IN THE HIGH COURT OF NEW ZEALAND
WHANGANUI REGISTRY

I TE KŌTI MATUA O AOTEAROA
WHANGANUI ROHE

CIV-2018-483-004
[2018] NZHC 2981

IN THE MATTER	of an appeal pursuant to section 106(2) of the Health Practitioners Competence Assurance Act 2003
BETWEEN	PETER NAPIER LISTON Appellant
AND	THE DIRECTOR OF PROCEEDINGS Respondent

Hearing: 30 July 2018

Appearances: A H Waalkens QC for Appellant
L C Preston and C R McCulloch for Respondent

Judgment: 16 November 2018

JUDGMENT OF CLARK J

Introduction

[1] On a number of occasions Dr Liston failed to act on pathology reports following excisional tongue biopsy of his patient and diagnoses of squamous cell carcinoma. At a hearing before the Health and Practitioners Disciplinary Tribunal Dr Liston admitted professional misconduct.[1] The Tribunal censured Dr Liston, fined him $5,000 and ordered him to pay a 30 per cent contribution towards costs. Intended to assist Dr Liston in his future practice, the Tribunal also made recommendations to the Whanganui District Health Board.

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1 *Director of Proceedings v Liston* NZHPDT 940/Den17/387/D, 24 January 2018.

[2] Dr Liston appeals part of the penalty. He contends the fine was excessive and unreasonable and imposed without sufficient regard to mitigating factors. He seeks to have the fine set aside.

Background in brief

[3] Dr Liston is a registered oral and maxillofacial surgeon practising privately in New Plymouth. At the relevant time Dr Liston attended the Whanganui Hospital two half-days per week on a locum basis.

[4] Mr Hindson, who was 54 at the time, consulted his general practitioner regarding a painful tongue. Mr Hindson was referred to Dr Liston. Dr Liston conducted an initial examination at Whanganui Hospital in December 2011. A fortnight later Dr Liston performed a biopsy. Dr Liston's clinical notes record 12 consultations until Mr Hindson's last visit which was in November 2013.[2]

[5] Dr Liston performed one incisional biopsy and two excisional biopsies. Dr Liston did not act correctly on the results he received of the excisional biopsies and failed to recommend or provide treatment appropriate to the biopsy results which revealed squamous cell carcinoma. Although the result of an excisional biopsy performed in February 2013 showed "squamous cell carcinoma in-situ, incompletely excised"[3] Dr Liston reassured his patient (who was anxious about the possibility the lesion on his tongue was cancerous or pre-cancerous) that his condition was definitely not cancer. Dr Liston's clinical note following the consultation recorded "pathology shows carcinoma in situ clear of margins, review in six weeks". Dr Liston acknowledges his clinical note was wrong and that a re-excision of the lesion should have been undertaken or Mr Hindson should have been referred to a multi-disciplinary team.[4]

[6] Because prompt re-excision was not carried out it transpired the opportunity for further excision was lost until the lesion on Mr Hindson's tongue recurred.[5]

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2 At [7].
3 At [9].
4 At [10].
5 At [11].

[7] The pathology results of an excisional biopsy carried out in October 2013 found widespread features of carcinoma in-situ extending to involve the right excision margin (which had been incompletely excised).

[8] When Dr Liston consulted with Mr Hindson about the pathology results he advised the biopsy showed "nothing nasty" and reassured Mr Hindson there was time to deal with the condition before it became cancerous. Dr Liston wrote in his clinical notes: "Review with pathology. Carcinoma in situ advised manuka honey and review in four weeks' time".[6]

[9] Following their final consultation on 27 November 2013 Dr Liston referred Mr Hindson to the Palmerston North Hospital Combined Head and Neck Clinic. Mr Hindson was seen by specialists in early December 2013. He was advised he required surgery for a cancerous condition. In early January 2014, a squamous cell carcinoma tumour was removed following which Mr Hindson required consequential treatment.[7]

The charges

[10] Because it is part of Dr Liston's case that the Tribunal overstated the extent, or significance, of his acts and omissions, it is necessary to set out the charge which Dr Liston faced and which he ultimately admitted.

