New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO: 8/Med04/03P

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of a charge laid by a Professional Conduct Committee pursuant to Section 91(1)(b) of the Act against **ADAM JEREMY NUTTALL** medical practitioner, formerly of Queenstown

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chairperson)

Dr L Ding, Dr R De Luca, PhD, Dr R S J Gellatly and

Dr P M Jacobs (Members)

Ms G J Fraser (Executive Officer)

Ms G Rogers (Stenographer)

Hearing held at Wellington on 31 March 2005

APPEARANCES: Ms K P McDonald QC and Ms J Hughson for a Professional Conduct Committee

Mr M Parker for Dr A J Nuttall.

Introduction

1. Doctor Nuttall is registered as a medical practitioner. He formerly practised in Queenstown. Doctor Nuttall currently practises in Australia.

2. On 23 December 2004 a Professional Conduct Committee ("PCC") laid a charge against Dr Nuttall with the Tribunal. The charge was laid pursuant to s91(1)(b) Health Practitioners Competence Assurance Act 2003 ("HPCA Act").

3. The charge contained four allegations, namely:

   3.1 That Dr Nuttall entered into an inappropriate/or sexual relationship with a patient, in circumstances where Dr Nuttall was aware his patient was in a vulnerable state because of her marital problems and history of **[not for publication by Order of the Tribunal]** for which she was being counselled by Dr Nuttall. This aspect of the charge was said to relate to the period around June 1993;

   3.2 From June 1993 to August/September 1994 Dr Nuttall continued to treat the complainant and her children even though he had entered into a sexual relationship with her;

   3.3 From 1995 to at least March 1998 Dr Nuttall continued to prescribe medication and write medical reports for the complainant despite the fact they were having a sexual relationship; and

   3.4 Doctor Nuttall failed to make adequate notes in relation to his consultations and treatment of the complainant.

4. The charge alleged Dr Nuttall's conduct, when viewed separately or cumulatively amounted to professional misconduct.

5. Professional misconduct is defined in s.100(1)(a) and (b) of the HPCA Act to mean:

> *"(a) … any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time the conduct occurred; or*
>
> *(b) … any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time the conduct occurred."*

6. The charge "professional misconduct" set out in the HPCA Act includes matters previously categorised as "disgraceful conduct in a professional respect" contained in the Medical Practitioners Acts of 1995 and 1968.

7. The charge was heard in Wellington on 31 March 2005. At the hearing Dr Nuttall admitted a series of shortcomings which he acknowledged constituted professional misconduct as defined in the HPCA Act.

8. After the Tribunal heard and considered the evidence it adjourned to determine whether or not it was satisfied the charge had been established. After a brief adjournment the Tribunal advised Dr Nuttall was guilty of professional misconduct. The Tribunal then heard submissions on penalty. On the 31st March the Tribunal advised that in its written decision it would order:

   8.1 Doctor Nuttall's registration as a medical practitioner in New Zealand be cancelled; and

   8.2 Before Dr Nuttall applies for registration again he undergo an assessment by the Medical Council's Sexual Misconduct Assessment Team and comply with all directions and requirements of that Team.

   The Tribunal also advised that it was considering an order for costs pursuant to s100(1)(f) HPCA Act but wanted to reflect on this before advising what, if any, order for costs would be made. The Tribunal informed Dr Nuttall it was aware of and would have regard to his difficult financial circumstances when considering the question of costs.

9. In this decision the Tribunal explains its reasons for:

9.1 Finding Dr Nuttall guilty of professional misconduct; and

9.2 The penalties it has imposed.

The Tribunal orders take effect from the date of this decision.[1]

10. Before explaining its substantive decision the Tribunal records that it made the following orders prior to the hearing:

10.1 An order that nothing be published which names or otherwise identifies the complainant and her children. That order was made pursuant to s95(2)(d) of the HPCA Act. The Tribunal's reasons for that order are set out in Decision 7/Med04/03P;

10.2 That the Tribunal has the jurisdiction to allow in appropriate circumstances a complainant to give their evidence from behind a screen shielding them from the health practitioner. The Tribunal's reasons for that conclusion are also recorded in Decision7/Med04/03P. It transpired that the complainant elected not to pursue this issue at the hearing and so no screen was required;

10.3 That no media reports refer to:

- The town in New Zealand where the complainant lived with her children during the time of her relationship with Dr Nuttall;
- The name of the pharmacy from which the complainant and her children obtained medications prescribed by Dr Nuttall;
- The place where the complainant and Dr Nuttall lived together;
- The fact the complainant was the victim of **[not for publication by Order of the Tribunal]**.

These orders were made pursuant to s95(2)(b) of the HPCA Act to protect the privacy of the complainant and her children.

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[1] Refer s103(3) HPCA Act.

11. The Tribunal also considered and declined the following applications:

    11.1 An application from Dr Nuttall for orders prohibiting publication of his name and identifying features pending the determination of the charge by the Tribunal. The reasons for that decision are set out in 7/Med04/03P;

    11.2 A request from Radio New Zealand to record the Tribunal's proceedings. That application was declined to protect the privacy of the complainant. That application was declined pursuant to s.95(2)(b) of the HPCA Act.

