciplinary offence, as is conduct that has bought or is likely to bring discredit upon the profession per s 100(1)(b). Similarly s 241(a) of the LCA states that misconduct in a professional capacity ("professional misconduct") is a disciplinary offence which may be heard before the LCDT.[23] Whilst the relevant provisions are in slightly different forms, the conduct captured by the two sets of provisions is very similar. Firstly, both formulations of professional misconduct aim to

[22] It is worth noting that a number of LCDT decisions analysed in this paper included disciplinary charges that were laid pursuant to the Law Practitioners Act 1982 ["LPA"], as a result of the LCA transitional provisions (see s 351 of the LCA). These decisions were able to be included in the comparison because the offence provisions relevant to this paper are the same under both the LPA and LCA. Compare ss 112(1)(a),(c) and (d) of the LPA, with ss 241(1)(a),(c) and (d) of the LCA.

[23] Professional misconduct per s 241(a) of the LCA is defined in s 7 of the LCA.

capture conduct occurring within professional and private capacities.[24] Secondly, the test for professional misconduct accepted by the two tribunals is highly comparable, as discussed below.

(1) Professional misconduct in the LCDT

In assessing a professional misconduct charge the LCDT looks first for conduct falling below expected standards, and then for "something more" that elevates that failure to a level worthy of the professional misconduct label. This is a test that is understood to be encapsulated by Kirby J's much quoted formulation in the "Australian Medical Council" case of *Pillai v Messiter,* where he stated:[25]

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

This test has been affirmed by the High Court of New Zealand as the appropriate standard to be applied by the LCDT when considering professional misconduct charges.[26]

(2) Professional misconduct in the HPDT

Similarly the HPDT incorporates the "something more" element into its two-stage test for professional misconduct. The HPDT look for a departure from accepted standards constituting malpractice, negligence or the bringing of discredit to the profession. Secondly, the HPDT considers whether the departure is significant enough to warrant

---

[24] Section 7(1)(a) of the LCA and s 100(1)(a) of the HPCAA are aimed at professional conduct, whereas s 7(1)(b)(ii) of the LCA and s 100(1)(b) of the HPCAA address private conduct. For further discussion of this point see *Martin v Director of Proceedings* [2010] NZAR 333 at [18], (HPDT); and Donna Buckingham, "Putting the Legal House in Order – Responses to New Zealand Lawyers Who Break Trust" (2012) 15(2) JLE (forthcoming), (LCDT).

[25] *Pillai v Messiter* [No 2] (1989) 16 NSWLR 197 (CA) at 200, emphasis added.

[26] See *Complaints Committee No 1 of the Auckland District Law Society v C* [2008] 3 NZLR 105 at [31-33]; and *S v New Zealand Law Society (Auckland Standards Committee No 2)* HC Auckland CIV-2011-404-3044, 1 June 2012 at [22]. In these two cases it was stated that the s 7 definition of professional misconduct in the LCA, with reference to phrases such as "disgraceful", is not particularly helpful in assessing s 241(a) charges. Instead it was held that professional misconduct should be assessed by reference to the *Pillai v Messiter* formulation.

disciplinary sanction.[27] The HPDT's two-stage objective assessment is very similar to that undertaken by the LCDT. However, whether the appropriate HPDT test can be expressed by way of Kirby J's formulation has been the subject of recent comment in the High Court. In *Martin v Director of Proceedings* Courtney J held that whilst the "something more" threshold element was necessary for professional misconduct, requiring practitioners to show an indifference to the privileges of registration would unnecessarily constrain the HPDT.[28] Instead Courtney J stated that the "something more" limb should involve a straightforward assessment of whether a practitioner's proven negligence or malpractice warrants disciplinary sanction.[29] However, Courtney J's statements have not been readily taken up by the HPDT following the *Martin* decision.[30] Furthermore, the only High Court case to revisit the issue left open whether the full *Pillai v Messiter* formulation, or Courtney J's more simple approach, should be applied by the HPDT when determining professional misconduct.[31]

Despite the unsettled state of the law under the HPCAA, it is evident that both tribunals are looking for a departure from acceptable professional standards, with "something more" elevating the departure to a level deserving the "professional misconduct" label.

2.1.2. Negligence, Incompetence, and Malpractice

Section 241(c) of the LCA provides that negligence or incompetence in a professional capacity, to such a degree or frequency as to reflect on one's fitness to practice or bring the profession into disrepute, is a disciplinary offence. As discussed above, the HPCAA provides that negligence or malpractice comes under the heading of professional misconduct.[32] The concepts of negligence, incompetence, and malpractice are largely overlapping in the professional disciplinary context and are often used

[27] See *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC), at [71]; and *Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council* HC Wellington CIV-2009-485-259, 14 August 2009 at [8].
[28] See *Martin v Director of Proceedings*, above n 24, at [30].
[29] At [31].
[30] Numerous HPDT decisions following the *Martin* case have made no reference to *Martin* and have instead approved the specific *Pillai v Messiter* formulation. See for example *Professional Conduct Committee v Jayaprakash* 327/Med10/153P at [14].
[31] See *Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council*, above n 27, at [8].
[32] HPCAA, ss 100(1)(a) and (b).

interchangeably by the tribunals.[33] As a result, the two tribunals are concerned with very similar conduct when assessing charges under s 100(1)(a) of the HPCAA or s 241(c) of the LCA.

2.1.3 Practising Without, or Outside the Scope or Conditions of, an Annual Practising Certificate

The HPCAA specifically provides for charges to be laid against medical practitioners who practise without, or outside the scope or conditions of, an annual practising certificate.[34] The LCA incorporates offences for breaches of practising certificates and breaches of conditions under the professional misconduct provision.[35] Accordingly, both Acts allow for disciplinary action to be bought before the two tribunals where practitioners practise outside their permitted scope of practice, or without a current practising certificate at all.

2.1.4 Conviction in the Courts

Both the HPCAA and LCA provide that disciplinary charges may be laid against medical or legal practitioners following certain convictions in the courts.[36] Yet again the relevant provisions are not identical. However, they are aimed at capturing very similar conduct.

Section 241(d) of the LCA allows disciplinary charges to be laid against legal practitioners following conviction of an offence punishable by imprisonment, where that conviction reflects on the lawyer's fitness to practise, or tends to bring the legal profession into disrepute. The HPCAA states that a disciplinary charge under s 100(1)(c) may be laid against a medical practitioner following conviction of an offence

---

[33] See *Professional Conduct Committee of the Medical Council of New Zealand v Vatsyayann,* above n 1, at [9-14].
[34] HPCAA, ss 100(1)(e-g).
[35] For example, to practise without a practising certificate is an offence under s 21(1) of the LCA (having regard to the definition of "lawyer" in s 6), thus triggering a charge per s 241(a) of the LCA by virtue of s 7(1)(a)(ii).
[36] HPCAA, s 100(1)(c); and LCA, s 241(d). The charges provided for in these sections can be laid against practitioners once the prosecuting bodies become aware of any relevant convictions. In regard to medical practitioners, s 67 of the HPCAA provides that the court registrar must notify the relevant authority (New Zealand Medical Council) of any medical practitioners who have been convicted in the courts. The NZLS relies on legal practitioners to report their own convictions as required by r 8 of the Lawyers and Conveyancers Act (Lawyers: Practice Rules) Regulations 2008 ["LCA Regulations"].

under one of 12 stipulated Acts that relate to the medical profession,[37] or for an offence punishable by three months' of imprisonment or more.[38]

Any variations between the two Acts regarding the convictions that trigger disciplinary charges before the HPDT or LCDT are either justified in the relevant contexts, or slight when considering the reality of each section's application.

(1) The non-imprisonable offences under s 100(2)(a) of the HPCAA

The offences listed under s 100(2)(a) of the HPCAA prima facie make the HPCAA provision wider than the LCA equivalent, by capturing convictions for non-imprisonable offences. However, the 12 enactments listed are so closely related to the health sector that their inclusion under s 100(1)(c) seems appropriate. As an example, ss 135(1) and 135(2)(a) of the Coroners Act 2006 create an offence for medical practitioners who make statements or omit a matter in a coroner's report, knowing, or reckless to the fact, that statement/omission makes the report false or misleading. Whilst non-imprisonable, a conviction for that offence would clearly reflect adversely on a medical practitioner's fitness to practise. It would be absurd if such a conviction fell outside the scope of s 100(1)(c) purely because it is not an imprisonable offence.

(2) The omission of a minimum prison length under s 241(d) of the LCA

The omission of a minimum prison length under s 241(d) of the LCA indicates that a legal practitioner could face disciplinary action for an offence punishable by less than three months' of imprisonment, whereas a medical practitioner could not.[39] However, it seems likely that almost all imprisonable offences meeting the threshold of "reflecting adversely on a lawyer's fitness to practice", would include at least the possibility of a three month imprisonment period. For example, despite first time drink driving offences rarely being penalised by imprisonment, the relevant offence provision does provide for a possible three month imprisonment period.[40] This means

[37] HPCAA, s 100(2)(a).
[38] HPCAA, s 100(2)(b).
[39] Charges under s 100(1)(c) of the HPCAA are only triggered by convictions for offences that are punishable by at least three months' of imprisonment. The only exception to this is where a medical practitioner is convicted pursuant to one of the 12 Acts listed in s 100(2)(a) of the HPCAA.
[40] Land Transport Act 1998, s 56(3)(a).

that any drink driving conviction could trigger disciplinary charges for medical and legal practitioners under the relevant offence provision of both Acts.

2.1.5 Onus and Standard of Proof

Across all the disciplinary offences outlined above, the onus falls on the prosecuting body to establish the alleged charge. This burden rests with the Professional Conduct Committee ("PCC") or Director of Proceedings ("DP") before the HPDT, or the relevant Standards Committee ("SC") or Legal Complaints Review Officer ("LCRO") before the LCDT. Both the HPDT and LCDT require any charge(s) to be proven to a flexible variation of the civil standard of the "balance of probabilities". This means that the cogency of the evidence required to satisfy either tribunal varies according to the seriousness of the allegations made.[41]

In summary, whilst the professional disciplinary offence provisions of the HPCAA and LCA may not be carbon copies of one another, when looking past the labels it is clear that the range of conduct aimed at by the relevant sections is very similar indeed.

2.1.6 A Note on Less Serious Professional Conduct Issues

Whilst this paper focuses on the grave end of professional discipline that is handled by the formal disciplinary tribunals, there is also a less serious disciplinary charge that can be considered by the LCDT, not available in the HPDT. This is a notable difference that is worth discussing briefly as a final element of this part, in order to provide a full overview of the conduct that is considered by the tribunals.[42]

---

[41] The Supreme Court affirmed the flexible balance of probabilities standard as appropriate in professional disciplinary proceedings against health practitioners in *Z v Complaints Assessment Committee* [2008] 1 NZLR 65. This was applied by the High Court specifically in relation to medical practitioners in *Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council* [2012] NZHC 1138 at [44]. The standard was also applied by the High Court in relation to the discipline of legal practitioners in *S v New Zealand Law Society (Auckland Standards Committee No 2)*, above n 26, at [17].

[42] Whilst unsatisfactory conduct charges were excluded from the wider comparison, as this paper is focused on only the most serious end of professional discipline, a separate analysis of unsatisfactory conduct charges was undertaken for the purposes of part 2.1.6. The same sample period was used as in the rest of the paper. A total of five cases where unsatisfactory conduct charges were laid came within the sample period. See *Auckland Standards Committee v Johnston* [2011] NZLCDT 14; *Waikato Bay of Plenty Standards Committee v Parlane,* [2010] NZLCDT 18; *Canterbury-Westland Standards Committee 2 v Peters* [2012] NZLCDT 18; *National Standards Committee v Poananga* [2012] NZLCDT 12; and *Auckland Standards Committee v Sorenson* [2011] NZLCDT 10.

The LCA provides that the LCDT may discipline practitioners for unsatisfactory conduct that is not so gross, wilful, or reckless as to amount to misconduct.[43] The major impetus for including the unsatisfactory conduct provision as a charge that may be bought before the LCDT was to allow the tribunal to effectively deal with legal practitioners' competence more generally, and not just in the most serious cases.[44] This is necessary in the LCDT because the SCs that carry out the majority of prosecutions,[45] can only lay unsatisfactory conduct charges before the LCDT if no previous determinations have been made about the conduct in question.[46] Accordingly, unsatisfactory conduct charges laid in the alternative provide a necessary fallback provision, allowing SCs to rely on the less serious charge when they fail to satisfy the LCDT of more serious charges. Analysis of the LCDT decisions revealed that unsatisfactory conduct charges were laid in this way - as an alternative fallback provision, in the majority of the five cases where the charge was used.[47] This prevents legal practitioners with lower level competence issues leaving the disciplinary process having had no adverse findings made against them, and ensures any competence issues can be addressed.

In contrast, the HPCAA does not provide an offence capturing lower level competence issues that can be tried before the HPDT. Instead, the HPDT is reserved for dealing with only the most serious cases of incompetence and other misconduct. This should not, however, be seen as a weakness of the HPDT. As the wider regulatory regime of medical practitioners ensures that any lower level competence issues are addressed through the alternatives to formal HPDT proceedings. This removes the need for a fallback provision, as is required in the LCDT.[48] For example, the DP can only lay

[43] LCA, ss 12 and 241(b).
[44] (28 February 2006) 629 NZPD 1502. Notably the unsatisfactory conduct charge was not available under the previous LPA.
[45] SCs prosecuted all cases where unsatisfactory conduct charges were laid.
[46] See *Waikato Bay of Plenty Standards Committee v Parlane*, above n 42, at [4], where it was held that SCs cannot lay unsatisfactory conduct charges in the LCDT if an adverse finding has already been made.
[47] The unsatisfactory conduct charge was used as an alternative fallback charge in the majority of the five cases where the charge was laid. See *Canterbury-Westland Standards Committee 2 v Peters*, above n 42; *National Standards Committee v Poananga*, above n 42; and *Auckland Standards Committee v Sorenson*, above n 42.
[48] There is a wide range of lower level disciplinary options to deal with complaints against medical practitioners. For example, Skegg, above n 5, at 242-243 discusses how the "overwhelming majority" of complaints against practitioners in relation to the Code of Rights

charges where the HDC has previously held that a practitioner has breached the Code of Rights.[49] Or, if the PCC is prosecuting the case, the New Zealand Medical Council will have been alerted of any competence issues that may have arisen in the course of the PCC investigation. As a result a competence review will likely be initiated notwithstanding the fact that disciplinary charges may have been laid in the HPDT.[50]

In summary, whilst the ability to condemn and discipline unsatisfactory conduct is a notable difference between the two tribunals, the wider regulatory regimes of medical and legal practitioners ensure that lower level competence matters are adequately addressed. As this paper is focused on the grave end of professional discipline, discussion now returns to focus on issues related to the more serious professional disciplinary charges outlined above.

2.2 An Overview of the Types of Cases that Came Before the HPDT and LCDT

Having considered the charges that are available to both the HPDT and LCDT, this part summarises the types of conduct that commonly came before the tribunals in the cases analysed.[51]

2.2.1 HPDT Cases

The most common allegations made against practitioners in the HPDT, in descending order, concerned: conviction for offences reflecting adversely on the fitness of the practitioner or the profession;[52] inappropriate prescribing, and/or, administration of drugs;[53] inadequate diagnosis, treatment, or follow-up;[54] inadequate note taking or documentation;[55] practising without an annual practicing certificate, or outside the

---

are resolved by the advocacy service (provided for in the Code of Rights), and thus never come before the HPDT.

[49] See ss 42(4)(f)(iii) and 49 of the HDCA, and s 91(1)(a) of the HPCAA

[50] See ss 80(3)(b) and 91(1)(b) of the HPCAA. For further discussion of how HPDT proceedings are not necessary to ensure that competence issues are addressed see Skegg, above n 5, at 256-257.

[51] The summary of allegations made covers at least 75 per cent of the charges laid all HPDT and LCDT cases analysed.

[52] See cases: Med 2, Med 3, Med 7, Med 9, Med 21 and Med 24.

[53] See cases: Med 8, Med 11, Med 15, and Med 22-23.

[54] See cases: Med 1, Med 8, and Med 19-20.