[11] The Director of Proceedings charged Dr Liston under ss 91 and 100 of the Health Practitioners Competence Assurance Act 2003 (HPCAA) with acting in a way that amounted to professional misconduct between 2 December 2011 and 29 November 2013 whilst Mr Hindson was in his care.[8] The charge was particularised in detail. I have summarised the particulars as follows:

> (a) On 13 March 2013 having reviewed the pathology results, following Mr Hindson's excisional tongue biopsy completed on 27 February 2013, and after Dr Liston had reviewed the pathology results from that biopsy which included the diagnosis "SQUAMOUS CELL CARCINOMA IN-SITU, INCOMPLETELY EXCISED AT 9 O'CLOCK MARGIN", Dr Liston failed to recommend and/or provide appropriate treatment for Mr Hindson's

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6 At [15].
7 At [17].
8 The charge and its particulars appears in full as an annexure to the Tribunal's decision.

squamous cell carcinoma in situ, in that Dr Liston:

(i) failed to recommend and/or provide re-excision of Mr Hindson's tongue to achieve clear margins; and/or

(ii) failed to recommend referral and/or refer Mr Hindson to a multi-disciplinary team for review and/or management of his squamous cell carcinoma.

(b) On 24 April 2013, having failed to recommend or provide appropriate treatment as set out above, Dr Liston failed to recommend and/or provide appropriate treatment for Mr Hindson's squamous cell carcinoma in-situ, in that he:

(i) failed to recommend and/or undertake no less than six weekly monitoring of Mr Hindson; and/or

(ii) failed to recommend referral and/or refer Mr Hindson to a multi-disciplinary team for review and/or management of his squamous cell carcinoma in-situ.

(c) On 30 October 2013, having reviewed the pathology results following Mr Hindson's excisional biopsy completed on 23 October 2013, and which included the diagnosis: "SQUAMOUS CARCINOMA IN-SITU EXTENDING TO INVOLVE THE RIGHT EXCISION MARGIN", Dr Liston failed to recommend and/or provide appropriate treatment for Mr Hindson's squamous cell carcinoma in-situ, in that he:

(i) failed to recommend and/or provide re-excision of Mr Hindson's tongue to achieve clear margins; and/or

(ii) failed to recommend and /or refer Mr Hindson to a multi-disciplinary team for review and/or management of his squamous cell carcinoma in-situ.

(d) Around 13 March 2013, 24 April 2013, and 30 October 2013, Dr Liston failed to provide adequate and/or accurate information to Mr Hindson about his diagnosis and/or the results of his biopsy procedure and/or his options for treatment and/or failed to take appropriate steps to ensure Mr Hindson understood his diagnosis and/or the results of his biopsy procedure and/or his options for treatment and therefore failed to obtain his informed consent to Dr Liston's plan for his care and/or treatment. In particular Dr Liston:

(i) failed to adequately and/or accurately inform Mr Hindson of his diagnosis following the results of his biopsy procedure and/or failed to take appropriate steps to ensure Mr Hindson understood what his diagnosis was following the results of his biopsy procedure; and/or

(ii) failed to adequately explain to Mr Hindson where his diagnosis fit in the spectrum of disease process from dysplasia through to invasive carcinoma and/or failed to take appropriate steps to ensure Mr Hindson understood where his diagnosis fit in the spectrum of disease process; and/or;

(iii) failed to adequately explain to Mr Hindson and/or take appropriate steps to ensure that Mr Hindson understood what his treatment options were which included re-excision of his tongue to achieve clear margins and/or referral to a multi-disciplinary team for review and/or management; and/or

(iv) failed to adequately explain to Mr Hindson and/or take appropriate steps to ensure that Mr Hindson understood what the risks associated with not re-excising his tongue to achieve clear margins and/or not referring him to a multi-disciplinary team for review and/or

management were, including the risk of Mr Hindson's squamous cell carcinoma in-situ spreading and/or becoming invasive cancer; and/or

(v) failed to adequately explain to Mr Hindson and/or take appropriate steps to ensure that Mr Hindson understood the risks associated with adopting a plan for his care, such as periodic monitoring, including the risk of Mr Hindson's squamous cell carcinoma in-situ spreading and/or becoming invasive cancer.