12. Prior to giving her evidence the complainant was advised of the special protections available to her under s.97 of the HPCA Act. The complainant elected not to give her evidence in private.

The Evidence

13. The Tribunal received and considered written briefs of evidence from:

    13.1 Lois Middleton:

    Ms Middleton attended the hearing as a support person for the complainant. Ms Middleton is a psychiatric district nurse and has been a long time friend of the complainant. Ms Middleton gave unchallenged evidence about her knowledge of the relationship which developed between the complainant and Dr Nuttall. Ms Middleton also explained the deep concern she had at relevant times about the complainant's well being and Dr Nuttall's breaches of professional boundaries.

    13.2 Cherryl Caradoc-Davies:

    In 1997 Ms Caradoc-Davies was in her final year of training as a Gestalt Psychotherapist. She provided evidence of eleven consultations the complainant had with her between May and October 1997 during which the complainant told Ms Caradoc-Davies about Dr Nuttall's relationship with the complainant. Ms Caradoc-Davies' evidence was not challenged.

    13.3 Elizabeth Gutteridge:

Ms Gutteridge is a registered clinical psychologist. Ms Gutteridge first saw the complainant in January 1995. Ms Gutteridge also saw one of the complainant's children. In November 1996 the complainant told Ms Gutteridge about the intimate relationship between Dr Nuttall and the complainant. Ms Gutteridge's unchallenged evidence included her counselling and cautioning the complainant about Dr Nuttall's breaches of his ethical responsibilities by having a relationship with his patient.

13.4 Doctor Niall Holland:

Doctor Holland is a senior and highly respected general practitioner who is a past President of the Royal New Zealand College of General Practitioners. He reviewed Dr Nuttall's conduct and his management and treatment of the complainant. Doctor Holland's expert testimony was not challenged. He was very critical of Dr Nuttall and in no doubt Dr Nuttall's actions breached appropriate professional standards in a variety of respects. The Tribunal was greatly assisted by Dr Holland's expert testimony and is grateful for the efforts he made in assisting the Tribunal.

14. The Tribunal received written briefs of evidence from the complainant and Dr Nuttall. Both supplemented their written briefs with oral testimony. Appropriately, the complainant was not cross examined. Doctor Nuttall was cross examined by Ms McDonald QC. Both the complainant and Dr Nuttall answered questions from the Tribunal.

15. The Tribunal's assessment of the complainant is that she gave her evidence honestly and in a considered and objective manner. The Tribunal also believes Dr Nuttall's oral evidence was honest and candid. He frankly admitted his serious breaches of ethical and professional responsibilities.

16. The Tribunal obtained considerable assistance from a number of contemporaneous records and notes, namely:

16.1 A printout of prescriptions dispensed by a pharmacy to the complainant and her children. The prescriptions were mainly issued by Dr Nuttall and covered the period 7 August 1995 to 6 December 2001;

16.2 Doctor Nuttall's clinical records (many of which were incomplete and very brief);

16.3 Counselling notes made by Ms Caradoc-Davies;

16.4 Counselling notes made by Ms Gutteridge;

16.5 Medical records completed by other health practitioners relating to the complainant's children;

16.6 Medical records from another general practitioner relating to the complainant.

The Facts

17. The principal differences in the evidence of the complainant and Dr Nuttall concerned:

17.1 Precisely when their sexual relationship commenced;

17.2 The nature of certain financial arrangements they entered into after their separation.

It transpired that neither of these issues impacted on the key questions before the Tribunal.

18. The complainant and her children became patients of Dr Nuttall in October 1991. At that time Dr Nuttall was treating the complainant's husband (the complainant and her husband subsequently separated).

19. The complainant and her husband were having marital difficulties. Doctor Nuttall offered them counselling. Initially the marital counselling sessions were joint sessions, but soon evolved into separate consultations.

20. In early 1992 the complainant was subjected to **[not for publication by Order of the Tribunal]**. This event evoked repressed memories of prior **[not for publication by Order of the Tribunal]**. The complainant told Dr Nuttall about the **[not for publication by Order of the Tribunal]**. Doctor Nuttall offered the complainant **[not for publication by Order of the Tribunal]**counselling even though he had no

training or experience in such matters. The marital counselling sessions ceased. The **[not for publication by Order of the Tribunal]** counselling started in April 1992.

21. The counselling sessions Dr Nuttall conducted involved intimacies which increased as the counselling sessions continued. The intimacies started with Dr Nuttall holding the complainant's hand. Doctor Nuttall then started touching the complainant's legs and upper arms and started cuddling her.

22. The number of counselling sessions was significant. Doctor Nuttall's very brief records confirm a total of 61 sessions between 14 October 1991 and 23 August 1994. Doctor Holland described this number of counselling sessions as "… *unusually intensive counselling for a general practitioner who does not have a special interest in psychotherapy*".

23. In her evidence the complainant said that as the counselling sessions evolved Dr Nuttall became more intimate. He massaged the complainant's shoulders and stroked her hair.