[55] See cases: Med 8, Med 11, Med 16, and Med 19.

scope of permitted practise;[56] and entering into inappropriate sexual, and/or other intimate relationships with patients or former patients.[57]

2.2.2 LCDT Cases

The most common allegations made against practitioners in the LCDT, in descending order, concerned: misleading or providing false information to the courts, other practitioners, or relevant agencies;[58] conviction for offences reflecting adversely on the practitioner's fitness;[59] misuse of client trust account funds;[60] failing to comply with requirements made in the ordinary course of the profession, such as providing requested documents;[61] inappropriate claiming of fees from clients directly, and/or, from legal aid services;[62] acting in, or failing to disclose a conflict of interest;[63] abusing the relationship of trust and confidence with a client;[64] breaching undertakings;[65] and failing to adequately advise or communicate with clients.[66]

2.3 Comparing How Charges are Laid Before the HPDT and LCDT

This part considers how the prosecuting bodies form and lay charges against medical and legal practitioners.

On the face of it, the prosecuting bodies appear to take similar approaches by laying out the charge(s) and listing the particulars that are alleged to amount to the offence(s). However, closer analysis revealed that the most common offence of professional misconduct is charged in two very different ways.[67] The DP/PCC often utilise a specific "duplicitous charge",[68] when laying professional misconduct charges before

---

[56] See cases: Med 1, Med 10, and Med 13-14.
[57] See cases: Med 6, Med 8, and Med 10.
[58] See cases: Law 1-2, Law 4, Law 9, Law 14-15, Law 18, Law 22, Law 27-28, and Law 30.
[59] See cases: Law 8, Law 11, Law 14, Law 20-21, and Law 31.
[60] See cases: Law 10, Law 15, Law 21-22, Law 26, and Law 29.
[61] See cases: Law 6, Law 15-17, and Law 26.
[62] See cases: Law 2, Law 6-7, and Law 26.
[63] See cases: Law 3-4, Law 13, and Law 15.
[64] See cases: Law 5, Law 14-15, and Law 26.
[65] See cases: Law 15, and Law 25-26.
[66] See cases: Law 5, Law 13, and Law 15.
[67] Professional misconduct charges under s 100(1)(a) and (b) of the HPCAA, and s 241(a) of the LCA were laid in 17 of the 24 HPDT cases, and 26 of the 31 LCDT cases.
[68] The word "duplicitous" is used in this paper strictly in relation to its legal meaning, "a charge which joins two or more distinct grounds of action in the same count". It is noted that

the HPDT, whereas this charge is not relied upon by the LCRO/SCs. The difference in charging style directly affects how the two tribunals consider professional misconduct and this has significant consequences for the practitioners involved, and the wider public. Before exploring those consequences, it is first necessary to highlight how the duplicitous charge works, and what makes it unique.

2.3.1 An Introduction to the Duplicitous Charge

The DP/PCC commonly use a duplicitous charge to lay just one charge of professional misconduct made up of various particulars,[69] often including a wide range of alleged misconduct.[70] An example is the case of *PCC v Dr N*.[71] Dr N was charged and convicted of one offence for professional misconduct comprised of two particulars. The first particular concerned a sexual relationship Dr N had entered into with a patient whom he continued to treat (including throughout her pregnancy to him). The second particular concerned Dr N's failure to adequately comply with conditions placed upon him by the Medical Council (unrelated to the sexual relationship). The particulars clearly involved two very different instances of misconduct, yet both were considered as part of one duplicitous charge. Analysis revealed that the DP/PCC frequently laid duplicitous charges, as in the *Dr N* case, aggregating a range of alleged misconduct under a single professional misconduct charge.[72]

The LCRO/SCs do not rely upon duplicitous charges. Unlike the DP or PCC, the LCRO and SCs lay multiple charges of professional misconduct when a range of conduct is at issue, one charge for each different type of misconduct alleged. For example, in *Auckland Standards Committee v Johnston*, Mr Johnston faced five separate professional misconduct charges for inappropriate personal borrowing, inappropriate investing, failure to promptly account for monies due to an estate,

---

the word "duplicitous" is often associated with negative behaviours involving deceit, however, this is in no way the meaning relied upon in this paper.

[69] HPCAA, ss 100(1)(a) and (b).

[70] The term "range" refers to various different types of misconduct, for example inappropriate prescribing and failing to obtain informed consent. The term does not include various instances of the same type of misconduct.

[71] See *Professional Conduct Committee of the New Zealand Medical Council v Dr N* [2009] 261/Med09/120P.

[72] In all 11 HPDT decisions where various types of professional misconduct were alleged, each type of misconduct was aggregated under one duplicitous charge per s 100(1)(a) and/or (b) of

misleading the NZLS, and inadequate management of a trust account.[73] Analysis of the LCDT decisions revealed that this style of charging was consistent across all professional misconduct cases where a range of misconduct was alleged, with one exception.[74]

In short, duplicitous charges appear to be commonly relied upon for charging medical practitioners with professional misconduct,[75] yet are almost never utilised for laying professional misconduct charges against legal practitioners.[76]

2.3.2 Use of the Duplicitous Charge to Bring Alleged Misconduct within the Scope of Adverse Findings

In the 11 HPDT cases identified as utilising the duplicitous charge, there were 10 cases where the varying particulars aggregated under the one charge were said to amount to professional misconduct, either separately or *cumulatively*.[77] The possibility of considering the full range of alleged misconduct *cumulatively* in these cases opens the door for the HPDT to aggregate the seriousness of the conduct when assessing whether the professional misconduct threshold has been reached. The LCDT, however, is prevented from making holistic considerations in this way as a result of the current charging practice relied upon by the LCRO/SCs. This indicates that alleged misconduct may be brought within the scope of adverse findings more easily in the HPDT, in comparison to the LCDT. To put these propositions into context, it is helpful to consider two examples, one from each tribunal, where a range of professional misconduct issues were relevant.

---

the HPCA, see cases: Med 1, Med 8, Med 10-11, Med 13-14, Med 16-17, Med 19-20 and Med 22.

[73] See *Auckland Standards Committee v Johnston*, above n 42.

[74] Of the 16 LCDT decisions analysed where multiple types of misconduct were alleged, separate charges were laid for each type of professional misconduct in 15 of those decisions, see cases: Law 2, Law 4, Law 6-7, Law 12, Law 14-15, Law 18-22, Law 24, and Law 27-28. There was one early case before the LCDT where a duplicitous style charge was used, the deviation of this case from the charging style usually relied on in the LCDT was not explained, and has not been repeated since, see case: Law 17.

[75] HPCAA, ss 100(1)(a) and/or (b).

[76] LCA, s 241(1)(a).

(1) Professional Conduct Committee of the New Zealand Medical Council v MacDonald

This case involved Dr MacDonald and Mr K, who were employees of the same clinic.[78] As Medical Director, Dr MacDonald was required to provide medical treatment to fellow employees, including Mr K. Over time, however, the professional relationship between the two led to numerous allegations being laid by the PCC against Dr MacDonald. They included, the inappropriate use of supply orders, inappropriate prescription and administration of morphine, record keeping issues, insufficient referral of Mr K (as a patient) to specialists, and the entering into of an inappropriate sexual/intimate relationship with Mr K (as a patient). As is permitted by the duplicitous charge, each different type of conduct was framed as one of seven particulars, alleged to separately or *cumulatively* amount to one charge of professional misconduct.[79]

The HPDT found that the facts established particulars two to seven (particular one was dismissed) and thus went on to consider the second stage of the professional misconduct test, whether those particulars met the threshold for professional misconduct by warranting disciplinary sanction.[80] Only particulars two, four and five were viewed to have been sufficiently serious to justify a finding of professional misconduct when considered separately.[81] However, the tribunal considered that the "interconnectedness" of the conduct justified a "cumulative" consideration.[82] This allowed all six particulars to be considered together as sufficiently serious instances of malpractice, negligence and professional discredit to warrant discipline. All six types of misconduct were thus bought within the scope of the professional misconduct finding.[83] The reasoning of the HPDT in *PCC v MacDonald* was utilised in a total of six cases (including *PCC v MacDonald)*, to bring a range of alleged misconduct within

---

[77] See cases: Med 1, Med 8, Med 10-11, Med 13-14, Med 16-17, Med 19, and Med 22.
[78] *Professional Conduct Committee of the Medical Council of New Zealand v MacDonald* 220/Med08/120P.
[79] HPCAA, ss 100(1)(a) and (b).
[80] See 2.1.1(1) above for a discussion of the two-stage test for assessing professional misconduct used in the HPDT.
[81] At [258].
[82] At [255-257].
[83] Specifically, the inadequate clinical note taking and record keeping (particular 3), the failure to transfer Mr K to another practitioner having entered into an intimate/sexual relationship with him (particular 6), and the inappropriate use of supply orders to provide morphine to Mr K (particular seven), were bought within the professional misconduct finding despite not amounting to professional misconduct when considered separately.

the scope of adverse findings.[84] Similarly to *PCC v MacDonald,* in each of the other five cases it was accepted that at least one of the allegations included in the professional misconduct finding would not have reached the threshold if charged separately. This suggests that the HPDT does not hesitate to rely on the duplicitous charge in conjunction with a *cumulative* assessment, to bring the full range of proven conduct within an adverse finding

(2) Nelson Standards Committee v Webb

In the decision of *Nelson Standards Committee v Mr Webb*, legal practitioner Mr Webb faced professional misconduct charges regarding his administration of a deceased's estate.[85] Three charges of professional misconduct were laid against Mr Webb, one for each different type of misconduct alleged, as is the norm before the LCDT. One charge (alleging the sale of estate chattels below value) could not be established on the facts. A second charge of permitting his parents to occupy estate property below market rent, without disclosing his relationship with the tenants to the solicitors acting for the executors of the estate, was held to amount to professional misconduct. It is however the third "email charge" that was dismissed that is most relevant to present discussion.

The "email charge" alleged that Mr Webb, in emailing the UK based solicitors that were acting for the estate's executors, falsely misrepresented numerous details. These included: his contention that is was normal practice in Nelson to have "rent free" house sitters occupy estate property, and that his firm had many elderly couples on its "books", when in fact there were no such books and he had his parents in mind to carry out the "house sitting". Whilst the LCDT held that Mr Webb had been less than "strictly accurate" in providing information, it did not feel his representations were a serious enough departure from the truth to warrant a professional misconduct finding. As a separate charge, unable to be considered alongside the failed disclosure that was proven in the second charge, the "email charge" had to be dismissed.[86]

These two contrasting cases highlight how the different charging styles of the DP/PCC, in comparison to the LCRO/SCs, affects the ease with which alleged misconduct can

[84] See cases: Med 1, Med 8, Med 10-11, Med 13, and Med 22.
[85] *Nelson Standards Committee v Webb* [2011] NZLCDT 2.
[86] At [52-53]

be brought within the scope of an adverse finding. Before discussing the consequences of this difference, it is first necessary to consider the authority for each approach.

2.3.3 Authority Permitting or Preventing the Duplicitous Charge

When looking to the legislation there are no specific statutory provisions in either the HPCAA or LCA permitting or preventing the use of duplicitous charges. The only limit on how charges are framed is commonly understood to be the requirement in both statutes for the prosecuting bodies to lay "appropriate" charges before the respective disciplinary tribunals.[87] In both contexts "appropriate" is understood to mean that the practitioner must be aware of precisely the conduct that is being called into question.[88] In regard to disciplining medical practitioners, the duplicitous charge was affirmed as being "appropriate" in the necessary sense by the Court of Appeal in *Preliminary Proceedings Committee v Duncan.*[89] Unfortunately, there has never been any discussion as to the legitimacy of the duplicitous charge in the disciplining of legal practitioners, as it has only been used in one case and the issue was not challenged.[90]

Having considered the authorities (or lack thereof), discussion can now turn to assess the benefits and detriments of the duplicitous charge for effectively disciplining practitioners and protecting the public.

---

[87] HPCAA, s 81(2)(a); and LCA, ss 154(1)(a) and 212(1)(a).

[88] See the majority decision in *Preliminary Proceedings Committee of the Medical Council of New Zealand v Duncan* [1986] 1 NZLR 513 at 24 where "appropriate" is discussed in relation to s 56(3) of the Medical Practitioners Act 1968 (now s 82(1)(a) of the HPCAA). In regard to the LCDT, see the LCA Regulations, rr 5 and 6. An anonymous but knowledgeable source confirms that rr 5 and 6 require legal practitioners to be precisely aware of the conduct that is being called into question.

[89] In *Preliminary Proceedings Committee of the Medical Council of New Zealand v Duncan*, above n 88, at 23, the Court of Appeal held that duplicitous charges did not offend the "appropriate" charge requirement under s 56(3) of the Medical Practitioners Act 1968 in force at the time (now s 81(2)(a) of the HPCAA). In making this affirmation the Court relied upon *Peatfield v General Medical Society* [1986] 1 WLR 243.

[90] As noted above at n 74, there is only one record of the duplicitous charge having been used in the LCDT and in that case its use was not contested. On this basis it seems open for argument that the charge could be used, although the issue has never been discussed in the tribunal or the courts.

2.3.4 Repercussions of the Duplicitous Charge

(1) Benefits

The major advantage of allowing professional misconduct charges to cover the range of a practitioner's alleged failings is that the HPDT can assess practitioners' general attitudes towards their professional responsibilities.[91] This avoids the potential for absurd results whereby a medical practitioner could escape the stigma and consequences of a professional misconduct finding purely because no one type of professional failing was significant enough to cross the threshold alone, despite their range of lesser failings evidencing a clear indifference to their professional responsibilities.

The potential benefits of the duplicitous charge can also be seen to extend to penalty, given that the HPDT assesses penalty on the basis of all conduct held to constitute the established offence.[92] Therefore, by incorporating conduct that would not on its own result in a professional misconduct finding, the HPDT is able to take account of such conduct when determining penalty. The practical realities of this advantage are demonstrated by the case of Dr MacDonald where the HPDT would not have been able to consider numerous elements of Dr MacDonald's negligence in assessing penalty but for the duplicitous charge.[93] For instance, despite the entry into a sexual relationship with patient Mr K being relevant, Dr MacDonald's failure to refer Mr K to a different practitioner following the initiation of the relationship would have been outside the scope of penalty considerations.[94] By being able to consider practitioners' conduct as a whole, the HPDT is in a better position to assess the risk posed by medical practitioners and protect the public accordingly.

(2) Detriments

In the past it has been argued that the use of duplicitous charges breaches medical practitioners' rights to natural justice by resulting in unfair hearings.[95] Ultimately, however, this argument is unconvincing. The argument suggests that duplicitous

[91] See *Preliminary Proceedings Committee of the Medical Council of New Zealand v Duncan,* above n 88, at 25.
[92] See *Director of Proceedings v Vatsyayann* 428/Med10/170D at [302].
[93] See 2.3.2(1).
[94] See 2.3.2(1).

charges can be "unfair" and "confusing" for practitioners, as the complex aggregation of alleged conduct could render practitioners unable to properly answer any charges faced and defend the allegations against them.[96] However, the underlying rationale behind this argument contains an inherent flaw. Firstly, it must be remembered that the HPCAA requires medical practitioners to be informed of precisely the charges they face.[97] This can be achieved with duplicitous charges provided proper use is made of particulars and sub-particulars to specify the precise conduct in question.[98] Secondly, the extensive reasoning given in tribunal decisions ensures certainty as to why charges are established against medical practitioners.[99] Considered in the light of these procedural fairness requirements, the risk of a practitioner being "confused" by the duplicitous charge to the extent of excluding a proper defence appears far-fetched.

2.3.5 Recommendations

In summary, the use of the duplicitous charge in HPDT proceedings can be justified on the basis that any possible "natural justice" concerns can be overcome, and there is thus no reason to deny the added public protection that flows from holistic considerations of a practitioner's conduct and attitude towards their professional responsibilities. The separate charging method used by the LCRO/SCs denies the LCDT the opportunity to consider a practitioner's conduct as a whole. This impairs the LCDT's ability to understand a practitioner's general attitude towards their professional responsibilities and compromises its protective function. Accordingly, it is suggested that the LCDT encourage the LCRO/SCs to embrace the charging style of the DP/PCC, so it can reap the advantages of making holistic considerations of alleged misconduct. As in the HPDT, any "natural justice" concerns can be met as the LCA Regulations require practitioners to be informed of precisely the allegations against

---

[95] The right to natural justice for medical practitioners facing HPDT proceedings is explicitly confirmed in sch 1, sub-cls 5(3) of the HPCAA.
[96] *Preliminary Proceedings Committee of the Medical Council of New Zealand v Duncan,* above n 88, at 1-6 per Casey J dissenting.
[97] See 2.3.3.
[98] See *Preliminary Proceedings Committee of the Medical Council of New Zealand v Duncan,* above n 88, at 24.
[99] Sections 103(1)(a),(b) and (c) of the HPCAA require the HPDT to provide written reasons for its decisions.

them.[100] Thus, provided the LCRO/SCs were specific in particularising duplicitous charges, any risk of "confusing" legal practitioners seems unlikely.