(e) Between 2 December 2011 and 27 November 2013, Dr Liston failed to keep clear and/or detailed and/or accurate clinical notes of his consultations with Mr Hindson. In particular, the clinical notes lacked appropriate detail regarding:

(i) Mr Hindson's report of symptoms; and/or
(ii) relevant clinical findings from any clinical examination of Mr Hindson and/or your observations of Mr Hindson's clinical presentation; and/or
(iii) Mr Hindson's biopsy results and/or what information was provided to Mr Hindson about those biopsy results; and/or
(iv) any and all treatment options recommended to Mr Hindson and what information Mr Hindson was provided about those treatment options including what risks and benefits were discussed; and/or
(v) what decisions were made about treatment and/or what treatment was provided to Mr Hindson.

(f) Around 14 December 2011, 27 February 2013, and 23 October 2013 Dr Liston failed to keep a clear and/or detailed operative note of the biopsy procedure he performed on Mr Hindson's tongue. In particular, the operative notes lacked appropriate detail regarding:

(i) the appearance of the lesion to be biopsied; and/or
(ii) how much of the lesion was removed during the biopsy; and/or
(iii) whether a margin had been taken around the lesion and if so how wide a margin was taken; and/or
(iv) where the biopsied sample was taken from and/or any information about markings made on the sample to guide orientation of the biopsied lesion.

[12] The above particulars were alleged to amount to professional misconduct. Dr Liston initially defended the charge but at the hearing admitted that, the particulars set out at (a) to (d) separately constituted misconduct, and the particulars set out at (e) and (f) cumulatively constituted misconduct.

[13] Although Dr Liston accepted the particularised conduct amounted to professional misconduct because it involved negligence or malpractice bringing discredit to the dental profession, the Tribunal proceeded to make its own assessment despite the agreement between the parties.[9]

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9 *Director of Proceedings v Liston,* above n 1, at [23]. The Tribunal earlier recorded (at [2] and [4]) that as a result of the concessions made by Dr Liston, the Director of Proceedings had withdrawn one of the particulars.

Tribunal's decision

[14] The Tribunal proceeded on the basis of a number of statements of evidence. Dr Jacobus Erasmus, a specialist oral and maxillofacial surgeon, gave expert testimony about the consequence of the re-excision not being carried out in a timely manner.

[15] Dr Francis Rawlinson, psychiatrist and Chief Medical Officer at the Whanganui District Health Board, was called by Dr Liston. Dr Rawlinson's oral evidence addressed the circumstances in which Dr Liston performed his oral and maxillofacial duties. Dr Rawlinson was the only witness to be cross-examined.

[16] Having set out the factual background to the charges, the Tribunal found "unquestionabl[e] negligence" in Dr Liston's reading of the biopsy reports and the multiple failures described in the particulars.[10] The conduct was also found to amount to "malpractice" in terms of the authorities, and to have brought discredit to the dental profession.[11] The charge and its particulars having been made out, and warranting disciplinary sanction, the Tribunal turned to the issue of penalty.

[17] Following its consideration of the principles applicable to the imposition of a penalty and the evidence bearing on Dr Liston's work environment at the hospital and the "pressures and stresses" he was under at the time, the Tribunal concluded significant allowance should be made for those factors and the limited resources available to Dr Liston.[12] It recommended that the DHB put in place resources and facilities to support Dr Liston in the discharge of his clinical role.[13]

[18] Ultimately the Tribunal regarded the situation as a "one-off" and that the sequence of negligent acts and malpractice in relation to a single patient were explicable to a degree by "mental block".[14] The Tribunal rejected the suggestion of a full competency review or supervision.[15] An inability to read biopsy results properly

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10 At [23].
11 At [23].
12 At [34].
13 At [35].
14 At [38].
15 At [40].

had been demonstrated in the particular case but there was no broader demonstrated failure in practice necessitating supervision.[16]

[19] An order for censure reflected the Tribunal's "significant disquiet" at the events and the distressing consequences Dr Liston had occasioned for Mr Hindson.[17] The Tribunal considered merely censuring Dr Liston would be to send the wrong message. His failures were significant acts and omissions. They brought significant discredit to the dental profession. A deterrence factor was to be built into the penalties not only for Dr Liston but for the whole of the profession. Having considered the relevant cases, the Tribunal concluded the correct level of fine to be $5,000.[18]

[20] Dr Liston was ordered to pay a 30 per cent contribution towards costs totalling $21,000. The Tribunal recommended that the DHB put in place certain resources and facilities to enhance Dr Liston's work environment at the hospital. Finally, the Tribunal directed publication of its decision on the Tribunal's website and requested the Dental Council of New Zealand to either publish a summary of the Tribunal's decision or include a reference to it in the Council's next available publication.