24. The complainant became increasingly dependent upon Dr Nuttall. She told the Tribunal about how Dr Nuttall confided in her about difficulties he was having with his marriage, and that he "sexualised questions" during the counselling sessions.

25. The complainant told two friends about her developing relationship with Dr Nuttall. One of those friends, Ms Middleton, warned the complainant that she should stop seeing Dr Nuttall.

26. In early 1994 Dr Nuttall started to telephone the complainant at her home and elsewhere. One of these telephone calls occurred soon after **[not for publication by Order of the Tribunal]**. The telephone call from Dr Nuttall was on a Sunday evening and lasted for about an hour.

27. The level of intimacy between the complainant and Dr Nuttall continued to increase during 1994. The complainant was adamant that at a session held on 10 June 1994 Dr Nuttall kissed her sexually on the lips and caressed her genitals. Doctor Nuttall denied these events occurred at this time, but did not dispute that his relationship with the complainant became extremely intimate during 1995.

28. The complainant's evidence was that during the balance of 1994 she and Dr Nuttall would meet for "counselling" sessions in his clinic and that during those sessions they would "fool around in his surgery". This "fooling around" including "touching, kissing and having oral sex".

29. In September 1994 the complainant and her husband separated.

30. The complainant explained to the Tribunal that she and Dr Nuttall had sexual intercourse in his clinic in early 1995. Doctor Nutall thought intercourse did not occur until later in 1995.

31. The Tribunal is not concerned about exactly when Dr Nuttall and the complainant had sexual intercourse because it is abundantly clear Dr Nuttall engaged in a totally inappropriate sexual relationship with a woman who continued to be his patient for a number of years after their sexual relationship started. Furthermore, Dr Nuttall continued to treat the complainant's children for a number of matters during the ensuing years.

32. Doctor Nuttall initially suggested that the doctor/patient relationship with the complainant terminated in March 1995 when, at his suggestion, the complainant saw another general practitioner for gynaecological matters.

33. The records clearly establish however that Dr Nuttall continued to treat the complainant and her children after March 1995:

    33.1 The Tribunal examined records of prescriptions dispensed by a pharmacy between 7 August 1995 and 6 December 2001 for the complainant and her children. The pharmacy records from 7 August 1995 to 29 June 1998 do not identify the prescriber but Dr Nuttall acknowledged most of the 41 prescriptions issued for the complainant during that time were likely to have been issued by him.

    33.2 From 29 June 1998 to 6 December Dr Nuttall issued 38 prescriptions for the complainant. During the same time the doctor who Dr Nuttall had referred the complainant to issued just 3 prescriptions. The medication prescribed by Dr Nuttall included significant quantities of Hypnovel, a potentially addictive benzodizapine, Dihydrocodeine (a narcotic known to cause dependence)

Norfloxacin (used to treat urinary tract infections) analgesics, antibiotics and Prozac which Dr Nuttall said he prescribed because the complainant was "depressed and needed medication". The records also show significant quantities of Digesic (which contains a narcotic known to cause sedation and dependence) being prescribed for the complainant by Dr Nuttall.

33.3 The pharmacy records also record 28 prescriptions were issued by Dr Nuttall for the complainant's children between 15 May 1998 and 7 November 2001. The medications included antibiotics, anti-inflamatories, Paracetamol and other medications.

33.4 Doctor Nuttall's records show that on 1 September 1995, 5 November 1995, 21 December 1995, and 31 March 1998 he issued medical certificates and letters for the complainant.

34. The records made available to the Tribunal leave the Tribunal in absolutely no doubt Dr Nuttall continued to treat the complainant and her children for a variety of significant medical issues long after his attempt to terminate his professional relationship with the complainant in 1995. It is significant that the records show no formal transfer of the complainant's care to another general practitioner. The Tribunal is in absolutely no doubt the complainant saw another general practitioner for gynaecological and other matters after March 1995 but that Dr Nuttall remained her primary general practitioner and provided significant levels of professional assistance to her and her children.

35. In November 1995 the complainant was the victim of **[not for publication by Order of the Tribunal]**. She was treated by Dr Nuttall who admitted her to a local hospital under his care, even though he was not on call at the time. The hospital records clearly record Dr Nuttall's role as the complainant's general practitioner at this time.

36. Doctor Nuttall's intimate sexual relationship continued with the complainant through to July 2000. The relationship fluctuated in its intensity during the years 1995 to 2000. There were occasions when Dr Nuttall endeavoured to end the relationship but it is apparent that the complainant and Dr Nuttall had deep feelings for each other, and any periods of "cooling off" were short lived. Throughout this time the relationship

had been kept secret, although the complainant did confide in two friends and two counsellors about her relationship with Dr Nuttall.

37. In July 2000 Dr Nuttall left his wife and children. His relationship with the complainant ceased to be a secret. The following year Dr Nuttall left his practice. The complainant, her children and Dr Nuttall lived together overseas until the complainant returned to New Zealand in late 2003.