2.4 Comparing How Charges are Assessed and Determined by the HPDT and LCDT

Subject to the requirements to provide notice to practitioners,[101] and the application of the Evidence Act 2006 so far as it is applicable,[102] the HPDT and LCDT are largely permitted to regulate their own procedure for assessing charges. Both tribunals appear to follow a similar procedure to that seen in the criminal courts, hearing first the prosecution and then the practitioner, before retiring to decide whether they are satisfied the charges have been established to the applicable balance of probabilities standard. In the decisions analysed, the HPDT found 23 of 24 medical practitioners guilty of at least one offence charged under s 100(1) of the HPCAA.[103] Before the LCDT, 29 of 31 legal practitioners charged were found guilty of at least one offence under s 241(a),(c) or (d) of the LCA.[104] The consistently high successful prosecution rate suggests that practitioners are only bought before the two tribunals where the prosecuting bodies are confident that charges will be established. However, the evidence required to satisfy the two tribunals of a practitioner's guilt varies significantly, depending on the tribunal and on whether charges are defended.

2.4.1 Two Different Approaches to Dealing with Admitted Charges

Analysis of the decisions revealed that the LCDT takes a similar approach to the criminal courts whereby a "charge admitted equals a charge established".[105] Unlike

---

[100] See 2.3.3.

[101] Both tribunals are required to give any practitioner charged with a disciplinary offence under s 100 of the HPCAA, or s 241 of the LCA, written notice of the decision to charge alongside a copy of the charge and notice of the hearing. See s 92(1) of the HPCAA, s 154(1)(b) of the LCA, and r 12 of the LCA Regulations.

[102] Both tribunals are allowed to consider any evidence that would assist them in dealing with a case, regardless of whether that evidence would normally be admissible in a court of law (HPCAA, sch 1, sub-cls 5(1); and LCA, s 249(1)). Beyond this, the rules of evidence provided by the Evidence Act 2006 apply to proceedings of both the HPDT and LCDT (HPCAA, sch 1, cl 6; and LCA, s 239).

[103] The only HPDT case where a practitioner was found not guilty was case Med 17.

[104] The only two LCDT cases where practitioners were found not guilty, were cases Law 23 and Law 31.

[105] The LCDT applied a "charge admitted equals a charge established" approach and relied solely on practitioners' admissions as sufficiently establishing the relevant charges in 22 of the 23 cases where charges were admitted, see cases: Law 1-3, Law 5, Law 7-11, Law 13-16, Law

charges that are defended, when guilty pleas are entered the LCDT does not provide any reasoning at to why a practitioner's conduct amounts to the offence in question. The approach of the LCDT removes the need to provide any substantive discussion of charges that are admitted and allows the tribunal to move swiftly to deal with penalty. In the words of the LCDT, "In light of the charges having been admitted … the task of the tribunal is to decide the appropriate sanction".[106]

In contrast to the approach of the LCDT, the HPDT requires itself to be independently satisfied of a practitioner's guilt, notwithstanding any admissions made.[107] The prosecution (DP/PCC) is put to proof in every case, regardless of whether charges are admitted or defended. In the words of the tribunal "Dr S admitted that the charge … was established. Nonetheless, it was necessary for the tribunal to consider the evidence carefully and determine whether the charge was made out".[108] As a result, the HPDT provides full reasoning as to why a practitioner's conduct amounts to the offence charged in all decisions.[109]

2.4.2 Repercussions of the Two Approaches to Dealing with Admitted Charges

(1) Benefits of the HPDT approach, and corresponding detriments of the LCDT approach

The full reasoning provided by the HPDT in relation to all charges allows every decision to act as a possible resource for the wider profession, and its advisers. When the HPDT compares a practitioner's conduct to the elements of the relevant statutory offence, the abstract HPCAA provisions take on real meaning. The HPDT is thus able to facilitate in the setting of standards, a key element of professional discipline.[110]

18-22, Law 26-27, and Law 29. There was one unexplained exception where the LCDT provided further reasoning as to why it felt an admitted charge was established in contrast to the general trend, see case: Law 25.

[106] *Auckland Standards Committee v Korver* [2011] NZLCDT 22 at [17].

[107] The HPDT made an independent consideration of the charge(s) laid against medical practitioners in every case, regardless of whether the practitioner admitted or defended the charge(s).

[108] *Professional Conduct Committee of the Medical Council of New Zealand v Dr S* 449/Med11/197P at [19].

[109] An anonymous but knowledgeable source has confirmed that this is a self-imposed requirement and that there is no authority for why the HPDT undertakes this approach.

[110] See Joanna Manning "Professional Discipline of Health Practitioners" in PDG Skegg and Ron Paterson *Medical Law in New Zealand* (Brookers Ltd, Wellington, 2006) 613 at 616.

Conversely, the LCDT's "charge admitted equals a charge established" approach precludes such an opportunity where practitioners plead guilty and no reasoning is provided. This denies members of the wider profession a chance to see how their conduct might stack up against the LCA. The lost opportunity resulting from the LCDT approach is demonstrated by the case of *Auckland Standards Committee v Ravelich.*[111] Mr Ravelich admitted a number of charges under s 241(d) of the LCA (and the LPA equivalent), for convictions relating to drink driving and resisting arrest. The tribunal stated that, as a guilty plea had been entered, it was no longer "required to undertake the qualitative assessment of the conduct which would otherwise be necessary".[112] Admittedly Mr Ravelich's conduct was not borderline, but what of an otherwise law-abiding practitioner caught out just over the limit, on a single occasion? As a result of the "charge admitted equals a charge established" approach, the LCDT passed up the opportunity to make some general comments on how drink driving convictions may fit with the relevant disciplinary offence provision.[113] The chance to send a message to legal practitioners that pushing their luck after Friday night drinks could have devastating consequences was thrown away. The LCDT's approach thus conflicts with one of the primary purposes of professional discipline, to uphold professional standards. As by passing up the opportunity to use case law as a tool for setting standards, the LCDT compromises its ability to maintain standards.

(2) Benefits of the LCDT approach, and corresponding detriments of the HPDT approach

The principal advantage of the LCDT's "charge admitted equals a charge established" approach, is that admitted charges are dealt with more efficiently before the LCDT, in comparison to the HPDT. The LCDT and the prosecuting body presumably save time and resources by not independently assessing admitted charges.[114] The efficiency of the LCDT also holds potential benefits for those legal practitioners subject to proceedings. Assuming that a practitioner who is prepared to admit charges wants

[111] *Auckland Standards Committee v Ravelich* [2011] NZLCDT 11.
[112] At [7].
[113] LCA, s 241(d).
[114] Unfortunately a comparison of the average time taken for proceedings to be concluded or the costs of proceedings, could not be undertaken. This is because the LCDT rarely provide details such as the date when charges are first laid, or the total costs of proceedings. Accordingly it must be acknowledged that there can only be a presumption as to the resources saved by the LCDT approach.

efficient resolution of what is inevitably a stressful process,[115] the expeditious approach of the LCDT is probably welcomed by practitioners, as it likely reduces the time practitioners are subjected to the professional disciplinary process. In contrast, medical practitioners have to endure the extra time that is presumably taken up by a full hearing, despite the fact they may have admitted their errors and want to move on with their careers where possible.

A final note must be given to a possible, albeit improbable, detriment that could arise under the HPDT's approach. The independent assessment requirement opens the door for an absurd outcome whereby a medical practitioner admits the charge laid by the prosecuting body, yet the HPDT determines the practitioner to be "not guilty". This result could have negative implications for the public's confidence in the ability of the HPDT to effectively discipline medical practitioners. If all parties involved agree a medical practitioner is guilty of professional misconduct, the HPDT's rejection of this view might cause the public to question the HPDT's standards. However, considering that charges appear to be laid only when the prosecuting bodies are reasonably confident of a guilty finding,[116] the chances of an admitted charge being "let go" by the HPDT seems minimal. So, whilst this underlying albeit dormant issue is interesting to note, it appears to be more of an academic point than a criticism that should affect the evaluation of the HPDT approach.

There are undoubtedly benefits and detriments that accompany both approaches to dealing with admitted charges. In comparison to the HPDT, the LCDT approach is less effective in educating members of the profession and setting professional standards, yet dealing with individual cases is presumably simpler and cheaper for those involved.

2.4.3 Recommendations: An Intermediate Solution

There is a possible middle ground that could be adopted by the LCDT. In cases like that of Mr Ravelich[117], for example, the LCDT could make a general obiter statement as to how drink driving convictions are likely to be viewed by the tribunal. In this way

[115] See *Auckland Standards Committee v Stirling* [2010] NZLCDT 4 at [4] where the rigors and stress of formal tribunal proceedings were acknowledged by the LCDT.
[116] Given the very high successful prosecution rate, the prosecuting bodies appear to lay charges only when they are reasonably confident the charges can be established, see 2.4.

it could still utilise decisions as a learning tool whilst maintaining similar levels of efficiency. Of course, the HPDT could consider departing from their independent assessment approach to take up this intermediate position and hence reap the possible efficiency advantages that are enjoyed in the LCDT. The intermediate solution suggested could allow both tribunals to strike an appropriate balance between education and efficiency.

2.5 Quasi-inquisitorial Powers and the Appointment of Technical Advisers

The last part of this chapter explores some of the resources that are drawn upon by the two tribunals in making their substantive determinations.

2.5.1 Quasi-inquisitorial Powers

It is well accepted that both the HPDT and LCDT, whilst essentially adversarial, also have quasi-inquisitorial powers that permit the direct questioning of witnesses by tribunal members more readily than may occur in a court.[118] This power undoubtedly helps ensure that the tribunals determine charges based on a proper understanding of the issues in question. This advantage is particularly important, given that the tribunals make findings on the balance of probabilities that can affect the careers of medical and legal practitioners. Therefore, the ability for tribunal members to question any aspect of a case they may be unclear about seems appropriate.

2.5.2 Technical Advisers

(1) The ability of the HPDT to appoint a technical adviser

Schedule 1 of the HPCAA stipulates that the HPDT may appoint a technical adviser to advise the tribunal on any legal or procedural questions, or any clinical or scientific questions.[119] The advantages of appointing an adviser can be separated into two categories that highlight the different ways advisers can aid the HPDT.

---

[117] *Auckland Standards Committee v Ravelich,* above n 111.

[118] See Joanna Manning, above n 110, at 667 for further discussion on the inquisitorial powers of the HPDT; In relation to the LCDT, an anonymous but knowledgeable source confirms that the tribunal has a quasi-inquisitorial nature and that tribunal members regularly ask direct questions of witnesses as a result.

[119] HPCAA , sch 1, cl 16.

(i) Obvious value

The ability of technical advisers to advise on legal, procedural, clinical or scientific matters can obviously be of some value to the HPDT. However, given that any sitting chairperson has significant legal experience,[120] this suggests the HPDT has inherent access to general legal or procedural guidance.[121] Secondly, any experts called by the parties are expected to provide unbiased, objective opinions when giving evidence.[122] The independent nature of the expert, in conjunction with the quasi-inquisitorial powers that permit direct questioning of witnesses, thus provides the tribunal with considerable impartial clinical or scientific expertise. Accordingly, whilst the appointment of an unbiased technical adviser can no doubt provide added guidance to that already available to the HPDT, it is speculated that the true value of the adviser lies elsewhere.

(ii) Value in practice

Analysis of the decisions suggests that the greatest value of the adviser to the HPDT is in providing reassurance that proceedings are fair for unrepresented practitioners. Because technical advisers can engage with practitioners, they are able to ensure that practitioners without legal representation understand the legal and procedural ramifications of the choices they make and convey this information back to the HPDT. For example, in the only two HPDT proceedings where advisers were relied upon, both cases involved self-representing practitioners who made major procedural choices regarding pleas and the giving of evidence.[123]

In proceedings against Dr Vatsyayann, the HPDT relied upon Mr Upton QC to ensure Dr Vatsyayann was fully aware that by failing to give evidence he was at particular

[120] Section 86(1)(a) of the HPCAA dictates that the chairperson and deputy chairperson of the HPDT must have no less than 7 years experience as a practising barrister or solicitor of the High Court.

[121] See Joanna Manning, above n 110, at 617 where it is suggested that the legal experience of the chairperson and deputy chairperson can help to maintain legal and procedural standards within the HPDT.

[122] See sch 4 of High Court Rules which apply to the HPCAA per s 26(1) of the Evidence Act 2006, and sch 1, sub-cl 6(5) of the HPCAA.

[123] See *Vatsyayann v Professional Conduct Committee of the Medical Council of New Zealand*, above n 1; and *Ranchhod v Professional Conduct Committee of the Medical Council of New Zealand* 273/Med09/129P.

risk of an adverse finding, should the PCC establish a prima facie case.[124] Similarly, in proceedings against Dr Ranchhod the HPDT relied on an adviser, Mr Manning, to provide assurance that Dr Ranchhod was aware of all the implications of pleading guilty.[125] These two cases demonstrate how a technical adviser can be used to provide peace of mind that self-represented practitioners receive fair hearings. Furthermore, the use of advisers in this way helps to safeguard the efficacy of the wider disciplinary system, ensuring tribunal decisions would survive appeal to the High Court if challenged on the basis of procedural fairness. Given the general right of appeal, the appointment of advisers cannot of itself prevent appeals on the grounds of unfair procedure.[126] However, the use of a technical adviser at the tribunal level can be relied upon by the DP/PCC in responding to any appeals. This is precisely what occurred when Dr Vatsyayann appealed the HPDT decision above relying on the ground, amongst others, that he did not understand the consequences of failing to give evidence. The High Court was able to dismiss that ground of appeal, relying on the fact Mr Upton QC had properly informed Dr Vatsyayann of the ramifications of his decision at the tribunal level.[127]

(2) The inability of the LCDT to appoint a technical adviser

In contrast to the HPCAA, the LCA confers no power upon the LCDT to appoint a technical adviser. However, considering the two possible values discussed above, there appears to be little scope for technical advisers in the LCDT, where practitioners are presumably versed in legal and procedural matters.

(i) Obvious Value

As with the HPDT, it appears that the LCDT is well resourced when it comes to advice on any legal, procedural, or other complex profession-specific issues. A sitting quorum of the LCDT is comprised by a majority of practising, or previously practicing, legal practitioners. The tribunal is therefore unlikely to be short of expertise on appropriate

[124] See *Vatsyayann v Professional Conduct Committee of the Medical Council of New Zealand*, above n 1, at [23].
[125] See *Ranchhod v Professional Conduct Committee of the Medical Council of New Zealand*, above n 123, at [5].
[126] Section 106(2) of the HPCAA provides for a general right of appeal to the High Court from all HPDT decisions.
[127] See *Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council*, above n 41, at [46].

legal or procedural standards.[128] The tribunal can also be seen to have access to sufficient impartial advice from expert witnesses for any complex profession-specific matters, such as forensic accounting issues in a trust fund case for example. As with the HPDT, any experts giving evidence owe an overriding duty to assist the tribunal by presenting unbiased and objective opinions.[129] The quasi-inquisitorial powers of the LCDT further ensure the tribunal is adequately informed, permitting direct questioning of experts by tribunal members where complex issues may need clarification.