The appeal

[21] Dr Liston appeals the Tribunal's imposition of a fine. The grounds for Dr Liston's appeal are set out in his notice of appeal:

> (a) The imposition of a fine was unreasonable and excessive;
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> (b) The Tribunal failed to consider the harm and damage (penalty) the appellant had already incurred as a consequence of this matter and in particular the adverse publicity he had already incurred and would continue to incur as a result of the disciplinary hearing;
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> (c) The Tribunal overstated the extent or significance of the acts and omissions on the part of the appellant;
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> (d) It wrongly minimised peer reviewed specialist opinion as to the frequency of misdiagnosis and misinterpretation of biopsy results; and
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> (e) It failed to adequately consider the context within which the omissions and acts occurred including the lack of adequate resourcing and

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16 At [42].
17 At [46].
18 At [47].

> support available to the appellant at the Whanganui DHB and the related work/time pressures he was under as a consequence.

[22] Dr Liston seeks an order quashing the $5,000 fine.[19]

[23] The Director of Proceedings views the penalty decision as an orthodox exercise of the Tribunal's discretion. The professional conduct in this case was significant, serious and sustained. The penalty imposed, including the fine, was commensurate with the Tribunal's assessment of the "sequence of negligent and malpractice acts" committed by Dr Liston and with comparable cases. Counsel for the Director of Proceedings, Ms Preston, submitted the penalty was arguably lenient considering Dr Liston's malpractice viewed in light of comparable cases.

Approach to an appeal

[24] This is an appeal under s 106 of the HPCAA. Section 106(2)(b) confers a right to appeal to the High Court against any part of a penalty order made by the Tribunal under s 101 of the HPCAA.

[25] Decisions of the High Court in the past decade reflect divergent views as to the correct approach to appeals against penalty decisions under the HPCAA. In *Sisson v Standards Committee (2) of the Canterbury-Westland Branch of the New Zealand Law Society* a Full Court of the High Court considered the division of opinion that flowed "from the difficulty in applying *Austin, Nichols & Co Inc v Stichting Lodestar*" to disciplinary appeals.[20]

[26] It is unnecessary to canvass the competing arguments. Downs J undertook that exercise in *Emmerson v A Professional Conduct Committee Appointed by the Medical Council of New Zealand*.[21] Downs J preferred an approach to penalty appeals which is analogous to the approach to an appeal against sentence. In both contexts, a range of options is available to the decision-maker "who must settle on one that best reflects

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19 A challenge was made to the recommendations made by the Tribunal but that challenge was withdrawn at the hearing.

20 *Sisson v Standards Committee (2) of the Canterbury-Westland Branch of the New Zealand Law Society* [2013] NZHC 349, [2013] NZAR 416 at [15]. Referring to *Austin, Nichols & Co Inc v Stichting Lodestar* [2007] NZSC 103, [2008] 2 NZLR 141.

21 *Emmerson v A Professional Conduct Committee Appointed by the Medical Council of New Zealand* [2017] NZHC 2847 at [86]–[97].

the various purposes and principles underlying the assessment".[22] In both contexts, consistency with other cases is important. His Honour considered that categorising a penalty appeal as an appeal against discretion does not relieve the disciplinary tribunal of its duty to impose a penalty in accordance with principle.[23] If the Tribunal reached a decision that is plainly wrong the appellate Court, applying the appellate principles confirmed in *May v May*[24], would be expected to correct the error.[25]

[27] Notwithstanding his analysis and preference for an approach that recognises a penalty appeal is from the exercise of a discretion, Downs J concluded, "with considerable reluctance", the penalty appeal before him was to be approached, as required by binding authority, as a general appeal to which *Austin, Nichols* applies.[26]

[28] Thus, the approach to penalty appeals under the HPCAA is as set out in *Sisson*:[27]

> … both misconduct findings, and the resulting penalty decision, require an assessment of fact and degree and entail a value judgment; such that it is incumbent upon the appellate Court to reach its own view on both aspects.