38. In May 2004 the complainant became aware another woman was having a relationship with Dr Nuttall. That matter is referred to later in this decision under the heading of penalty. Suffice to say, the complainant resolved to pursue her complaint against Dr Nuttall when she became aware of Dr Nuttall's relationship with another woman.

39. Doctor Nuttall's medical records are extremely sparse and incomplete. Doctor Holland described Dr Nuttall's record keeping as "very poor". Doctor Nuttall did not dispute this assessment.

40. Doctor Nuttall's records refer to 61 consultations during which some form of counselling occurred. The records do not give an indication of the contents of the counselling.

41. Doctor Holland correctly pointed out that because:

> *"…in this case counselling evolved into an intimate relationship, there was added importance in documenting when the medical relationship was terminated and in documenting what steps were taken to ensure the patient was not harmed by the change in the relationship. There is no document covering either issue."*

42. Doctor Nuttall's relationship with the complainant has caused considerable harm to her. The complainant has received counselling and treatment from Ms Gutteridge since June 2004. In an affidavit provided to the Tribunal Ms Gutteridge describes the complainant as continuing to be *"extremely vulnerable"* and *"deeply traumatised by matters arising from her relationship with Dr Nuttall, and by the prospect of having to attend to give evidence [before the Tribunal] …"*. It was very apparent to the Tribunal that the complainant was very vulnerable at the time she entered into a sexual relationship with Dr Nuttall, and continues to be deeply affected by the nature of her relationship with Dr Nuttall.

Dr Nuttall's Ethical Obligations

43. Ethicists and medical experts have identified three reasons why sexual relationships between doctors and patients are unethical and frequently harmful.[2] Those reasons are:

43.1 Breach of Trust:

A doctor who forms a sexual relationship with a patient commits a fundamental breach of trust. A doctor is always required to have their patient's best interests uppermost in their mind. A doctor must always put to one side their needs or desires when addressing their patient's requirements. The relationship between a patient and doctor is one of fundamental trust which enables the patient to trust their doctor with intimate physical and psychological matters. There is a clear difference in power between the doctor and patient which the patient relies upon when seeking the doctor's expert knowledge, skill and professional services. This difference in position puts the patient into a state of vulnerability. If the doctor breaches the boundaries of the doctor/patient relationship there is an automatic exploitation of the patient, who consults their doctor in the expectation that the doctor will honour their fiduciary duty to meet the patient's needs before their own. Patients are never able to fully consent to a sexual relationship because they are in a dependent position. It is therefore essential doctors not breach the trust their patients and society have reposed in them by abusing the power and authority they enjoy.

43.2 Compromising Treatment:

It is extremely difficult, if not impossible for a doctor to maintain objectivity and professional judgment if they are engaged in an intimate relationship with

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[2] Refer for example to:
"Professional Boundaries in the Physician-Patient Relationship"; JAMA, May 10 1995, Vol.273, G Gabbard and C Nadelson.
"Sexual Exploitation in Professional Relationships", Washington DC; American Psychiatric Press, 1989, Ed G Gabbard;
"Lessons to be Learned from the Study of Sexual Boundary Violations", American J Psychotherapy, June 1, 1996; Vol 50 No. 3 G Gabbard;
"Sexualisation of the Doctor-Patient Relationship: is it ever ethically permissible?" Family Practice Vol 18, No.5 2001, K Hall.

their patient. This in turn can lead to seriously deficient treatments for medical and psychological conditions.[3]

43.3 Harm to the Patient:

As evidenced in this case, a doctor is more likely to enter into a sexual relationship with a patient who is already vulnerable[4]. There is a much greater incidence of previous **[not for publication by Order of the Tribunal]**, in patients who have become engaged in sexual relationships with their doctors. It is the doctor's responsibility to be aware of these vulnerabilities and manage those conditions. The nature and risk of transferance is such that when a relationship between a doctor and patient ends the damage to the patient may be quite severe, as the patient's underlying problems may never have been properly addressed.

44. The point made in paragraph 43.3 above was well illustrated in a judgment of the United States Court of Appeals, 9th Circuit in which it was said:

> *"The impacts of sexual involvement with one's counsellor are more severe than the impacts of merely 'having an affair' … because the client's attraction is based on transference, the sexual contact is ordinarily akin to engaging in sexual activity with a parent, and carries with it feelings of shame, guilt and anxiety experienced by incest victims".*[5]

All doctors in New Zealand should be aware of the phenomenon of transference, particularly in the setting of a female patient: male doctor relationship.

45. Medical Codes of Ethics, dating back to the Hippocratic Oath through to the New Zealand Medical Association's Code of Ethics have always emphasised the need for doctors to ensure that their practice of medicine is beyond reproach:

45.1 The Hippocratic Oath dealt with the issue in this way:

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3 "Sexual Abuse in Therapy-Gender Issues" Aust NZ Journal of Psychiatry, Vol 30, No 1 1996, C Quadro

4 Although it is not part of the case the Tribunal has serious concerns about Dr Nuttall's pattern of prescribing for the complainant during the period August 1995 to December 2001 and questions if in fact the complainant received appropriate medical care from Dr Nuttall during this period.