(ii) Value in practice

The professional context within which the LCDT operates suggests that the practical value of the technical adviser evident in some HPDT decisions does not translate to the LCDT. This is because the LCDT decisions analysed indicate that the tribunal operates on a presumption that the legal background of those facing proceedings precludes the need for any unease regarding self-represented practitioners and fair procedure.[130]

No decision of the LCDT has been appealed by a self-represented practitioner on the basis of procedural unfairness, so the presumption of procedural knowledge that the LCDT appears to rely upon has not been tested. However, the High Court and Court of Appeal did deal with this issue recently in regards to an appeal from the Canterbury District Disciplinary Tribunal under the previous LPA regime. In the case of *Sisson v Canterbury District Law Society,*[131] Ms Sisson applied for judicial review of a previous tribunal decision that found her guilty of two charges of professional misconduct for the inappropriate claiming of legal aid.[132] The application was based in part on apparent bias. Ms Sisson alleged that a tribunal member had a personal interest in the outcome and that her "waiver" concerning this member's position on the panel was invalid, as she was not aware of the full consequences of the "waiver". The High Court

[128] Section 230 and 235 of the LCA dictate that any quorum hearing a case must have a chairperson with no less than seven years legal experience, as well as at least two other members who are in practice.
[129] See sch 4 of the High Court Rules which apply to the LCDT as per s 26(1) of the Evidence Act 2006 and s 239(4) of the LCA.
[130] Of the eight LCDT cases where practitioners were self-represented or failed to engage with the LCDT process whatsoever, there was no evidence of the LCDT seeking to ensure their understanding of the process or any procedural decisions made, see cases: Law 4, Law 6, Law 14-15, Law 19, Law 21, Law 26, and Law 30.
[131] *Sisson v Canterbury District Law Society* [2011] NZLJ 169.
[132] *Sisson v Canterbury District Law Society*, above n 131.

dismissed the appeal and held that as a trained lawyer Ms Sisson, whilst self-represented, would have been aware of the legal ramifications of waiving her right to object.[133] The presumption of procedural knowledge was further affirmed when the Court of Appeal upheld the High Court's determination.[134] The decisions of the High Court and Court of Appeal, albeit implicit and relating to a previous regime, suggests the LCDT's presumption of procedural knowledge is likely to withstand any future appeals.

In summary, the provision for appointment of technical advisers in HPDT proceedings seems entirely appropriate, ensuring that self-represented practitioners unversed in legal proceedings receive fair hearings and safeguarding the efficiency of the wider disciplinary system. In contrast, the presumption of procedural knowledge in the LCDT suggests there would be little scope for a technical adviser to contribute to LCDT proceedings.

2.6 Chapter Two Summary

The two tribunals are concerned with the same sorts of conduct and share numerous common features. Analysis does however reveal some key differences between the tribunals in their approach to determining charges. The use of the duplicitous charge suggests the HPDT is better placed to protect the public from professional misconduct, by allowing the tribunal to consider practitioners' whole attitudes towards their professional responsibilities. The LCDT is advised to encourage the SC/LCRO to utilise the duplicitous charge so it can reap the advantages of considering practitioners' conduct holistically. Furthermore, it is suggested that both tribunals reconsider their approach to dealing with admitted charges, thereby achieving the best possible balance between efficiency, and education. This suggestion is particularly pertinent to the LCDT, as its current approach compromises its ability to help set professional standards.

[133] See *Sisson v Canterbury District Law Society*, above n 131, at [38].

Chapter Three

Penalty: A Comparison of Penalty Orders and the HPDT and LCDT Approach to Determining Penalty

Both the LCDT and HPDT seek to advance the same principal objectives in disciplining practitioners: to protect the public and to maintain professional standards.[135] This being so, it is hardly surprising that the two tribunals adopt similar principles in determining penalty orders where adverse findings have been made. The first part of this chapter discusses the features of penalty that the two tribunals share, including the similarity of the orders provided by the legislation, the purposes and principles utilised for determining penalty, and the extent of discretion afforded to the two tribunals in making orders. This chapter then explores how each tribunal utilises its discretion by comparing the factors taken into account by the tribunals when determining penalty. The analysis for the chapter included 22 HPDT and 29 LCDT penalty determinations.[136]

3.1 An Overview of the Penalty Orders Available

The HPCAA and LCA provide for a range of similar penalty orders that may be imposed by the two tribunals following any charge(s) having been established.[137] These include: cancellation of registration/strike off from the roll,[138] suspension for a maximum period of 36 months,[139] censure,[140] the imposition of conditions upon

[134] See *Sisson v Canterbury District Law Society* [2011] NZCA 55.
[135] HPCAA, s 3(1); and LCA, s 3(1).
[136] One HPDT decision and two LCDT decisions analysed for the purposes of chapter two did not include penalty determinations as a result of the practitioners being found not guilty, see cases: Med 17, Law 23, Law 31. A further HPDT decision is awaiting a penalty re-hearing, see case: Med 20. These four cases were thus excluded from the penalty analysis. As a result, there were 22 HPDT penalty decisions and 29 LCDT penalty decisions that could be analysed for the purposes of chapter three.
[137] Section 101 of the HPCAA and s 242 of the LCA outline the penalties that may be imposed following any finding under s 100 of the HPCAA, or s 241 of the LCA (respectively).
[138] HPCAA, s 101(1)(a); and LCA, s 242(1)(c).
[139] HPCAA, s 101(1)(b); and LCA, s 242(1)(e).
[140] HPCAA, s 101(1)(d); and LCA, ss 242(1)(a) and 156(1)(b).

practise,[141] and a maximum fine of $30,000,[142] and finally the enforcement of costs against practitioners.[143]

3.2 Purposes of Penalty

Both tribunals operate on the understanding that the primary purpose of making penalty orders is to reinforce the principal objectives of professional discipline: to protect the public and maintain professional standards.[144] Whilst acknowledging that the proceedings are not criminal ones, it is commonly accepted that punishment will often accompany the other purposes of penalty, particularly in more serious cases.[145] The tribunals also view rehabilitation as an appropriate component in certain penalty determinations.[146] There is also a wider deterrent function where penalties imposed are made known to other members of the profession.[147]

3.3 The Overarching Principles of Determining Penalty

The HPDT and LCDT are both afforded a wide discretion to determining penalties by the relevant legislation in recognition that each case will turn on its facts.[148] Underscored by the general propositions requiring proportionality and consistency within and between decisions, it is largely left to the tribunals to determine the

---

[141] HPCAA, s 101(1)(c); and LCA, s 242(1)(a) in conjunction with ss 156(1),(j),(l),(m), 242(1)(b) and (g).
[142] HPCAA, s 101(1)(e); and LCA, s 242(1)(i).
[143] HPCAA, s 101(1)(f); and LCA, ss 242(1)(a), 156(1)(n) and (o). It is important to note that many of the decisions analysed involved penalties that were determined pursuant to the LPA, as per the transitional provisions of the LCA (s 352). The range of orders available under s 112(2) of the LPA were almost identical to those available under the LCA, the only difference was that the maximum fine imposable was previously $5,000 (s 112(2)(d), LPA). The principles and purposes informing penalty determinations were also the same under the LPA. This being so, decisions inside the sample period involving penalty orders made pursuant to the LPA were included in the comparison.
[144] See *N v Professional Conduct Committee of the Medical Council of New Zealand* HC Wellington, 19 March 2012, CIV-2009-0485-2347 at [13-14], (HPDT); and *Daniels v Complaints Committee 2 of the Wellington District Law Society* [2011] NZLR 850 at [22], (LCDT).
[145] See *N v PCC,* above n 144, at [15], (HPDT); and *Auckland Standards Committee 1 v Fendall* [2012] NZHC 1825 at [36], (LCDT).
[146] See *N v Professional Conduct Committee of the Medical Council of New Zealand*, above n 144, at [16], (HPDT); and *Daniels v Complaints Committee 2 of the Wellington District Law Society*, above n 144, at [22], (LCDT).
[147] See *N v Professional Conduct Committee of the Medical Council of New Zealand,* above n 144, at [17], (HPDT); and *Auckland Standards Committee 1 v Fendall*, above n 145, at [42], (LCDT).
[148] HPCAA, s 101; and LCA, s 242.

appropriate penalty - having regard to the seriousness of the conduct and to any relevant aggravating or mitigating features. Since the coming into force of the HPCAA in September 2004, there are no longer any specific tariffs restricting certain penalties for certain offences in either tribunal.[149] Whilst each tribunal's discretion is reasonably extensive, two caveats are discussed below.

3.3.1 Restrictions on the Discretion of the HPDT and LCDT

Firstly, every penalty determination made is vulnerable to appeal to the High Court as of right.[150] Secondly, the discretion of both tribunals is restricted in regard to the more severe penalties of cancelation/strike off and suspension. Specifically, the LCDT is required to be satisfied that in all the circumstances a lawyer is "not a fit and proper person" to be a practitioner before ordering strike off from the roll.[151] Furthermore, neither strike off nor suspension may be enforced without unanimous agreement or a 5 member majority of the LCDT, unless by consent.[152] There is no statutory fetter on the HPDT's ability to cancel a practitioner's registration or suspend. However, the "fit and proper person" stipulation is still the central consideration where such options are explored regarding medical practitioners.[153] The HPDT requires only a regular majority to suspend or strike off,[154] but as with the LCDT, the majority must not make any order unless satisfied it is the "least restrictive outcome" available that still serves the purpose of protecting the public.[155]

---

[149] The LCDT (and predecessors) have long been unrestricted in their ability to attach any penalty to any offence provided the penalty is appropriate, see s 242 of the LCA, and s 112(2) of the LPA. In contrast, the HPCAA only recently bought penalisation of medical practitioners into line with that of legal practitioners, as it moved away from the former tiered approach to offences and penalty, contrast s 110(2) of the Medical Practitioners Act 1995, with s 100(2) of the HPCAA.

[150] HPCAA, s 106; and LCA, s 253.

[151] LCA, s 244(1).

[152] LCA, s 244(2).

[153] See *PCC v Martin,* above n 24, at [24]. As with legal practitioners the focus on a medical practitioners fitness makes the test for exclusion from the profession the same as the test for entry, see ss 15 and 16 of the HPCAA; and r 4(1)(a) of the LCA Regulations.

[154] HPCAA, s 89(4).

[155] See *Vatsyayann v Professional Conduct Committee of the Medical Council of New Zealand*, above n 41, at [38], (HPDT); and *Daniels v Complaints Committee 2 of the Wellington District Law Society,* above n 144, at [22], (LCDT).

3.4 An Overview of the Penalty Orders Made by the HPDT and LCDT

3.4.1 Cancellation of Registration/Strike Off

The most serious penalty orders of cancellation/strike off were generally, although not always, utilised in LCDT cases involving dishonest or deceptive conduct (including dishonesty convictions in the courts), and in HPDT cases where a doctor's acts or omissions endangered the safety of the public.[156]

3.4.2 Suspension

In the LCDT practitioners were most commonly suspended for providing false or misleading information to the court.[157] Almost all cases where suspension was ordered in the HPDT related to practitioners who had been convicted of offences that were held to reflect adversely on their own, or the professions', fitness.[158]

3.4.3 Fines

Both tribunals generally fined all practitioners whose offending had a financial element, such as medical practitioners who made illegitimate claims to the Ministry of Health, or legal practitioners who inappropriately borrowed from clients.[159] Unlike the LCDT, the HPDT also ordered fines in relation to a vast array of other conduct, ranging from breaches of confidence to failures regarding informed consent.

3.4.4 Conditions

Conditions were commonly imposed by both tribunals in a variety of cases to ensure that practitioners received the assistance/retraining considered necessary and to protect the public from any ongoing risks.[160]

---

[156] In total there were 12 LCDT cases where legal practitioners were struck off the roll, see cases: Law 4, Law 6(P), Law 8, Law 14-15, Law 17(P), Law 18, Law 21, Law 24(P), Law 26, and Law 29. In the HPDT medical practitioners had their registrations cancelled in five cases, see cases: Med 1, Med 10, and Med 20-22.

[157] Legal practitioners were suspended from practice in six LCDT cases, see cases: Law 2, Law 5, Law 9, Law 13, Law 20, and Law 30(P).

[158] Medical practitioners were suspended from practice in nine HPDT cases, see cases: Med 2-3, Med 5, Med 7-9, Med 13-14, and Med 24.

[159] Fines were imposed against practitioners in four LCDT cases and nine HPDT cases, see cases: Law 1, Law 3, Law 12, Law 16, Med 4-6, Med 12-13, Med 16, Med 18, and Med 22-23.

[160] Conditions were placed upon practitioners in nine LCDT cases and 15 HPDT cases, see cases: Law 2, Law 5, Law 12-13, Law 19, Law 22, Law 27, Law 28(P), Med 2-4, Med 6-16, Med 18-19, and Med 23-24.

3.4.5 Censure

In the HPDT and LCDT censure was the most common penalty order made and was utilised by both tribunals in relation to a vast range of conduct.[161]

Because each case is so different, involving its own complex factual matrix, extensive comparison of the orders made beyond this point provides little insight into the operation of each tribunal. However, given that each tribunal seeks to advance the same purposes in making penalty orders, analysis of the factors taken into account by the two tribunals is interesting. Accordingly, discussion now turns to focus on the more common penalty factors considered by the two tribunals as part of their discretion.

3.3 Factors Taken into Account by the HPDT and LCDT in Determining Penalty

3.3.1 Nature and Seriousness of the Conduct Subject to the Established Charge(s)

As was to be expected, the seriousness of the conduct that amounted to the relevant charge(s) was the central consideration in all cases examined across both tribunals. Whilst this can be seen to demonstrate the two tribunals' commitment to proportionality, the dedication to conduct-penalty consistency was less explicit. Analysis revealed a pattern whereby the HPDT placed significant reliance upon comparison with like decisions involving similar conduct, commonly stating the importance of analogy in achieving consistent results. This is an approach affirmed by the High Court, where appropriate categorisation of conduct, including reliance on like cases, was held to be pivotal in HPDT cases.[162] In contrast, the LCDT was much less reliant on analogising and distinguishing the conduct of other practitioners. This does not necessarily mean the decisions were any less consistent, rather the LCDT simply appear less concerned with explicitly demonstrating consistency by comparison with like cases. The LCDT's approach does not appear to be causing any problems as only two cases analysed were appealed to the High Court on the basis of inconsistent penalty and these were dismissed.[163] Nonetheless, the demonstration of consistency in decisions might need re-thinking in future, if appeals based on inconsistent LCDT

[161] Orders were made for censure in 20 HPDT cases and 17 LCDT cases, see cases: Law 1, Law 3, Law 5, Law 7, Law 9-10, Law 12-13, Law 16, Law 19, Law 20, Law 22, Law 25(P), Law 26-27, Law 28(P), Law 30(P), Med 1-13, Med 15-21, and Med 23-24.

[162] See *N v Professional Conduct Committee of the New Zealand Medical Council*, above n 144, at [22].

penalties increased in frequency. In summary, whilst the difference in approach is interesting, albeit largely inconsequential, it is certainly worth monitoring.

3.3.2 Professional and Personal Pressure

(1) Professional Pressure

A certain level of pressure and stress is inherent in the work of legal and medical practitioners. Nonetheless, a tough stance is taken by both tribunals in regard to professional pressure, as registration in both contexts is looked upon as a privilege that is accompanied by responsibility.[164] As a result of this thinking, analysis revealed that submissions asserting everyday instances of professional pressure as a mitigating feature were commonly rejected by both tribunals.[165] A good example of the tribunals' approach can be seen in the LCDT decision of *National Standards Committee v Poananga*.[166] Ms Poananga had been found guilty of professional misconduct for breaching her duty of fidelity to the court and for the forgery and falsification of legal aid documents. Amongst other submissions as to penalty, it was contended that the extra pressures involved in providing services to Maori clients in the context of Tikanga Maori expectations were a relevant mitigating feature of the offending. However, having found that the pressure and stress faced by Ms Poananga were not "unique" to Maori practitioners, the tribunal rejected the submission and held Ms Poananga fully responsible for her misconduct.[167]

However, as was alluded to in the *Poananga* decision, the tribunals will accept professional pressure as a mitigating factor where it is "unique".[168] This requires the

---

[163] See *Parlane v New Zealand Law Society* [2011] HC Hamilton CIV-2010-419-1209, 20 December 2010; and *Dorbu v New Zealand Law Society (No 2)* [2012] NZHC 564.

[164] See *Professional Conduct Committee of the New Zealand Medical Council v Ranchhod*, above n 123, at [65].

[165] In total practitioners attempted to claim "professional pressure" as a mitigating factor in five HPDT cases and six LCDT cases, see cases: Med 3, Med 7, Med 10, Med 14, Med 16, Law 7, Law 10, Law 18, Law 27, Law 29, and Law 30(P). These submissions were rejected in two HPDT cases, and four LCDT cases, see cases: Med 10, Med 16, Law 18, Law 29, and Law 30(P).

[166] *National Standards Committee v Poananga*, above n 42.

[167] At [32].