[29] Accordingly, in respect of this appeal:[28]

(a) The appeal court has the responsibility of arriving at its own assessment of the merits of the case.[29] The weight to be given to the reasoning of the Tribunal below is a matter for the appellate court's assessment.[30] Where the Tribunal appealed from has a particular expertise the appellate court may rightly hesitate to conclude findings of fact or fact or degree are wrong.[31]

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22 At [93].
23 At [95].
24 *May v May* [1982] 1 NZFLR 165 (CA).
25 *Emmerson v A Professional Conduct Committee Appointed by the Medical Council of New* Zealand, above n 21, at [95].
26 At [96].
27 *Sisson v Standards Committee (2) of the Canterbury-Westland Branch of the New Zealand Law Society*, above n 20, at [15].
28 Applying the approach which the Supreme Court commended in *Austin, Nichols & Co Inc v Stichting Lodestar*, above n 20, and elaborated in *Kacem v Bashir* [2010] NZSC 112, [2011] 2 NZLR 1.
29 *Austin, Nichols & Co Inc v Stichting Lodestar*, above n 20, at [5].
30 *Kacem v Bashir*, above n 28, at [31].
31 *Austin, Nichols & Co Inc v Stichting Lodestar*, above n 20, at [5].

(b) But if the appellate court reaches a different view from the Tribunal appealed from the appellate court must act on its own view.[32]

(c) The appellate court may confirm, reverse or modify the decision or order appealed against.[33]

Principles guiding imposition of penalty

[30] The principal purpose of the HPCAA is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.[34] To achieve that purpose, the HPCAA provides a consistent accountability regime for all health professionals.[35] Part 4 of the HPCAA provides for mechanisms by which complaints are investigated. The Tribunal is established pursuant to s 84. One of its functions is to hear and determine charges against health practitioners.[36]

[31] The Tribunal may penalise a practitioner if, among other things, it finds the practitioner is guilty of professional misconduct because of any act or omission that:[37]

(a) amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered;[38] or

(b) has brought or was likely to bring discredit to the profession that the health practitioner practised.[39]

[32] Where the Tribunal finds a health practitioner has been guilty of professional misconduct the Tribunal may:[40]

(a) cancel a health practitioner's registration;

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32 At [3].
33 Health Practitioners Competence Assurance Act 2003, s 109(3)(a).
34 Section 3(1).
35 Section 3(2).
36 Section 85(a).
37 Section 100.
38 Section 100 (1)(a).
39 Section 100(1)(b).
40 Section 101.

(b) suspend registration for a period not exceeding three years;

(c) impose conditions on practice for a period not exceeding three years;

(d) censure the practitioner;

(e) impose a fine not exceeding $30,000; and

(f) order the practitioner to pay all or part of a costs award.

[33] Importantly, while the work of the Tribunal resembles, in many respects, the courts' criminal processes, medical disciplinary proceedings are not criminal in nature. Their purpose is not to punish but to ensure appropriate standards of conduct in the medical profession.[41]

[34] In *Roberts v Professional Conduct Committee*, Collins J drew from the authorities eight factors that are relevant to the Tribunal's consideration of an appropriate penalty.[42] In *Katamat v Professional Conduct Committee* the "*Roberts* factors" were summarised in the following way:[43]

> [The factors] are which penalty:
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> (a) most appropriately protects the public and deters others;
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> (b) facilitates the Tribunal's important role in setting professional standards;
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> (c) punishes the practitioner;
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> (d) allows for the rehabilitation of the health practitioner;
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> (e) promotes consistency with penalties in similar cases;
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> (f) reflects the seriousness of the misconduct;
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> (g) is the least restrictive penalty appropriate in the circumstances; and

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41 *Complaints Assessment Committee v Medical Practitioners Disciplinary Tribunal* [2006] NZSC 48, [2006] 3 NZLR 577 at [102] and *Z v Dental Complaints Assessment Committee* [2008] NZSC 55, [2009] 1 NZLR 1 at [97].

42 *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 3354 at [44]–[51].

43 *Katamat v Professional Conduct Committee* [2012] NZHC 1633 at [49].

(h) looked at overall, is the penalty which is 'fair, reasonable and proportionate in the circumstances'.