5 *Simmons v United States* 805 F2d 1363 (1986) at 1367.

> *"In every house where I come I will enter only for the good of my patients, keeping myself from intentional ill doing and seduction, especially from the pleasures of love …".*

45.2 The New Zealand Medical Association's Code of Ethics in force in 1995 required doctors to:

> *"Ensure that all conduct in the practice of the profession is above reproach, and that neither physical, emotional nor financial advantage is taken of any patient".*[6]

46. On 16 June 1994 the Medical Council of New Zealand issued a statement for the profession concerning "sexual abuse in the doctor/patient relationship".

The Medical Council's statement clearly warned medical practitioners that "sexual behaviour in a professional context is abuse". The Medical Council also warned that:

> *"… the issue of power differential between patient and doctor means that consent of the patient is not a defence in disciplinary findings of sexual abuse. It may become an issue in the consideration of penalty. Each case must be examined in relation to the degree of dependency between patient and doctor and the duration and nature of the professional relationship."*

47. In 1996 the Medical Council issued a further policy statement in which it warned:

> *"A sexual relationship between a doctor and a former patient will be presumed to be unethical if any of the following apply:*
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> - *the doctor/patient relationship involved psychotherapy or long term counselling and support;*
> - *the patient suffered a disorder likely to impair judgment or hinder decision making;*
> - *the doctor knew that the patient had been sexually abused in the past;*
> - *the patient was under the age of 20 when the doctor/patient relationship ended.".*

48. At the time the Medical Council was specifically warning doctors of their ethical obligations not to become sexually involved with patients and former patients the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996[7] were promulgated. That Code recorded the rights of patients to receive health services without being subject to "sexual

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6 Paragraph 5 NZMA Code of Ethics
7 SR 78/96

exploitation"[8]. Exploitation is defined in the Regulations to include *"any abuse of a position of trust, breach of fiduciary duty, or exercise of undue influence"*.[9]

49. In addition to the warnings found in:

49.1 Ethical Codes;

49.2 The Medical Council's Statements of 1994 and 1996;

49.3 The Code of Health and Disability Services Consumers Rights

disciplinary bodies and the Courts had made it very clear that doctors who engage in sexual relationships with their patients are likely to face serious disciplinary sanctions.

50. An examination of the records of the Medical Practitioners Disciplinary Tribunal show that from 1997 to 2004 five doctors were found guilty of disgraceful conduct in a professional respect when they were found to have engaged in sexual activities with their patients and former patients. Of the five doctors found guilty of disgraceful conduct, four were punished by having their names removed from the register of medical practitioners. It is difficult to believe that any doctor in New Zealand would fail to appreciate how seriously the responsible authorities view those who engage in sexual activities with their patients.

51. Courts in New Zealand and other Commonwealth countries have usually upheld decisions by professional disciplinary tribunals where they have severely disciplined health professionals for engaging in a sexual relationship with their patients.

51.1 New Zealand – see for example:

Gurusinghe v Medical Council of New Zealand[10]
Brake v PPC[11]

51.2 United Kingdom – see for example:

McCoan v General Medical Council[12]
Jettle v General Medical Council[13]

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8 Right 2 SR 78/96
9 Clause 4 ST 78/96
10 [1989] 1 NZLR 139
11 [1997] 1 NZLR 71
12 [1964] 1 WLR 1107

51.3 Australia – see for example:

Re Frederick[14]
Bowen-James v Walton[15]

Legal Principles

52. The allegations levelled against Dr Nuttall are very serious. Accordingly the onus placed upon the PCC to establish the charge requires a high standard of proof.

53. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[16] where the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[17]

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy.*[18] *Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

54. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[19] where it was emphasized that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*[20]:

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

55. In *Cullen v The Medical Council of New Zealand*[21] Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall correctly described it in the directions which he gave the Committee:*

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13 (unreported, PC, 14 February 1995)
14 [1957] SASR 149
15 (1992) 27 NSWLR 457
16 (1984) 4 NZAR 369
17 (1967) 1 NSWLR 609
18 [1966] ALR 270
19 [1989] 1 NZLR 139 at 163
20 Unreported HC Wellington M 239/87 11 October 1990
21 Unreported HC Auckland 68/95, 20 March 1996

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

56. In this case where the Tribunal has made findings adverse to Dr Nuttall it has done so because the evidence satisfies the test as to the burden of proof set out in paragraphs 53 to 55 of this decision. Indeed, in relation to the four particulars where the Tribunal finds Dr Nuttall's conduct constitutes professional misconduct the Tribunal believes the evidence against Dr Nuttall is very compelling.

Professional Misconduct

57. The definition of professional misconduct, found in s101(1)(a)(b) of HPCA Act is set out in paragraph 5 of this decision. The definition in s100(1)(a) if the HPCA Act refers to professional misconduct as meaning:

> Malpractice; or
> Negligence

in relation to the way a health practitioner discharges their professional responsibilities.