[168] In total "professional pressure" submissions were accepted as being "unique" enough to act as a mitigating factor in one HPDT case and two LCDT cases, see cases: Med 14, Law 7, and Law 10. Notably there were two HPDT cases and one LCDT case where "professional pressure" submissions did not attract comment by the tribunals, see cases Med 3, Med 7, and Law 27.

particular circumstances to extend beyond the normal level of stress practitioners are expected to rise above, as part of their privileged position. An example is provided by the case of *Canterbury District Law Society v Horne*.[169] Mr Horne was found guilty of professional misconduct for making an unauthorised transfer of a client's money held in a trust account to one of the client's debtors. In that case, the unusual situation and significant pressure Mr Horne was placed under by his client was accepted as a mitigating factor.[170]

(2) Personal Pressure

In regard to any personal pressure or stress faced by practitioners, both tribunals maintain their stance regarding professional circumstances. The HPDT and LCDT hold practitioners to high levels of professional responsibility, irrespective of personal or life stressors short of the extraordinary.[171] Put succinctly by the LCDT in *Auckland Standards Committee v Eteuati,* practitioners "must be able to live to professional obligations even during stressful life events."[172] As with professional pressures, defining the "unique" personal factors that justify some mitigation of penalty is difficult, given they are so wide ranging and that detail is rarely given. What could be taken from the decisions, however, is that the more commonly accepted submissions tended to be based on personal issues including severe health problems of the practitioners or their families.[173]

In summary, both tribunals' commitment to protecting the public and maintaining professional standards is demonstrated by their approach to assessing professional and personal circumstances. By refusing to allow the pressures inherent within the

[169] *Canterbury District Law Society v Horne* [2009] NZLCDT 4.
[170] Mr Horne's client was trying to avoid paying his debtors which Mr Horne recognised was not in the clients best interests. Accordingly Mr Horne's misconduct was accepted as having a paternalistic, rather than a dishonest genesis, see [6] and [10].
[171] In total practitioners attempted to claim "personal pressure" as a mitigating factor in five HPDT cases and seven LCDT cases, see cases: Med 4, Med 9, Med 14, Med 23-24, Law 5, Law 7, Law 9, Law 13, Law 20, Law 27, and Law 29. These submissions were rejected on the basis that the circumstances were nothing extraordinary in one HPDT case and four LCDT cases, see cases: Med 23, Law 5, Law 13 and Law 29.
[172] *Auckland Standards Committee v Eteuati* [2009] NZLCDT 17 at [11].
[173] Unique or extraordinary personal circumstances were accepted as a mitigating factor in three HPDT cases and four LCDT cases, see cases: Med 4, Med 9, Med 14, Law 7, Law 9, Law 20, and Law 27. Notably the HPDT made no comment on the "personal pressure" submission that was made in Med 24.

profession and everyday life to excuse the conduct of practitioners, the HPDT and LCDT ensure that the wider interests of the profession and the public are prioritised over the fortunes of any one practitioner.[174]

3.3.3 Value of the Practitioner to the Community

There were numerous instances of penalty determinations being influenced by the proposition that there is benefit to be had in allowing medical and legal practitioners to continue serving their communities. Before both the HPDT and LCDT, submissions to this effect were most commonly made to dissuade the tribunals against ordering cancellation/strike off or suspension.[175] The readiness of the two tribunals to allow a practitioner's purported community value to influence their decision was, however, quite different. The LCDT demonstrated a narrower application, accepting the proposition only in limited circumstances. This was in contrast to the HPDT's more general acceptance of the proposition.

(1) HPDT approach to assessing community value

The HPDT commonly relied upon the very general principle, that "there is a public interest in not ending the career of a competent doctor",[176] as a factor counting against more severe penalties of cancellation or a long period of suspension.[177]

(2) LCDT approach to assessing community value

Whilst the LCDT does recognise that a practitioner's value in the community can weigh against the imposition of more serious penalty orders, the tribunal appears to have narrowed the scope of this possible mitigating factor. The LCDT seems to require

---

[174] See *Professional Conduct Committee v MacDonald*, above n 78, at [279.1], (HPDT); and *Chow v Canterbury District Law Society* [2006] NZAR 160 at [42], affirming *Auckland District Law Society v Leary* HC Auckland M1471/84, 12 November 1985, (LCDT).

[175] There were six HPDT cases and four LCDT cases where practitioners' claimed that the value of their medical or legal services suggested against penalty orders that would remove them from practice, see cases: Med 2, Med 4, Med 8, Med 14, Med 15, Med 23, Law 7, Law 10, Law 12, and Law 27.

[176] See *A v Professional Conduct Committee* HC Auckland CIV-2008-404-2927, 5 September 2008 at [82].

[177] Practitioners' value to their communities was accepted as a mitigating factor in three of the six HPDT cases and all four of the LCDT cases where submissions to this effect were made, see cases: Med 14-15, Med 23, Law 7, Law 10, Law 12, and Law 27. Notably there were three other HPDT cases where the tribunal did not comment on such submissions, see cases: Med 2, Med 4, and Med 8.

specific skills or a particular community to be identified as the subject of potential benefit, rather than simply applying the more general proposition accepted in the HPDT.[178] So, whilst the LCDT is clearly willing to take account of a legal practitioner's potential value to the community in determining an appropriate penalty, it appears to do so under stricter conditions.

(3) Justifications and consequences of the two different approaches

The difference in approach prima facie suggests this ground is more likely to aid an otherwise competent medical practitioner in avoiding suspension or reducing the length of their suspension, given the much more general principle they are able to rely upon. The question thus becomes whether the benefit to medical practitioners in being better placed to utilise this ground to their advantage is justified? This is a question that can be answered in the affirmative, given the general shortage of medical practitioners in New Zealand. In 2009 New Zealand was said to have 70 per cent of the average number of doctors per capita for OECD countries, rendering us with one of the most significant shortages of medical practitioners in the OECD.[179] Furthermore, the resulting pressures on our health system can be seen to become all the more concerning when considering our ageing population and the imminent retirement of the "baby boomers". The HDPT's willingness to be influenced by a practitioner's general community value can thus be seen as the result of the shortages plaguing the medical profession. Therefore, provided the HPDT does not allow the shortages to justify unfit and dangerous practitioners remaining in practice, its approach seems apposite given the present need to keep as many medical practitioners in practise as possible.

In contrast, concerns regarding the number of lawyers per capita in New Zealand appear to relate to possible over-supply rather than a shortage. Research conducted in 2009 shows New Zealand as ranking second in the world for lawyers per population, behind only the United States.[180] Accordingly the LCDT's stricter approach, requiring

[178] In the four LCDT cases where a practitioner's value to the community was raised as a mitigating factor, the LCDT focused upon the practitioner's specific value to certain communities or their specific expertise to justify the influence of the submission upon their decision, see cases: Law 7, Law 10, Law 12, and Law 27.

[179] DF Gorman *On Solutions to the Shortage of Medical Practitioners in Australia and New Zealand* 2009 190(3) Med J Aust 152 at 152.

[180] Ashley Balls "Challenging Law's sacred cows" *NZLawyer* (New Zealand, 6 March 2009) at 22.

legal practitioners to identify specific skills or communities that would suffer as a consequence of their strike off or suspension seems justified.

3.3.4 Acknowledgment and Appreciation of Wrongdoing

A practitioner's insight into their offending is a further factor that can influence penalty determinations. Both tribunals considered appreciation as to why a course of conduct was unacceptable, acknowledgment of harm or potential harm, remorse, and guilty pleas as mitigating factors. It appears that such acknowledgment helps lessen the tribunals' concerns about possible re-offending and the likelihood of practitioners obtaining the assistance or retraining considered necessary.[181] An explicit example of this reasoning is provided by the case of Dr K, who was found guilty of professional misconduct by having entered into an inappropriate emotional relationship with a recent former patient, a "relatively young and vulnerable women".[182] The HPDT considered Dr K's insight into his wrongdoing, albeit ex post facto, was an important mitigating feature of the case. Such insight suggested that Dr K would obtain appropriate assistance and learn to exercise the professional judgement required if such a situation were to arise again.[183]

Conversely, both tribunals considered that a practitioner's failure to acknowledge wrongdoing and the seriousness of their conduct was an aggravating factor. Indicating that more severe orders of strike off/cancelation or suspension may be appropriate, given the ongoing risk presented to the public when practitioners cannot appreciate the errors of their ways and are thus less likely to change them. This view was stated explicitly in the case of *Auckland District Law Society v Dorbu*, where Mr Dorbu's failure to appreciate the seriousness of the undertakings he breached was equated with a continuing risk to the community.[184]

---

[181] Acknowledgement of wrongdoing by practitioners was accepted as a mitigating factor in 10 HPDT cases and six LCDT cases, see cases: Med 2-3, Med 6-9, Med 12-13, Med 15, Med 21, Law 1-2, Law 7, Law 9-10, and Law 21.

[182] *Professional Conduct Committee v Dr K* 349/Med10/157P at [56].

[183] At [25.2 and 25.4]

[184] *Auckland District Law Society v Dorbu* [2010] NZLCDT 9 at [35]. In total practitioners' failure to appreciate their wrongdoing was an aggravating factor in three HPDT cases and five LCDT cases, see cases: Med 14, Med 16, Med 19, Law 4, Law 6(P), Law 11, Law 17(P), and Law 18. Notably there were five HPDT cases and three LCDT cases where the tribunals did not comment on practitioners' acceptance or denial of wrongdoing, despite submissions being made on the issue, see cases: Med 4-5, Med 10, Med 24-25, Law 3, Law 13, and Law 29.

3.3.5 Previous Disciplinary Record

As is to be expected, a practitioner's previous disciplinary record is a relevant factor in determining penalty. It may help where a practitioner's record is unblemished, or hinder where a practitioner has been the subject of adverse disciplinary findings in the past. Practitioners' disciplinary records were considered by the HPDT and LCDT in just under half of the decisions made by each tribunal.[185]

The absence of any past disciplinary action against a practitioner was accepted by both tribunals as a mitigating feature of penalty in numerous decisions.[186] Interestingly, practitioners that did have prior disciplinary histories (viewed as an aggravating factor in all cases) came before the LCDT in just under one in three cases, whereas medical practitioners with prior histories came before the HPDT in just under one in seven cases.[187] Of all the medical and legal practitioners who had previously been disciplined, an equally high proportion came before the tribunals for conduct of the same, or at any rate similar, conduct to that in their past.[188]

(1) Difference in approach to assessing previous disciplinary records

Whilst there does appear to be a higher rate of individual recidivism in the LCDT, as compared with the HPDT, there are grounds for caution before jumping to conclusions about the LCDT's inability to deter reoffenders. This is because the higher figures in the LCDT can plausibly be explained by the wider range of past disciplinary action accounted for. The HPDT allows weight to be given only to disciplinary matters tried and upheld before the tribunal, or its predecessor the Medical Practitioners

[185] Practitioners' past disciplinary histories were submitted as either a mitigating or aggravating factor in nine HPDT cases and 13 LCDT cases, see cases: Med 3-4, Med 6, Med 12, Med 14-16, Med 19, Med 23, Law 1, Law 3-5, Law 7, Law 11, Law 14-15, Law 17(P)-18, Law 22, Law 25(P), and Law 29.

[186] In total practitioners' unblemished records were considered as a mitigating factor in four HPDT cases and six LCDT cases, see cases: Med 3, Med 6, Med 12, Med 15, Law 1, Law 3, Law 7, Law 14, Law 18, and Law 25(P). Notably there were two HPDT cases where the tribunal did not comment upon submissions regarding practitioners' unblemished records, see cases: Med 4, and Med 23.

[187] In total practitioners' adverse disciplinary histories were considered as an aggravating factor in three HPDT cases and seven LCDT cases, see cases: Med 14, Med 16, Med 19, Law 4-5, Law 11, Law 15, Law 17(P), Law 22, and Law 29. Notably there were two HPDT cases where the tribunal did not comment on submissions that were made regarding practitioners' professional histories.

[188] In every case across both tribunals where practitioners had negative disciplinary histories (see above n 187), their adverse records related to the same, or similar conduct.

Disciplinary Tribunal.[189] In contrast, the LCDT will consider any previous disciplinary finding, regardless of whether it concerned a statutory offence tried before the LCDT or, for example, was a lower level standards committee determination.[190] There does not appear to be any specific statutory or common law authority for the wider range of conduct of which the LCDT takes account, in contrast to the HPDT.

The broader approach of the LCDT undoubtedly advances the public protection aspect of penalty determinations. By taking account of practitioners' wider disciplinary records, the LCDT is able to make properly informed decisions armed with a better understanding of practitioners' whole attitudes to their professional responsibilities. In contrast, the HPDT appear to be at risk of making decisions that are ill informed and out of context. Can the HPDT really impose a proportionate penalty that is sufficient to protect the public, if it is unable to place weight upon a practitioner's disciplinary history - especially when that history may be extensive and relate to the same issues subject to the current charges?[191]

It is possible to argue the HPDT's approach is somehow fairer by only accounting for disciplinary action tried before a full hearing, but this reasoning seems to be unduly protective of medical practitioners. At all levels of possible disciplinary action, medical practitioners have a chance to respond to any complaints or allegations made and put their case.[192] As a result, there does not appear to be any "abuse of process" issues that justify the HPDT's narrow approach to considering past disciplinary histories.

(2) Recommendations

In summary, so long as practitioners continue to receive fair treatment at the lower levels of the professional disciplinary regimes, the reliance on any findings made at

[189] *Director of Proceedings v Stubbs* 271/Med09/113D at [90]. An anonymous but knowledgeable source confirms that the approach in Stubbs, allowing real weight to be given to only previous proven tribunal action, is the general approach of the HPDT.
[190] See *Auckland Standards Committee v Witehira* [2012] NZLCDT 5 at [36]. An anonymous but knowledgeable source confirms that the LCDT take a broad approach to considering practitioners' disciplinary histories.
[191] See Ron Paterson *The Good Doctor: what patients want* (Auckland University Press, Auckland, 2012) at 100 for further discussion on the inability of the HPDT to rely upon past disciplinary or regulation information.

those lower levels can be seen as a major advantage of the LCDT. By considering practitioners' full history and their wider attitude towards their professional responsibilities, the LCDT is better able to identify the true risks presented by practitioners and assess penalties accordingly. Whilst the HPDT is advised to adopt the approach of the LCDT, it is recognised that an information barrier exists that must be addressed before any changes can be made.

(3) Removing the information barrier

Even if the HPDT was willing to consider previous action taken against a practitioner, in many cases this information may not be available. Whilst the tribunal could obtain employment information from District Health Boards for example,[193] the names of practitioners subject to proceedings and adverse findings by the HDC are rarely made available. The current naming policy of the HDC dictates that practitioners' who (in the opinion of the Commissioner) have "breached" the Code of Rights, will only be named when: the practitioner's conduct shows a flagrant disregard for consumers' rights, the practitioner refuses to comply with the Commissioner's recommendations, or, the practitioner has been the subject of three breach findings in the previous five years.[194] Accordingly, practitioners who have had two recent "breach" findings made against them may in some cases be able to claim a "clean record" for the purpose of HPDT proceedings. It is thus suggested that the HDC maintains some form of private database that can be cross-referenced by the HPDT whenever a practitioner comes before it. This would prevent practitioners from being able to make assertions as to their prior record, that can arguably be misleading. The HPDT would therefore be in a position to consider the full range of practitioners' professional history and assess penalty on a more informed basis, as in the LCDT.

---

[192] HPCAA, s 76(1)(b); and HDCA, s 44(1)(a). Medical Practitioners are also likely to have an opportunity to respond to any disciplinary action taken by their employer, such as an investigation by a District Health Board.

[193] An anonymous, but knowledgeable source has indicated that the HPDT could gain access to a practitioner's disciplinary history within their specific place of employment in most circumstances.

[194] See HDC "Policy Document – Naming Providers in Public HDC" (1 July 2008) Health and Disability Commissioner <http://www.hdc.org.nz>. For further discussion on the inability of

3.4 Double Jeopardy

The provision of disciplinary offences resulting from criminal convictions brings the issue of double jeopardy into play in both tribunals.[195] Whilst there are no obvious differences between the two tribunals in dealing with issues of double jeopardy, a right guaranteed by s 26(2) of the New Zealand Bill of Rights Act 1990,[196] it is a noteworthy aspect of penalty determinations.

Practitioners facing charges under the relevant provisions will often have been punished following conviction in the courts. It is therefore possible to argue that it would be an abuse of process for them to receive a second penalty from the HPDT or LCDT in respect of that offending. However, this argument loses its force considering, as the tribunals do, that the distinct purposes of criminal and disciplinary proceedings allow court and tribunal penalties to sit alongside one another. The principal purpose of penalty in criminal proceedings being punishment and deterrence, in contrast to the public protection and professional standards focus of disciplinary proceedings.[197]

The distinct purposes of criminal and disciplinary proceedings also provide the one major caveat that prevents double jeopardy arguments arising. That is, the prohibition on fines where practitioners are being disciplined following criminal conviction. The HPCAA prevents the HPDT from imposing a fine where the offence in question involved conviction in a criminal court.[198] The same proposition is found in case law as far as the LCDT is concerned, with the High Court having settled the issue for legal disciplinary proceedings in the case of *Pickering v Auckland District Law Society*.[199] In that case it was stated that it would be inappropriate for fines to be handed down where

---

the HPDT to access information relating to the past conduct of practitioners, see Saul Holt and Ron Paterson "Medico-legal secrecy in New Zealand" (2008) 15(1) JLM 602 at 603-604.