[35] The characterisation of a fine as punitive ((c) above) is discussed below at [63]–[67].

Assessment of grounds of appeal

[36] The organisation of this part of my judgment reflects the heads of argument under which, in his written and oral submissions, Mr Waalkens QC advanced his client's appeal.

First head: 'Significance' or 'seriousness' of the acts and omissions

[37] Dr Liston accepts his acts and omissions were sufficiently serious to warrant disciplinary sanction and that the high disciplinary threshold for a finding of professional misconduct had been met. But he argues the Tribunal identified no aggravating features relating to his conduct. Beyond its broad categorisation of conduct as 'significant' the Tribunal gave inadequate (if any) consideration to where Dr Liston's case fell on a broad spectrum of seriousness.

[38] Mr Waalkens submitted penalties should reflect a wide range of potential offending. At the lowest end of the range are the "human error" or "clinical misjudgement" cases, such as Dr Liston's. Mr Waalkens expressed surprise the Tribunal had imposed any fine given it had identified no aggravating features elevating the seriousness of the case. In reliance on the decision of Simon France J in *Vatsyayann v Professional Conduct Committee* Mr Waalkens submitted something more than a breach of professional standards was necessary.[44] The threshold is "high". The Tribunal's finding attracts stigma which itself constitutes a significant penalty.

[39] The passage from *Vatsyayann* upon which Mr Waalkens places particular reliance follows:

> [8] Generally in terms of the approach to be taken, I observe that it is plain that something more than a breach of acceptable standards is required, because

[44] *Vatsyayann v Professional Conduct Committee* HC Wellington CIV-2009-485-259, 14 August 2009.

> otherwise there would be no need for step 2. It is also plain that the breach must be of sufficient significance to merit recording a finding of professional misconduct against the practitioner. It is important to bear in mind that it is a finding that carries stigma, and represents a message about the person's conduct of their professional responsibilities that will be keenly felt by the person, and noted by his or her peers.

[40] I do not take Simon France J's observations as indicating a requirement that professional misconduct must be serious, or at the upper range of offending, to attract a penalty.

[41] The two-stage test stated in *F v Medical Practitioners Disciplinary Tribunal*,[45] which Simon France J accepted was applicable to the case before him,[46] is a test for whether a disciplinary finding is merited not a test for the assessment of penalty once a finding is made.

[42] The two-stage test for a disciplinary finding which the Court of Appeal approved in *F v Medical Practitioners Disciplinary Tribunal* was articulated by Venning J in *McKenzie v Medical Practitioners Disciplinary Tribunal*:[47]

> In summary, the test for whether a disciplinary finding is merited is a two-stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in a consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner.

[43] In *Vatsyayann*, the parties were at odds over the conduct required to meet the second stage of the two-stage process.[48] Simon France J's view of the facts of the case was such that he considered the debate was unlikely to affect the outcome. It was therefore unnecessary to consider the cases in further detail.[49] The Judge's paragraph [8] on which Mr Waalkens relies contains the test for determining whether

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45 *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA) at [54] and [80].
46 *Vatsyayann v Professional Conduct* Committee, above n 44, at [5].
47 *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC) at [71].
48 *Vatsyayann v Professional Conduct* Committee, above n 44, at [6].
49 At [8].

a disciplinary finding is merited. It is not directed to any question about the nature of any penalty.

[44] As Ms Preston submitted, recent authorities recognise that the threshold for imposition of a penalty is not unduly high. The breach must be of sufficient significance to merit a finding of professional conduct against the practitioner.[50]

[45] Conduct amounting to negligence or malpractice is behaviour which falls seriously short of acceptable practice. Turning to the facts of this case, negligence and malpractice were established. Mere inadvertence, or oversight, even carelessness will not in every context constitute conduct falling "seriously" short. But such human error did not account for Dr Liston's repeated failure to respond to the clear pathology results following the second excisional biopsy. Eight months later the lesion was incompletely excised because it had reappeared again. There was further delay between March and October 2013 when Dr Liston was fully furnished with accurate information.