58. Subsection 100(1)(b) of the HPCA Act also categorises as professional misconduct acts or omissions that have or are likely to bring discredit to the practitioner's profession, regardless of whether the acts or omissions in question occurred in relation to the practitioner's "scope of practice".

The definition of professional misconduct in the HPCA Act is modelled on the definition of professional misconduct found in the Nurses Act 1977.

59. Those who drafted s100(1)(a) of the HPCA Act intended to draw a distinction between malpractice and negligence. Whilst there are differences between malpractice and negligence, it is quite conceivable for acts and omissions to constitute both malpractice and negligence.

60. Malpractice is defined in the Collins English dictionary[22] as meaning:

> *"The immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct"*

The same term is defined in the new Shorter Oxford English dictionary[23] as meaning:

> *"Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer …a criminal or illegal action: wrong doing, misconduct"*.

Negligence

61. The term negligence has a specific meaning in law. Before a plaintiff could successfully sue a health practitioner for negligence they would need to prove four matters, namely:

61.1 That the practitioner owed the plaintiff a duty of care;

61.2 That the practitioner breached the duty of care they owed the plaintiff;

61.3 That the plaintiff suffered compensatible damage;

61.4 That the damage suffered by the plaintiff was caused by the practitioner's breach of the duty of care they owed the plaintiff.

62. It is highly unlikely the drafters of s100(1)(a) HPCA Act envisaged those prosecuting health practitioners would need to prove all criteria required by the common law to establish negligence on the part of a health practitioner. In the Tribunal's view, the term "negligence", as used in s100(1)(a) of the HPCA Act focuses on a practitioner's breach of their duty in a professional setting. The test as to what constitutes negligence in s100(1)(a) of the HPCA Act requires, as a first step in the analysis, a determination of whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal. Whether or not there has

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[22] 2nd Edition

[23] 1993 Edition

been a breach of the appropriate standards is measured against the standards of a responsible body of the practitioner's peers.[24]

63. The approach set out in paragraph 62 of this decision avoids the need for prosecuting authorities to prove damage. Thus for example, a practitioner who fails to make appropriate notes of a consultation may not cause damage to their patient, but may nevertheless be guilty of negligence within the meaning of s100(1)(a) HPCA Act.

Discredit to the Profession

64. The term to "bring discredit to the profession" was considered by Gendall J in *Collie v Nursing Council of New Zealand*[25] when considering an appeal brought under the Nurses Act 1977. His Honour noted:

> *"To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the nursing profession was lowered by the behaviour of the nurse concerned."*

65. **Background Jurisprudence**

66. In New Zealand, most discussions about the meaning of professional misconduct in a medical setting commence with a reference to the judgment of Jeffries J in *Ongley v Medical Council of New Zealand*[26]. In that case His Honour formulated the test as to what constituted professional misconduct as a question:

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

67. Legislative changes to the composition and structure of medical disciplinary bodies in 1995 caused the analysis as to what constituted professional misconduct to evolve from the seminal test articulated by Jeffries J in *Ongley*.

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[24] See for example, *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 (HL).

68. Under the Medical Practitioners Act 1995, the test as to what constituted professional misconduct became distilled to two questions:

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

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

68.2 Secondly, if the established conduct fell below the standards expected of a doctor was the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the doctor?

69. The words "representatives of the community" in the first limb of the test were considered essential because under the Medical Practitioners Act 1995 those who sat in judgment of doctors comprised three members of the medical profession, a lay representative and a lawyer as chairperson. The makeup of medical disciplinary bodies under the 1995 Act was different from the composition of medical disciplinary bodies at the time Jeffries J delivered his decision in *Ongley*. It was also recognised that under the Medical Practitioners Act 1995 it was necessary to assess a doctor's conduct against the expectations of the profession and society. In part, the Medical Practitioners Disciplinary Tribunal's role was one of setting standards and in some cases the communities' expectations required the Tribunal to be critical of the usual standards of the profession.[27]

70. This second limb to the test referred to in paragraph 68.2 above recognised the observations in *Pillai v Messiter*[28], *B v Medical Council*[29], *Staite v Psychologists Board*[30] and *Tan v ARIC*[31] that not all acts or omissions which constituted a failure to

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25 HC Wellington, AP 300/99, 5 September 2000
26 Supra
27 Refer *B v Medical Council* (unreported High Court, Auckland, HC11/96, 8 July 1996, Elias J); *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J)
28 (1989) 16 NSWLR 197
29 supra
30 (1998) 18 FRNZ 18
31 (1999) NZAR 369

adhere to the standards expected of a doctor would in themselves constitute professional misconduct.

Professional Misconduct under the HPCA Act

71. The Tribunal is of the view that much of the jurisprudence concerning the meaning of professional misconduct under earlier legislative regimes continues to be relevant under the HPCA Act. In particular, the Tribunal believes that the test as to what constitutes professional misconduct continues to involve a two step process:

    71.1 The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can be reasonably regarded by the Tribunal as constituting:

    Malpractice; or

    Negligence; or

    Otherwise meets the standard of having brought, or was likely to bring discredit to the practitioner's profession.