[195] HPCAA, s 100(1)(c); and LCA, s 241(d).

[196] The HPDT and LCDT both appear to satisfy the s 3(b) test under the New Zealand Bill of Rights Act 1990. Their primary purpose of protecting the public suggests they have more of a "governmental", rather than "private" function (as per the test in *Ransfield v The Radio Network Ltd.* [2005] 1 NZLR 233). Secondly, both tribunals operate pursuant to statute (see s 84 of the HPCAA, and s 226 of the LCA). Accordingly, the New Zealand Bill of Rights Act can be seen to apply to both tribunals.

[197] See *Z v Dental Complaints Assessment Committee* [2009], above n 41, at [128] where the Supreme Court confirmed that the distinct purposes of criminal and professional disciplinary proceedings allow penalties to be handed down in both contexts without constituting an abuse of process.

[198] HPCAA, s 101(d).

convictions had preceded disciplinary action. The court held that the solely punitive role of fines would overlap with the major objective of criminal proceedings, and would thus amount to an unacceptable form of double jeopardy.[200]

3.5 Chapter Three Summary

On the whole, the interests of wider justice, the profession, and the public are largely prioritised over the fortunes of individual practitioners when penalty orders are made by the HPDT and LCDT. Comparison did, however, reveal some significant differences between the two tribunals. Most importantly, the HPDT must reconsider its approach to assessing disciplinary histories if it is going to properly assess the risk presented by practitioners, and protect the public accordingly.[201] It is also suggested that the LCDT needs to be aware that in determining penalties its demonstration of consistency is not at all explicit. If the number of appeals alleging inconsistent penalties increased, the LCDT would be wise to consider demonstrating its reasoning by explicit comparison to other decisions, as is done by the HPDT.

---

[199] *Pickering v Auckland District Law Society* [1985] 1 NZLR 1.
[200] *Pickering v Auckland District Law Society*, above n 199, at 4-5.
[201] Note the information barrier that would need to be broken down for the HPDT to make this change, see 3.3.5(3).

Chapter 4
Costs

The LCDT and HPDT have the power to order a practitioner found guilty of any disciplinary offence to pay all or part of the costs incurred by any party to proceedings.[202] This chapter commences by comparing each tribunal's general approach to fixing costs, discussion then turns to explore the specific factors taken into account as part of the costs determination.

4.1 General Approach to Determining Costs

The two tribunals take varying approaches in determining the extent of costs payable. The HPDT operates under a loose formula whereby 50 per cent of total costs are viewed as a starting point that can be adjusted up or down to account for the circumstances of each individual case.[203] In contrast, the LCDT chooses not to be bound by any percentage or formula in fixing costs, preserving the full discretion of the tribunal to determine costs on a case-by-case basis.[204] Nonetheless the fixing of costs, as with the rest of penalty determinations, can be seen as a discretionary exercise ungoverned by statutory restrictions in both the HPDT and LCDT.

4.2 Relevant Factors Taken Into Account for Determining Costs

In exercising their discretion to order partial, full, or no costs against practitioners, both the HPDT and LCDT consider a number of factors. These can include the burden on the members of both professions who fund disciplinary proceedings, as well as features specific to individual practitioners such as their financial circumstances or any efforts made to reduce costs.

---

[202] Section 101(1)(f) of the HPCAA provides that the HPDT may order a practitioner found guilty of any s 100 offence to pay all, or part of the costs of the HDC, DP, PCC or HPDT. Sections 241(a) and 156(1)(n) of the LCA provide that the LCDT may order a practitioner to pay all, or part of the costs of the relevant SC or LCRO (including the prosecuting bodies costs for reimbursing the NZLS for the cost of the LCDT hearing itself (s 251(1) of the LCA)).

[203] See *Cooray v Preliminary Proceedings Committee HC Wellington* AP 23/94, 14 September 1995, affirmed in *Vatsyayann v Professional Conduct Committee of the Medical Council of New Zealand*, above n 41, at [34].

[204] See the High Court decision of *Daniels v Complaints Committee 2 of the Wellington District Law Society* (above n 144) where the principle in *Cooray v Preliminary Proceedings Committee* (above n 203) was explicitly stated to have no bearing on the professional discipline of legal practitioners at [46 - 47].

4.2.1 The Overarching Consideration: Reducing the Financial Burden on the Wider Medical and Legal Professions

At first instance, the costs of disciplinary proceedings before the HPDT and LCDT fall upon the members of the two professions by virtue of levies paid to the Medical Council or NZLS, who largely fund the tribunals and the relevant prosecuting bodies. The need to reduce this burden wherever appropriate is commonly cited as the major impetus for choosing to order at least partial costs against a practitioner.[205]

A futile consideration?

It is possible to argue that the HPDT's efforts to reduce the burden upon the wider medical profession are fruitless when considering that either way the wider profession covers the costs of proceedings in a large proportion of cases. This is because the majority of all medical practitioners in New Zealand belong to the Medical Protection Society ("MPS").[206] The MPS provides for an equivalent to professional indemnity insurance for all members, including cover for costs orders made against practitioners in the HPDT. Accordingly, when the HPDT makes a costs order against a practitioner, in the majority of cases it is simply shifting the burden from members' Medical Council levies onto members' MPS premiums. Whilst a practitioner's financial circumstances are relevant to determining appropriate costs orders,[207] the insurance arrangements of practitioners and the wider profession are considered to be immaterial.[208] The HPDT appears to uphold the principle that individual practitioners found wanting should be required to contribute to the costs of discipline, regardless of who may actually pay the bill. Whilst in theory the principle seems noble, there is no escaping the fact that in reality it is fundamentally flawed as a result of the insurance arrangements of the profession.

---

[205] *Vatsyayann v Professional Conduct Committee of the Medical Council of New Zealand*, above n 41, at [34], (HPDT); and *Auckland Standards Committee 3 v Johnston*, above n 42, at [80], (LCDT).

[206] See Lucy Ratclifee "New medical indemnity provider enters market" *NZDoctor* (online ed, New Zealand, 24 January 2011).

[207] *Vatsyayann v Professional Conduct Committee of the Medical Council of New Zealand*, above n 41, at [34].

[208] There was no evidence of the HPDT accounting for a medical practitioner's MPS/insurance arrangements when considering costs in any of the cases analysed. Furthermore, information provided by an anonymous but knowledgeable source confirms that the HPDT consider insurance arrangements to be irrelevant when determining costs.

In contrast, the indemnity market for the legal profession is understood to be more diffuse and is not dominated by one provider as in the medical profession.[209] As a result, the LCDT's commitment to reducing the financial burden on the wider profession through costs orders seems less artificial.

Whilst the underlying insurance frameworks of the medical and legal professions do provide an interesting comparison, it is acknowledged that the HPDT is in a difficult position and there is little they can do to work around insurance issues, short of abandoning costs orders altogether. Furthermore, the recent emergence of a newcomer to the medical indemnity market suggests that over time the HPDT's principled approach may become more realistic.[210]

4.2.2 Admissions and Co-operation

Both tribunals regard any admissions made by a practitioner, or other co-operative conduct, as being pertinent to cost determinations due to the direct influence such conduct has in reducing the time and expenditure of all involved.[211] Medical practitioners may be at a disadvantage in this respect, given that guilty pleas before the HPDT presumably produce smaller resource savings as a result of the HPDT's self-imposed requirement to independently consider admitted charges.[212] However analysis revealed that in cases where charges were admitted, the HPDT commonly reduced costs orders on the basis that guilty pleas aid in the progression of proceedings, notwithstanding its independent consideration of the charges.[213] This suggests that medical practitioners are duly rewarded for their co-operation in the disciplinary process and are not disadvantaged as a result of the HPDT's approach to determining admitted charges.

4.3 Imposing Costs Against Practitioners Found "Not Guilty"

Finally, it is worth noting the LCDT's ability to make a costs order in circumstances where a practitioner has been found "not guilty", provided proceedings were justified

[209] Information provided by anonymous, but knowledgeable source.
[210] See Ratclifee, above n 206.
[211] See *Professional Conduct Committee v Dr Henderson* 451/Med11/200P at [84], (HPDT); and *Auckland Standards Committee 3 v Johnston*, above n 42, at [80], (LCDT).
[212] For more detailed discussion refer to 2.4.1.
[213] See for example *Professional Conduct Committee v Dr Henderson*, above n 211.

and it is considered just to do so.[214] Whilst the relevant LCA provision was not relied upon by the LCDT in any of the decisions analysed, the possibility of invoking this power in appropriate circumstances is an advantage that the LCDT has over the HPDT, where no such power exists.[215]

As costs orders inevitably have some punitive effect, it is possible to argue that the LCA provision is unjust, in allowing punishment following a "not guilty" finding. But so long as the LCDT reserves the power for exceptional circumstances, the provision likely enhances rather than impedes just outcomes. For example, where legal practitioners found "not guilty" have significantly increased the costs of the parties involved by raising irrelevant arguments or causing needless delays, the recoupment of the unnecessary costs seems appropriate. Furthermore, it allows the LCDT to send a message to the wider profession that those facing disciplinary proceedings must show respect for the tribunal and the other parties involved, regardless of whether they think the charge(s) against them will be established.

Of course, the HPDT's ability to shift any unreasonable costs onto a "not guilty" practitioner would inevitably be compromised by the current insurance framework of the medical profession. However, the HPDT could still benefit from a provision for imposing costs against "not guilty" practitioners by making it clear that reasonable co-operation will usually be in medical practitioners' best interests.

[214] LCA, s 249(3).
[215] As the HPCAA provides no equivalent to s 249(3) in the LCA, and s 101 of the HPCAA can only be utilised following an adverse finding under s 100, the HPCAA cannot impose costs against medical practitioners found "not guilty".

Chapter 5
Name Suppression

Reports of professional disciplinary actions against legal and medical practitioners are not difficult to find in today's media. Whether as informed consumers or simply curious members of the community, the public interest in the disciplinary process of the two professions does not go unnoticed in tribunal decisions.[216] It is therefore easy to envisage how the publication of a practitioner's name can be of significant consequence, both professionally and personally.

Orders for permanent name suppression were actively sought in less than half of the HPDT and LCDT cases analysed.[217] However, this should not be seen as a sign of practitioners' indifference to publication; rather it appears to be the result of widespread acceptance on the part of practitioners that suppression is the exception to the general rule. This chapter explores how publication has come to be expected. It does this by considering each tribunal's application of the relevant legislation and the extent of their commitment to the public interest in disclosure. The chapter concludes by noting key differences in the way the HPDT and LCDT deal with name suppression applications.

5.1 Commitment to the Public Interest

As a consequence of the presumption of openness that operates in both disciplinary regimes,[218] practitioners can now expect to have their name published as part and parcel of the disciplinary process. Whilst name suppression orders can be made, they are exceptions to the rule. They are only made if a practitioner can convince the relevant tribunal that it would be desirable to grant suppression, having regard to the interests of any person involved and the wider public.[219] Given that both tribunals believe there is a significant public interest in disclosing the identity of those

[216] See *Professional Conduct Committee of the New Zealand Medical Council v Vatsyayann* 201/Med08/96P at [11], (HPDT); and *Auckland Standards Committee v Comeskey* [2010] NZLCDT 19 at [61], (LCDT).
[217] Permanent name suppression orders were sought in only nine LCDT cases and 10 HPDT cases, see cases: Med 3, Med 6, Med 8-10, Med 15, Med 16, Med 23-24, Law 1, Law 3-4, Law 7, Law 12-12, Law 19, Law 21, Law 28(P).
[218] HPCAA, s 95(1); and LCA, s 238(1).
[219] HPCAA, s 95(2)(d); and LCA, s 240(1)(c).

practitioners found wanting, and thereby enabling consumers to make informed decisions as to the services they seek,[220] obtaining a name suppression order is by no means simple.

As a result of both tribunals' commitment to the public interest, it is unsurprising that the only cases where permanent suppression orders were granted involved practitioners who were able to identify extraordinary personal or professional circumstances that outweighed the public interest in disclosure.[221] An example is provided by the case of *Professional Conduct Committee of the New Zealand Medical Council v Dr N*, where Dr N was found guilty of professional misconduct for his ongoing inappropriate sexual relationship with a patient (his stepdaughter).[222] The HPDT stated that in such circumstances the potential harm of publication for the young and vulnerable members of the practitioner's family (including the patient), had to be prioritised over the public interest.[223] This conclusion was reinforced by the practitioner's registration having been cancelled, thus eliminating any concerns of harm for the public.[224]

5.2 The Interests of the Wider Medical and Legal Professions

Alongside the emphasis on the public interest, both tribunals demonstrated concern for the interest of fellow practitioners when determining name suppression applications. Interestingly, however, despite being concerned for essentially equivalent groups of people (fellow professionals), the nature of each tribunal's concern was quite different.

In balancing the competing interests as part of the suppression determination, the LCDT commonly relied upon the idea that fellow members of the profession had an interest in knowing the identity of lawyers found wanting, in order to conduct

---

[220] See *Professional Conduct Committee of the Medical Council of New Zealand v Dr E* 345/Med10/155P at [115.3], (HPDT); and *Legal Complaints Review Officer v Denee* [2011] NZLCDT 6 at [25], (LCDT).

[221] Unique personal interests were seen as outweighing the public interest in disclosure and justifying a permanent suppression order in five HPDT cases and one LCDT case, see cases: Med 3, Med 6, Med 10, Med 15, Med 24, and Law 1. In all other cases the public interest in disclosure was seen to outweigh any interest of the practitioner or their families, see cases: Med 8-9, Med 16, Med 23, Law 3-4, Law 7, Law 12-13, Law 19, Law 21, and Law 28(P).

[222] See *Professional Conduct Committee of the New Zealand Medical Council v Dr N*, above n 71.

[223] At [220-223].

[224] At [224].

professional dealings on an informed and appropriate basis.[225] Although the HPDT also considered the interests of other medical practitioners in publication, the root of its concern was different. That is, rather than being anxious to warn fellow practitioners, the HPDT was more concerned with unfairly impugning the reputation of other medical practitioners as a result of name suppression encouraging public speculation.[226]

5.2.1 Justifications and Recommendations

The legal profession commonly requires lawyers to operate alongside other non-colleague practitioners. As a result, the LCDT's eagerness to warn fellow members of the profession seems fitting. Whilst medical practitioners operate under quite different circumstances, the need to work in conjunction with fellow medical professionals is ever present. For example, general practitioners must be able to trust the specialists to whom they refer patients. Accordingly, the notion of using publication as a warning tool for the wider profession should warrant the same level of consideration in the HPDT as it is afforded in the LCDT. By the same token, the LCDT could benefit from incorporating the possibility of undue damage to reputations into their considerations as the possibility for suspicion to follow suppression is easy to envisage where small towns or specialist practitioners are involved.[227] In this way, both tribunals could ensure they weighed and balanced the full range of interests affected by suppression orders, as is required by legislation.[228]

Overall, however, the tough stance taken by the two tribunals demonstrates yet again how the interests of the public are given precedence over the interests of individual practitioners. Crucially, this allows consumers to make informed choices as to the medical and legal services they seek and therefore provides the public with an opportunity to protect themselves.

---

[225] See *Legal Complaints Review Officer v Denee*, above n 220, at [25].
[226] *Professional Conduct Committee of the New Zealand Medical Council v MacDonald,* above n 78, at [303.5].
[227] For further discussion on how suspicion is often thought to accompany suppression, see Holt and Paterson, above n 194, at 609.
[228] HPCAA, s 95(2)(d); and LCA, s 240(1)(c).

Chapter Six
Conclusion

On the whole both the HPDT and LCDT demonstrate a firm commitment to protecting the public and upholding the high standards expected of medical and legal professionals. The consumer focus of both tribunals was evident in numerous aspects of the comparison, where the tribunals openly prioritised the interests of the public over the fortunes of individual practitioners. Where there were differences between the two tribunals in disciplining practitioners many could be explained when considering factors specific to the medical or legal professions. There were, however, variations that could not be justified and it is these differences that highlight the strengths and weaknesses of the tribunals and reveal where change is necessary.