    71.2 The second step of the process requires the Tribunal to be satisfied that the health practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

72. The Tribunal has assessed Dr Nuttall's conduct in this case by addressing the tests noted in paragraph 71 in relation to each particularised allegation in the Notice of Charge.

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

First Particularised Allegation

> **"In or around June 1993 [Dr Nuttall], entered into an inappropriate and/or sexual relationship with his patient Ms …, in circumstances where Dr Nuttall was aware that Ms … was vulnerable and/or at risk by virtue of her marital problems and past and [not for publication by Order of the Tribunal] in respect of which he had been counselling her in his capacity as her general practitioner".**

73. With one minor amendment the Tribunal is totally satisfied the PCC has established this element of the charge. The only aspect of the charge which requires alteration is that the events in question occurred in June 1994, not 1993. The Tribunal accordingly amends particular one of the Notice of Charge so that it refers to June 1994. That amendment, and other amendments referred to later in this decision are made pursuant to clause 15(1) of the First Schedule of the HPCA Act.

74. The evidence clearly establishes that in mid 1994 Dr Nuttall commenced an inappropriate and sexual relationship with the complainant. That relationship started against the background of the complainant seeking counselling and assistance from Dr Nuttall in dealing with marital difficulties, **[not for publication by Order of the Tribunal]**. The complainant was an extremely vulnerable patient. She required special care and assistance. Doctor Nuttall committed cardinal errors by entering a relationship with the complainant which was both sexual and inappropriate.

75. In the Tribunal's judgment Dr Nuttall's conduct, as alleged in the first particular of the Notice of Charge constituted gross negligence, malpractice and brought the medical profession into discredit. His actions justify a severe disciplinary sanction for the purpose of protecting the public, maintaining professional standards and to punish him.

Second Particularised Allegation

> **"In the period from June 1993 to August/September 1994 [Dr Nuttall] continued to treat Ms … and her children as their family doctor having entered a sexual relationship with Ms …".**

76. Again, the dates in the particularised allegation of the charge are not correct. That mistake does not detract from the fact that from June 1994 until at least November 2001 Dr Nuttall continued to treat the complainant and her children as their family

doctor having entered into a sexual relationship with the complainant. The Tribunal amends particular two so that it refers to the period June 1994 to November 2001.

77. It is abundantly clear that Dr Nuttall continued to provide a variety of professional services to the complainant and her xx children from June 1994 through to the time they left New Zealand to live with Dr Nuttall. The transcripts of the prescriptions issued by Dr Nuttall for the complainant and her children, the details of which have been set out in paragraphs 33.1 and 33.2 of this decision illustrate beyond any doubt that Dr Nuttall was treating the complainant and her children after entering a sexual relationship with her.

78. Although Dr Nuttall may have made an attempt to refer the complainant to another general practitioner for some purposes, there was clearly no formal termination of the doctor/patient relationship when Dr Nuttall and the complainant commenced their sexual relationship in June 1994. It is also very clear that for most purposes the complainant and her children regarded Dr Nuttall as their general practitioner from June 1994 to November 2001.

79. In the Tribunal's judgment Dr Nuttall's acts and omissions as set out in the second particular of the charge (as amended) constituted gross negligence, malpractice and brought the medical profession into discredit. His actions in this regard merit a severe disciplinary sanction for the purposes of protecting the public, maintaining professional standards, and punishing Dr Nuttall.

Third Particularised Allegation

"In the period from around March 1995 when Ms … started consulting another general practitioner, through to at least 31 March 1998, continued to prescribe medication, complete certificates and write medical reports and/or letters for Ms … while he and Ms … were in a sexual relationship".

80. As has already been made very clear in this decision, the Tribunal is in no doubt that Dr Nuttall continued to prescribe medication for the complainant and her children through to December 2001, even though the complainant was seeing another general practitioner for some limited purposes. Particular three of the Notice of Charge is amended to reflect this fact. The evidence, as set out in paragraphs 33.1 to 33.3 of this decision clearly show the serious extent to which Dr Nuttall prescribed medication for the complainant and her children from March 1995 to December 2001.

In addition, it is very clear Dr Nuttall provided medical certificates and reports for the complainant and her children during the time in issue.

81. In the Tribunal's judgment, Dr Nuttall's acts and omissions as set out in the third particular of the charge (as amended) constituted gross negligence, malpractice and brought the medical profession into discredit. His actions in this regard also warrant a severe disciplinary sanction for the purposes of protecting the public, maintaining professional standards and punishing him.

Fourth Particularised Allegation

> **"In the period from 1991 when Ms … became his patient, through to August/September 1994 [Dr Nuttall] failed to take adequate notes in Ms … medical records of his counselling with her, in particular, when she presented to him for marriage counselling and counselling in respect of her [not for publication by Order of the Tribunal]".**

82. The Tribunal entirely agrees with Dr Holland's comments that Dr Nuttall's records of his consultations with the complainant were "very poor". The consultations refer to 61 sessions when some form of counselling occurred. It is impossible to determine the content, nature and extent of that counselling. The complete absence of any meaningful records was both unusual and totally unacceptable.

83. In the Tribunal's judgment, Dr Nuttall's poor records constituted negligence on his part. His omissions in this regard justify a disciplinary sanction for the purposes of maintaining professional standards.

84. The Tribunal has found each particular of the charge constitutes professional misconduct as defined in s100(1) of the HPCA Act. Cumulatively the charges also constitute professional misconduct. The penalties which the Tribunal imposes are cumulative penalties. That is to say, the Tribunal imposes one set of penalties in relation to the total charge.

Penalties

85. After the Tribunal advised Dr Nuttall that it found the charge proven, the Tribunal heard further evidence from Dr Nuttall.

86. The Tribunal was advised at this stage Dr Nuttall had recently appeared before the Medical Registration Board of Western Australia. He has defended a charge that he

engaged in a sexual relationship with a patient. Dr Nuttall advised the Tribunal that while he had a sexual relationship with the woman concerned she was not a patient.

87. The decision of the Medical Registration Board of Western Australia is not yet available. The Tribunal is accordingly obliged to put that matter to one side as it would not be appropriate to give consideration to something which has not been proven at this juncture.

88. The Tribunal has given very careful consideration to the appropriate penalty in this case. The options considered by the Tribunal included:

88.1 Cancelling Dr Nuttall's registration;

88.2 Suspending Dr Nuttall;

88.3 Requiring Dr Nuttall to practise subject to conditions.

Cancellation of Registration

89. Ultimately the Tribunal believes it has no option other than to order the cancellation of Dr Nuttall's registration as a medical practitioner in New Zealand.

90. The Tribunal has imposed this ultimate penalty because it believes there are six aggravating factors in this case which require the imposition of the severest penalty available to the Tribunal. The aggravating factors are:

90.1 The complainant was clearly a very vulnerable patient. She sought counselling and assistance from Dr Nuttall for her marital difficulties, and subsequently issues associated with **[not for publication by Order of the Tribunal]**.

90.2 Doctor Nuttall lacked the requisite skills and experience to undertake the counselling services he attempted.

90.3 Doctor Nuttall continued to treat the complainant and her children after he developed romantic feelings towards the complainant and commenced a sexual relationship with her.

90.4 The treatment Dr Nuttall provided the complainant included prescribing medication that included drugs of dependence.

90.5 Doctor Nuttall did not undertake any formal or appropriate transfer of the complainant to another practitioner.

90.6 Doctor Nuttall's records and notes were totally inadequate.

Orders under s102

91. In addition to cancelling Dr Nuttall's registration the Tribunal orders that before Dr Nuttall applies for registration again in New Zealand he must undergo an assessment by the Medical Council's Sexual Misconduct Assessment Team and comply with all directions and requirements of that team. This condition is imposed pursuant to s102(2)(d) of the HPCA Act. The Tribunal believes Dr Nuttall needs to be carefully evaluated by the sexual misconduct assessment team and must be given instruction on identifying and adhering to the boundaries that exist between a health practitioner and patient.

Costs

92. The Tribunal appreciates Dr Nuttall is in a difficult financial position. He has no savings or realisable assets. He has no professional indemnity insurance and is not a member of the Medical Protection Society. Doctor Nuttall must meet his own legal fees in relation to this hearing, and the hearing that has occurred in Western Australia.

93. The Tribunal is also aware that practitioners found guilty of serious disciplinary offences can normally expect to pay a significant portion of the costs incurred in investigating and prosecuting them.

94. In this particular case the Tribunal proposes to give Dr Nuttall credit for his guilty plea and for the steps he has taken to try and ease the complainant's stress in relation to the hearing of the charge. The Tribunal also believes it appropriate to recognise Dr Nuttall voluntarily returned to New Zealand solely to face the Tribunal knowing his registration in New Zealand was likely to be cancelled. The Tribunal will accordingly discount the level of costs which Dr Nuttall would otherwise have been required to pay.

95. In the circumstances of this case, bearing in mind Dr Nuttall's limited financial position the Tribunal proposes to impose a comparatively modest costs order, namely $10,000 to be split equally as awards of costs to the PCC and the Tribunal pursuant to s101(1)(f)(ii) and (iv) of the HPCA Act.

Conclusion

96. Doctor Nuttall's registration as a medical practitioner in New Zealand is cancelled pursuant to s101(1)(a) of the HPCA Act.

97. Doctor Nuttall is ordered to pay a total of $10,000 costs pursuant to s101(1)(f)(ii) and (iv) of the HPCA Act.

98. Doctor Nuttall is required to undergo an assessment and comply with all directions and requirements of the Medical Council's Sexual Misconduct Assessment Team before applying again for registration as a medical practitioner in New Zealand. This order is made pursuant to s102(2)(d) of the HPCA Act.

99. The Tribunal's orders take effect from the date of this decision.

100. The Tribunal places on record its deep appreciation to all three counsel for the way they have represented the respective parties in this case.

DATED at Wellington this 18th day of April 2005

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Dr D B Collins QC

Chairperson

Health Practitioners Disciplinary Tribunal