It is suggested that the LCDT encourage the LCRO and SCs to embrace the duplicitous charge utilised by the DP and PCC when laying charges. This would provide the LCDT with the opportunity to consider practitioners' whole attitudes towards professional responsibilities when assessing charges. Likewise, the HPDT is advised to broaden their approach to considering practitioners' disciplinary histories to ensure that penalty orders are made on a fully informed basis. These simple changes would place both tribunals in a better position to assess the risks that practitioners pose to the public, and ensure that consumers are properly protected. Furthermore, it is suggested that the LCDT should alter its approach to dealing with admitted charges if the tribunal is going to help set standards, as well as just enforce them.

The key weaknesses of both tribunals were only revealed by virtue of case-by-case comparison and it is thus acknowledged that in many instances the tribunals may never have considered the issues highlighted by this paper. However, because both tribunals share common purposes and operate under similar regimes, the opportunity to learn from one another should not be overlooked. If either tribunal is to have the best chance of effectively disciplining practitioners, protecting the public, and maintaining professional standards, they should remain open to change and should ideally consider the suggestions made. There is no room for complacency if consumers are to be

adequately protected from those medical and legal practitioners who abuse their privileged positions.

Appendix I
Cases Analysed from Sample Period

This appendix lists and summarises the 24 HPDT cases, and 31 LCDT cases that were used for the major analysis in this research. In the majority of cases the same reference number was used for both the substantive, and the penalty decision. However, there were six LCDT decisions where separate reference numbers were used, these cases are noted below and the separate penalty citation is provided.

HPDT Cases

Med 1: *Professional Conduct Committee of the Medical Council of New Zealand v Bhatia* 344/Med10/151P

Dr Bhatia was found guilty of three charges per s 100(1) of the HPCAA. Dr Bhatia's offending included failing to provide an appropriate standard of care per s 100(1)(a), practising medicine without an annual practising certificate per s 100(1)(d), and failing to comply with practicing conditions per s 100(1)(f).

Med 2: *Professional Conduct Committee of the Medical Council of New Zealand v Dunkley* 368/Med11/175P

Dr Dunkley was found guilty of one charge per s 100(1)(c) of the HPCAA following conviction for an offence that reflected adversely on his fitness to practice. The convictions subject to the charge included possessing objectionable material, contrary to s 131A of the Films, Videos and Publications Classification Act 1993.

Med 3: *Professional Conduct Committee of the Medical Council of New Zealand v Dr E* 345/Med10/155P

Dr E was found guilty of one charge per s 100(1)(c) of the HPCAA following conviction for an offence that reflected adversely on her fitness to practice. The convictions subject to the charge included making and using false documents with an intent to obtain property, contrary to ss 256(1)(a) and 257(1)(a) of the Crimes Act 1961.

Med 4: *Professional Conduct Committee of the Medical Council of New Zealand v Henderson* 451/Med11/200P

Dr Henderson was found guilty of one charge of professional misconduct per s 100(1)(a) of the HPCAA. Dr Henderson's misconduct included inappropriate claiming from the Ministry of Health for maternity care subsidies.

Med 5: *Professional Conduct Committee of the Medical Council of New Zealand v Jayaprakash* 327/Med10/153P

Dr Jayaprakash was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr Jayaprakash's misconduct included making false/misleading claims about his anesthesia qualifications to the Auckland District Health Board to obtain work.

Med 6*: Professional Conduct Committee of the Medical Council of New Zealand v Dr K* 349/Med10/157P

Dr K was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr K's misconduct included entering into an inappropriate emotional relationship with a recent former patient.

Med 7: *Professional Conduct Committee of the Medical Council of New Zealand v Kong* 422/Med11/181P

Dr Kong was found guilty of one charge per s 100(1)(c) of the HPCAA following conviction for an offence that reflected adversely on his fitness to practice. The convictions subject to the charge included dishonestly using a document to obtain pecuniary advantage, contrary to s 228(b) of the Crimes Act 1961.

Med 8: Pr*ofessional Conduct Committee of the Medical Council of New Zealand v MacDonald* 220/Med08/120P

Dr MacDonald was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr MacDonald's misconduct included failing to adequately refer a patient to various specialists, failing to maintain adequate/accurate clinical records, failing to provide adequate medical services and to appropriately refer a patient after entering into a sexual relationship with that patient, and inappropriately using supply orders to provide morphine.

Med 9: *Professional Conduct Committee of the Medical Council of New Zealand v Marchand* 280/Med09/133P

Dr Marchand was found guilty of one charge per s 100(1)(c) of the HPCAA following conviction for an offence that reflected adversely on his fitness to practice. The convictions subject to the charge included using documents to obtain a pecuniary advantage both dishonestly and with intent to defraud, contrary to ss 229A(b) and 228(b) of the Crimes Act 1961.

Med 10: *Professional Misconduct Committee of the Medical Council of New Zealand v Dr N* 261/Med09/120P

Dr N was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr N's misconduct included entering into an inappropriate sexual relationship with a patient and failing to adequately comply with conditions on his scope of practice.

Med 11: *Professional Conduct Committee of the Medical Council of New Zealand v Paltridge* 328/Med11/172P

Dr Patridge was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr Paltridge's misconduct included inappropriate prescribing, failing to provide adequate information, and advertising in a variety of misleading and inappropriate ways.

Med 12: *Professional Conduct Committee of the Medical Council of New Zealand v Pollard* 341/Med10/154P

Dr Pollard was found guilty of one charge of professional misconduct per s 100(1)(a) of the HPCAA. Dr Pollard's misconduct included multiple instances of breaching a patient's right to confidentiality.

Med 13: *Professional Conduct Committee of the Medical Council of New Zealand v Ranchhod* 273/Med09/129P

Dr Ranchhod was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr Ranchhod's misconduct included practising

without an annual practising certificate and altering an annual practising certificate to represent that he was permitted to practice.

Med 14: *Professional Conduct Committee of the Medical Council of New Zealand v Ranchhod* 376/Med10/161P

Dr Ranchhod was found guilty of four charges per s 100(1) of the HPCAA. The charges included practising without an annual practising certificate per s 100(1)(d), practising outside the scope of conditions per s 100(1)(f), and practising during a period of suspension per s 100(1)(g). All three particulars were also held to constitute professional misconduct per s 100(1)(a) and (b).

Med 15: *Professional Conduct Committee of the Medical Council of New Zealand v Dr S* 449/Med11/197P

Dr S was found guilty of one charge or professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr S's misconduct included inappropriate prescribing of controlled drugs to a number of patients, and the facilitation of controlled drugs in circumstances deviating significantly from accepted practice.

Med 16: *Director of Proceedings v Stubbs* 271/Med09/113D

Dr Stubbs was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr Stubbs' misconduct included failing to provide adequate information prior to surgery (informed consent), and failing to adequately document care provided.

Med 17: *Director of Proceedings v Tomeu* 234/Med08/107D

Dr Tomeu was found not guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. The charge against Dr Tomeu alleged that in the course of delivery he had undertaken an inappropriate/ procedure, provided inadequate information, and behaved disrespectfully.

Med 18: *Professional Conduct Committee of the Medical Council of New Zealand v Vatsyayann* 201/Med08/96P

Dr Vatsyayann was found guilty of one charge of professional misconduct per s 100(1)(a) of the HPCAA. Dr Vatsyayann's conduct included producing notes that contained a number of different misleading assertions.

Med 19: *Director of Proceedings v Vatsyayann* 428/Med10/170D

Dr Vatsyayann was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr Vatsyayann's misconduct included failing to adequately follow up signs of pathology.

Med 20: *Professional Conduct Committee of the Medical Council of New Zealand v Vatsyayann* 355/Med10/152P

Dr Vatsyayann was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr Vatsyayann's misconduct included enrolling patients in his clinic without consent, allowing consultations to occur where two patients were in the same room, allowing his wife who was unregistered and unqualified to provide treatment to patients, and maintaining inaccurate records stating he had provided the treatments that were in fact performed by his wife.

Med 21: *Professional Conduct Committee of the Medical Council of New Zealand v Vautier* 291/Med09/140P

Dr Vautier was found guilty of one charge per s 100(1)(c) of the HPCAA following conviction for an offence reflecting adversely on his fitness to practice. The convictions subject to the charge included numerous offences of indecently assaulting a female under the age of 12 years between 1979 and 1988, contrary to s 133(1)(A) of the Crimes Act 1961.

Med 22: *Professional Conduct Committee of the Medical Council of New Zealand v Wilson* 314/Med10/145P

Dr Wilson was found guilty of one charge of professional misconduct per s 100(1)(a) and (b) of the HPCAA. Dr Wilson's misconduct included importing medicines without consent, inappropriate/inadequate prescribing, falsifying patient records, and exploiting patients by excess charging for medicines.

Med 23: *Professional Conduct Committee of the Medical Council of New Zealand v Wong* 461/Med11/120P

Dr Wong was found guilty of one charge of professional misconduct per s 100(1)(1) and (b) of the HPCAA. Dr Wong's misconduct included numerous instances of inappropriate prescribing.

Med 24: *Professional Conduct Committee of the Medical Council of New Zealand v Dr Y* 321/Med10/149P

Dr Y was convicted of one charge per s 100(1)(c) of the HPCAA following conviction for an offence reflecting adversely on his fitness to practice. The convictions subject to the charge included the possession of objectionable material, contrary to ss 131A and 124 of the Films, Videos and Publications Classification Act 1993.

LCDT Cases

Law 1: *Auckland Standards Committee No 5 v ABC* [2012] NZLCDT 14

ABC was found guilty of one charge of negligence/incompetence in her professional capacity per s 241(c) of the LCA. ABC's negligence/incompetence included giving a false undertaking to a lending institution.

Law 2: *Auckland Standards Committee v Comeskey* [2010] NZLCDT 19

Mr Comeskey was found guilty of two charges of professional misconduct per s 241(a) of the LCA and one charge of negligence/incompetence in a professional capacity per s 112(1)(c) of the LPA. Mr Comeskey's misconduct included breaching the Conduct Rules and inappropriate legal aid claiming. Mr Comeskey's negligence/incompetence included making misleading submissions to the Court of Appeal.

Law 3: *Legal Complaints Review Officer v Denee* [2011] NZLCDT 6

Mr Denee was found guilty of one charge of professional misconduct per s 241(a) of the LCA. Mr Denee's misconduct included preparing a will for a client where he was a beneficiary in that will, without insisting the client have the will prepared elsewhere or obtain independent legal advice.

Law 4: *Auckland District Law Society v Dorbu* [2010] NZLCDT 9

Mr Dorbu was found guilty of nine charges of professional misconduct per s 112(1)(a) of the LPA and two charges of professional misconduct per s 241(a) of the LCA. Mr Dorbu's misconduct included failing to promote proper standards of professionalism in relation to other practitioners and the judiciary, acting as a party to an unlawful conspiracy, practising without an annual practising certificate, misleading the court, attacking reputations in court without good cause, inaccurately swearing affidavits, and acting where there was a conflict of interest.

Law 5: *Auckland Standards Committee v Eteuati* [2009] NZLCDT 17

Mrs Eteuati was found guilty of one charge of professional misconduct per s 112(a) of the LPA . Mrs Eteuati's misconduct included abusing a client relationship and failing to properly advise and act for that client.

Law 6: *Auckland Standards Committee v Faleauto* [2009] NZLCDT 19

Mr Faleuato was found guilty of three charges of professional misconduct per s 112(a) of the LPA. Mr Faleuato's misconduct included refusing to comply with disclosure requirements, receiving fees without rendering invoices, and attempting to obtain money from clients when they were funded by legal aid. For the separate penalty decisions see, Law 6(P): *Auckland Standards Committee v Faleauto* [2010] NZLCDT 2.

Law 7: *Auckland Standards Committee v Fendall* [2012] NZLCDT 1

Ms Fendall was found guilty of one charge of professional misconduct per s 112(a) of the LPA. Ms Fendall's misconduct included inappropriate legal aid claiming.

Law 8: *Auckland Standards Committee v Flewitt* [2010] NZLCDT 12

Mr Flewitt was found guilty of one charge of professional misconduct per s 241(a) of the LCA. Mr Flewitt's misconduct included convictions for dishonesty offences and a conviction for assault.

Law 9: *Auckland Standards Committee v Garrett* [2011] NZLCDT 29
Mr Garrett was found guilty of one charge of professional misconduct per s 241(a) of the LCA. Mr Garrett's misconduct included swearing a false affidavit and omitting to tell the truth in respect of that affidavit.

Law 10: *Canterbury District Law Society v Horne* [2009] NLCDT 4
Mr Horne was found guilty of one charge of professional misconduct per s 112(a) of the LPA. Mr Horne's misconduct included paying a client's funds, held in a trust account, to a debtor of the client without authorisation.

Law 11: *Canterbury District Law Society Complaints Committee (No 2) v Iosefa* [2009] NZLCDT 5
Mr Iosefa was found guilty of one charge per s 241(d) of the LCA following conviction for an offence reflecting adversely on his fitness to practice/bringing the profession into disrepute. The conviction subject to the charge included theft by a person in a special relationship, contrary to ss 220 and 233 of the Crimes Act 1961.

Law 12: *Auckland Standards Committee v Johnston* [2011] NZLCDT 14
Mr Johnston was found guilty of two charges of profession misconduct per s 112(a) of the LPA and one charge of professional misconduct per s 241(a) of the LCA. Mr Jhonston's misconduct included inappropriate personal borrowing and investing of client's money, and inadequate managing of trust accounts.

Law 13: *Auckland Standards Committee v Korver* [2011] NZLCDT 22
Mr Korver was found guilty of two charges of negligence/incompetence in his professional capacity per s 241(c) of the LCA. Mr Korver's negligent/incompetent conduct included failing his professional duties and obligations by acting where there was a conflict of interest, and failing to appropriately deal and report to a client regarding a certain transaction.

Law 14: *Auckland Standards Committee v Martin* [2010] NZLCDT 17
Mr Martin was found guilty of 12 charges of professional misconduct per s 241(a) of the LCA. Mr Martin's misconduct included dishonestly taking files, abusing the relationship of trust and confidence with numerous clients, misleading a fellow

practitioner, applying for a practising certificate having agreed to surrender it, and engaging in misleading/deceptive conduct. Mr Martin was also found guilty of nine unspecified statutory charges following conviction for numerous offences of using a document to obtain a pecuniary advantage, contrary to s 228(b) of the Crimes Act 1961.

Law 15: *Auckland District Law Society v Mathias* [2010] NZLCDT 10
Mr Mathias was found guilty of six charges of professional misconduct per s 112(1)(a) of the LPA, and seven charges of professional misconduct per s 241(a) of the LCA. Mr Mathias's misconduct included acting when there was a conflict of interest, acting in breach of the relationship of trust and not in a client's best interests, failing to adequately advise, inappropriate charging and use of clients funds, failing to repay funds held when requested, allowing his trust account to be overdrawn on five occasions, failing to respond to requests in a timely manner, entering into transactions in inappropriate and misleading circumstances, breaching undertakings, inappropriate completion of transactions, providing misleading statements, failing to disclose his receipt of agency fees to the client, using a trust account for personal transactions, borrowing from clients in inappropriate circumstances, and failing to produce documents required for inspection.

Law 16: *Otago Standards Committee v Mawhinney* [2012] NZLCDT 19
Mr Mawhinney was found guilty of one charge of professional misconduct per s 241(a) of the LCA. Mr Mawhinney's misconduct included failing to supply a client with their files.

Law 17: *Waikato Bay of Plenty Standards Committee v Parlane* [2010] NZLCDT 08
Mr Parlane was found guilty of one charge of professional misconduct per s 241(a) of the LCA. Mr Parlane's misconduct included wrongly refusing to discharge a mortgage, and obstructing the Standards Committee and Complaints Committee. For the separate penalty decision see, Law 17(P): *Waikato Bay of Plenty Standards Committee v Parlane* [2010] NZLCDT 26.

Law 18: *National Standards Committee v Poananga* [2012] NZLCDT 12
Ms Poananga was found guilty of four charges of professional misconduct per s 241(a) of the LCA. Ms Poananga's misconduct included breaching her duty of fidelity to the Court, forgery and making false declarations.

Law 19: *Auckland Standards Committee v Ram* [2011] NZLCDT 32
Mr Ram was found guilty of two charges of professional misconduct per s 241(a) of the LCA. Mr Ram's misconduct included providing regulated services to persons other than his employer, and as a consequence practising on his own account when not entitled to do so.

Law 20: *Auckland Standards Committee v Ravelich* [2011] NZLCDT 11
Mr Ravelich was found guilty of two charges per s 112(d) of the LPA and 241(d) of the LCA following conviction for numerous offences reflecting adversely on his fitness to practise/bringing discredit to the profession. The convictions subject to the charges included driving with excess breath and blood alcohol, refusing to give a blood specimen and resisting arrest.

Law 21: *Hawkes Bay Standards Committee v Romana* [2009] NZLCDT 20
Ms Romana was found guilty of three unspecified statutory offences under s 112 of the LPA. The offences related to two convictions and one instance of improperly handling client's funds.

Law 22: *Auckland Standards Committee v Sanders* [2010] NZLCDT 21
Mr Sanders was found guilty of three professional misconduct offences per s 112(a) of the LPA. Mr Sanders' misconduct included transferring funds without authority, and making false representations to other practitioners as well as a Complaints Committee.

Law 23: *Canterbury/Westland District Law Society v Simes* [2012] NZLCDT 4
Ms Simes was found not guilty of one charge of professional misconduct per s 241(a) of the LCA. The charge alleged Ms Simes had been insufficient in the administration and supervision of her practice and its employees.

Law 24: *Auckland Standards Committee v Sorenson* [2011] NZLCDT 10
Mr Sorenson was found guilty of one charge of professional misconduct per s 421(a) of the LCA. Mr Sonenson's misconduct included facilitating a dishonest scheme of the executors and trustees of an estate. For the separate penalty decision see, Law 24(P): *Auckland Standards Committee v Sorenson* [2012] NZLCDT 23.

Law 25: *Auckland Standards Committee v Stirling* [2010] NZLCDT 4
Mr Stirling was found guilty of one charge of professional misconduct per s 112(a) of the LPA. Mr Stirling's misconduct included breaching undertakings made to clients. For the separate penalty decision see, Law 25(P): *Auckland Standards Committee v Stirling* [2010] NZLCDT 13.

Law 26: *Auckland Standards Committee v Thoman* [2011] NZLCDT 8
Ms Thoman was found guilty of three charges of professional misconduct per s 112(a) of the LPA, and six charges of professional misconduct per s 241(a) of the LCA. Ms Thoman's misconduct included failing to carry out promised work, failing to account for monies paid, accepting clients directly rather than through a solicitor, holding herself out as a barrister when she did not have a current practising certificate, engaging in abusive behavior towards a client, losing/failing to return valuable client documents, failing to respond to a client's communications, and receiving payments without rendering invoices.

Law 27: *Auckland Standards Committee v Tupou* [2010] NZLCDT 3
Mr Turpo was found guilty of two charges of professional misconduct per s 112(a) of the LPA. Mr Tupou's misconduct included recklessly filing incorrect information with the court.

Law 28: *Nelson Standards Committee v Webb* [2011] NZLCDT 2
Mr Webb was found guilty of one charge of professional misconduct per s 112(a) of the LPA. Mr Webb's misconduct included permitting his parents to occupy estate property rent-free without disclosing his relationship with the tenants to the UK solicitors who were acting for the estates executors. For the separate penalty decision see, Law 28(P); *Nelson Standards Committee v Webb* [2011] NZLCDT 13.

Law 29: *Auckland Standards Committee v Witehira* [2012] NZLCDT 5
Mr Witehira was found guilty of one charge of professional misconduct per s 241(a) of the LCA. Mr Witehira's misconduct included misappropriating client funds.

Law 30: *Canterbury District Law Society v Wood* [2009] NZLCDT 9
Mr Wood was found guilty of one charge of professional misconduct per s 112(a) of the LPA. Mr Wood's misconduct included misleading a High Court judge and a fellow practitioner. For the separate penalty decision, see Law 30(P): *Canterbury District Law Society v Wood* [2009] NZLCDT 11.

Law 31: *Auckland Standards Committee v X* [2011] NZLCDT 15
Ms X was found not guilty of one charge of professional misconduct per s 241(a) of the LCA. The charge alleged that a diversion given to Ms X by the District Court relating to a dishonesty offence suggested Ms X was unsuitable for the profession.

Appendix II

Bibliography

1. Cases

1.1 New Zealand

A v Professional Conduct Committee HC Auckland CIV-2008-404-2927, 5 September 2008.

Auckland District Law Society v Dorbu [2010] NZLCDT 9.

Auckland District Law Society v Leary HC Auckland M1471/84, 12 November 1985.

Auckland District Law Society v Mathias [2010] NZLCDT 10.

Auckland Standards Committee v ABC [2012] NZLCDT 14.

Auckland Standards Committee v Comeskey [2010] NZLCDT 19.

Auckland Standards Committee v *Eteuati* [2009] NZLCDT 17.

Auckland Standards Committee v Faleauto [2009] NZLCDT 19.

Auckland Standards Committee v Faleauto [2010] NZLCDT 2.

Auckland Standards Committee v Fendall [2012] NZLCDT 1.

Auckland Standards Committee v Flewitt [2010] NZLCDT 12.

Auckland Standards Committee v Garrett [2011] NZLCDT 29.

Auckland Standards Committee v Johnston [2011] NZLCDT 14.

Auckland Standards Committee v Korver [2011] NZLCDT 22.

Auckland Standards Committee v Martin [2010] NZLCDT 17.

Auckland Standards Committee v Ram [2011] NZLCDT 32.

Auckland Standards Committee v Ravelich [2011] NZLCDT 11.

Auckland Standards Committee v Sanders [2010] NZLCDT 21.

Auckland Standards Committee v Sorenson [2011] NZLCDT 10.

Auckland Standards Committee v Sorenson [2012] NZLCDT 23.

Auckland Standards Committee v Stirling [2010] NZLCDT 4.

Auckland Standards Committee v Stirling [2010] NZLCDT 13.

Auckland Standards Committee v Thoman [2011] NZLCDT 8.

Auckland Standards Committee v Tupou [2010] NZLCDT 3.

Auckland Standards Committee v Witehira [2012] NZLCDT 5.

Auckland Standards Committee v X [2011] NZLCDT 15.

Auckland Standards Committee 1 v Fendall [2012] NZHC 1825.

Canterbury District Law Society v Horne [2009] NLCDT 4.

Canterbury District Law Society Complaints Committee v Iosefa [2009] NZLCDT 5.

Canterbury District Law Society v Wood [2009] NZLCDT 9.

Canterbury District Law Society v Wood [2009] NZLCDT 13.

Canterbury-Westland Standards Committee v Peters [2012] NZLCDT 18.

Canterbury-Westland District Law Society v Simes [2012] NZLCDT 4.

Chow v Canterbury District Law Society [2006] NZAR 160.

Complaints Committee No 1 of the Auckland District Law Society v C [2008] 3 NZLR 105.

Cooray v Preliminary Proceedings Committee HC Wellington AP 23/94, 14 September 1995.

Daniels v Complaints Committee 2 of the Wellington District Law Society [2011] NZLR 850.

Director of Proceedings v Stubbs 271/Med09/113D.

Director of Proceedings v Tomeu 234/Med08/107D.

Director of Proceedings v Vatsyayann 428/Med10/170D.

Hawkes Bay Standards Committee v Romana [2009] NZLCDT 20.

Legal Complaints Review Officer v Denee [2011] NZLCDT 6.

Martin v Director of Proceedings [2010] NZAR 333.

McKenzie v Medical Practitioners Disciplinary Tribunal [2004] NZAR 47.

N v Professional Conduct Committee of the Medical Council of New Zealand HC Wellington, 19 March 2012, CIV-2009-0485-2347.

National Standards Committee v Poananga [2012] NZLCDT 12

Nelson Standards Committee v Webb [2011] NZLCDT 2.

Nelson Standards Committee v Webb [2011] NZLCDT 13.

Otago Standards Committee v Mawhinney [2012] NZLCDT 19.

Pickering v Auckland District Law Society [1985] 1 NZLR 1.

Preliminary Proceedings Committee of the Medical Council of New Zealand v Duncan [1986] 1 NZLR 51.

Professional Conduct Committee of the Medical Council of New Zealand v Bhatia 344/Med10/151P.

Professional Conduct Committee of the Medical Council of New Zealand v Dr E 345/Med10/155P.

Professional Conduct Committee of the Medical Council of New Zealand v Dunkley 368/Med11/175P.

Professional Conduct Committee of the Medical Council of New Zealand v Henderson 451/Med11/200P.

Professional Conduct Committee of the Medical Council of New Zealand v Jayaprakash 327/Med10/153P.

Professional Conduct Committee of the Medical Council of New Zealand v Dr K 349/Med10/157P.

Professional Conduct Committee of the Medical Council of New Zealand v Kong 422/Med11/181P.

Professional Conduct Committee of the Medical Council of New Zealand v MacDonald 220/Med08/120P.

Professional Conduct Committee of the Medical Council of New Zealand v Marchand 280/Med09/133P.

Professional Misconduct Committee of the Medical Council of New Zealand v Dr N 261/Med09/120P.

Professional Conduct Committee of the Medical Council of New Zealand v Paltridge 328/Med11/172P.

Professional Conduct Committee of the Medical Council of New Zealand v Pollard 341/Med10/154P.

Professional Conduct Committee of the Medical Council of New Zealand v Ranchhod 273/Med09/129P.

Professional Conduct Committee of the Medical Council of New Zealand v Ranchhod 376/Med10/161P.

Professional Conduct Committee of the Medical Council of New Zealand v Dr S 449/Med11/197P.

Professional Conduct Committee of the Medical Council of New Zealand v Vatsyayann 201/Med08/96P.

Professional Conduct Committee of the Medical Council of New Zealand v Vatsyayann 355/Med10/152P.

Professional Conduct Committee of the Medical Council of New Zealand v Vautier 291/Med09/140P.

Professional Conduct Committee of the Medical Council of New Zealand v Wilson 314/Med10/145P.

Professional Conduct Committee of the Medical Council of New Zealand v Wong 461/Med11/120P.

Professional Conduct Committee of the Medical Council of New Zealand v Dr Y 321/Med10/149P.

Ransfield v The Radio Network Ltd. [2005] 1 NZLR 233.

S v New Zealand Law Society (Auckland Standards Committee No 2) CIV-2011-404-3044 HC Auckland CIV-2011-404-3044, 1 June 2012.

Sisson v Canterbury District Law Society [2011] NZCA 55.

Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council HC Wellington CIV-2009-485-259, 14 August 2009.

Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council [2012] NZHC 1138.

Waikato Bay of Plenty Standards Committee v Parlane [2010] NZLCDT 8.

Waikato Bay of Plenty Standards Committee v Parlane [2010] NZLCDT 18.

Waikato Bay of Plenty Standards Committee v Parlane [2010] NZLCDT 26.

Z v Complaints Assessment Committee [2008] 1 NZLR 65.

1.2 Australia

Pillai v Messiter [No 2] (1989) 16 NSWLR 197 (CA).

1.3 England

Bolton v Law Society [1994] 2 ALL ER 486.

Peatfield v General Medical Society [1986] 1 WLR 243.

2. Legislation

2.1 New Zealand

Coroners Act 2006.

Evidence Act 2006.

Health and Disability Commissioner Act 1994.

Health Practitioners Competence Assurance Act 2004.

Judicature Act 1908.

Land Transport Act 1998.

Law Practitioners Act 1982.

Lawyers and Conveyancers Act 2006.

Medical Practitioners Act 1968.

Medical Practitioners Act 1995.

New Zealand Bill of Rights Act 1990.

Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

Lawyers and Conveyancers Act (Disciplinary Tribunal) Regulations 2008.

Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care Rules) 2008.

Lawyers and Conveyancers Act (Lawyers: Practice Rules) Regulations 2008.

New Zealand Law Society Rules of Professional Conduct for Barristers & Solicitors (7th Edition) 2004.

3. Journal Articles

Andrew Beck "Professional Disarray" (2008) NZLJ 285.

Donna Buckingham "Disciplining Lawyers in New Zealand: Repining the Badge of 'Professionalism'" (2012) 15(1) JLE 58.

Donna Buckingham, "Putting the Legal House in Order – Responses to New Zealand Lawyers Who Break Trust" (2012) 15(2) JLE (forthcoming).

DB Collins and CA Brown "The impact of the Cartwright Report upon the regulation, discipline and accountability of medical practitioners in New Zealand (2009)16(4) JLM 595.

Kevin Dew and Matthew Roorda "Institutional innovation and the handling of health complaints in New Zealand: an assessment" (2001) 57(1) Health Policy 27.

Ian Freckelton and Joanna Flynn "Paths towards reclamation: Therapeutic jurispuredence and the regulation of medical practitioners" (2004) 12(1) JLM 91.

DF Gorman "On Solutions to the Shortage of Medical Practitioners in Australia and New Zealand" 2009 190(3) Med J Aust 152.

L Haller "Dirty Linen: The public shaming of lawyers" (2003) 10(3) IJLP 281.

L Haller "Professional Dispicline for Incompotent Lawyers? Developments in the UK and Australia" (2010) 17(1) IJLP 83.

Saul Holt and Ron Paterson "Medico-legal secrecy in New Zealand" (2008) 15(1) JLM 602.

Charlotte Paul "The New Zealand cervical cancer study: Could it happen again" (1988) 297 BMJ 533.

Susan Rogers "Culling bad apples, blowing whistles and the Health Practitioners Competence Assurance Act 2003 (NZ)" (2004) 12(1) JLM 119.

PDG Skegg "A Fortunate Experiment? New Zealand's Experience With A Legislated Code of Patients Rights" (2011) 19(2) Med L Rev 235.

Duncan Webb "The Lawyers and Conveyancers Act: catching up with consumerism" (2007) NZLJ 13.

4. Books

David Collins *Medical Law in New Zealand* (Brooker & Friend Ltd, Wellington, 1992).

Ron Paterson *The Good Doctor: what patients want* (Auckland University Press, Auckland, 2012).

Duncan Webb *Ethics, Professional Responsibility and the Lawyer* (Butterworths, Wellington, 2000).

Duncan Webb *Ethics, Professional Responsibility and the Lawyer, Second Edition* (Butterworths, Wellington, 2006).

5. Chapters

Joanna Manning "Professional Discipline of Health Practitioners" in PDG Skegg and Ron Patterson *Medical Law in New Zealand* (Brookers Ltd, Wellington, 2006) at 613.

Ron Paterson "Regulation of Health Care" in PDG Skegg and Ron Patterson *Medical Law in New Zealand* (Brookers Ltd, Wellington, 2006) at 3.

PDG Skegg "The Code of Patients' Rights" in PDG Skegg and Ron Patterson *Medical Law in New Zealand* (Brookers Ltd, Wellington, 2006) at 23.

6. Parliamentary Materials

(28 February 2006) 629 NZPD 1502.

7. Reports and Papers

Silvia Cartwright *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (July 1988).

Judge Dale Clarkson *New Zealand Lawyers and Conveyancers Disciplinary Tribunal: Annual Report for the 12 months ended 30 June 2011* (2011).

Judge Dale Clarkson *New Zealand Lawyers and Conveyancers Disciplinary Tribunal: Annual Report for the 12 months ended 30 June 2010* (2010).

Judge Dale Clarkson *New Zealand Lawyers and Conveyancers Disciplinary Tribunal: Annual Report for the year ended 30 June 2009* (2009).

Health and Disability Commissioner *A Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumer Rights* (June 2004).

Health and Disability Commissioner *A Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumer Rights* (November 2008).

Director General of Health *Review of the Health Practitioners Competence Assurance Act 2003* (June 2009).

Medical Council of New Zealand *Annual Report 1995* (June 1995).

Duncan Webb *Discussion Draft: Rules of Conduct and Client Care for Lawyers* (A Paper for the Board of the New Zealand Law Society, 20 February 2007).

8. Magazine Articles

Ashley Balls "Challenging Law's sacred cows" *NZLawyer* (New Zealand, 6 March 2009) at 22.

Lucy Ratclifee "New medical indemnity provider enters market" *NZDoctor* (online ed, New Zealand, 24 January 2011).

Duncan Webb "Unsatisfactory Conduct under the Lawyers and Conveyancers Act 2006" *LawTalk* (New Zealand, 29 September 2008) at 18-21.

9. Dissertations

Kate Muirhead "Medicine for the Soul: Should the Code of Consumers' Rights Apply to Christian Healing Practices" (LLB (Hons) Dissertation, University of Otago, 2009).