[46] The particulars of the professional misconduct charge disclosed multiple failures of care and practice across different areas of practice including Dr Liston's responses to adverse pathology results, maintenance of adequate and legible clinical notes and informed consent. The Tribunal observed Dr Liston's acts were "significant" and brought "significant" discredit to the dental profession;[51] the misreading and failures to recommend are "serious matters" and for misinterpretation to have happened on two occasions only "aggravates" that.[52] I do not consider the Tribunal erred in its assessment of the seriousness of Dr Liston's errors.

[47] Nor did the Tribunal err in its approach to conceiving the seriousness of the acts and omissions. The Director had referred to multiple aggravating features but the Tribunal considered those features were already at the heart of the charge admitted by Dr Liston and found by the Tribunal to be made out.[53]

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50 See *Johns v Director of Proceedings* [2017] NZHC 2843 at [82] per Moore J affirming the approach set out by Courtney J in *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [30]–[31] as correct in the New Zealand context.

51 *Director of Proceedings v Liston*, above n 1, at [47].

52 At [36].

53 At [25].

[48] I am satisfied the Tribunal neither double-counted any aggravating feature nor overstated the seriousness of Dr Liston's misconduct.

Second head: mitigating features

[49] Mr Waalkens argued the Tribunal gave insufficient weight to numerous mitigating features of the case.

Dental unit environment

[50] Mr Waalkens emphasised the under-resourcing of the Whanganui DHB. He argued the "significant allowance" which the Tribunal said should be made for the pressures and stresses Dr Liston experienced, and the "limited resources" available to him, was not reflected in the penalty.

[51] For four years there was no oral surgeon in Whanganui at all. Dr Liston travels from New Plymouth to Whanganui to provide the service twice a week. Dr Rawlinson described the dental unit as "a physical small space" and a "very busy unit" with staffing shortage difficulties. Dr Liston is the only oral and maxillofacial surgeon and his work is "critical" to the unit although he is based with the Taranaki District Health Board. Importantly, Dr Rawlinson accepted that the lack of support had allowed the situation with regard to Mr Hinton's care to develop.

[52] Given all the circumstances outlined by Dr Rawlinson, and recognising the important role Dr Liston fulfilled in the community, and that the situation was a "one-off", the Tribunal:[54]

(a) made recommendations directed at the DHB putting resources and facilities in place;[55]

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54 At [34]–[35].
55 At [35].

(b) decided not to suspend Dr Liston because, while misreading of biopsy reports and failures in follow-up "are serious matters", suspension would be "excess to the requirements of the circumstance";[56] and

(c) declined to impose either of the conditions proposed by the Director (for full competency review or supervision).[57]

[53] The fact Dr Liston misread biopsy reports and failed to make appropriate recommendations for care on two occasions aggravated the charge. The Tribunal suggested suspension might well be an appropriate response but, in Dr Liston's case, was not necessary. It is apparent from the Tribunal's rejection of penalties proposed by the Director of Proceedings, and the Tribunal's reasons for doing so, that it made significant allowance for Dr Liston's circumstances.

Dr Liston's apology and admission of the charge

[54] It is said the Tribunal failed to acknowledge Dr Liston's apology to Mr Hindson, and Dr Liston's admission of the charge against him. The submission is contradicted by the decision itself. The Tribunal expressly considered the submission on behalf of the Director that his offer of an apology to Mr Hindson should be considered in mitigation of his conduct when considering a penalty.[58] On more than one occasion the Tribunal referred to Dr Liston's admission of the charge and specifically took it into account in considering costs. The Tribunal stated it was to Dr Liston's credit that he accepted his conduct amounted to negligence or malpractice bringing discredit to the dental profession although the acceptance and concession came at a late stage.[59]

Harm to Dr Liston from adverse publicity

[55] Mr Waalkens contended the Tribunal failed to give any consideration to the harm Dr Liston had already suffered as a result of the adverse determination itself

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56 At [36].
57 At [40].
58 At [25].
59 At [22].

together with censure, the costs award, publication of his name and the punitive impact of the disciplinary process. Seven articles in newspapers were published in relation to Dr Liston. Dr Liston lost the opportunity to tell his children, one of whom has autism, about the disciplinary process.

[56] I accept that refusal of name suppression is very much part of the total penalty.[60] The Tribunal was mindful of the likely impact of publication and took into account the consequences for Dr Liston in the publication of his name. Specifically, the Tribunal took into account the likely monetary consequences to Dr Liston from publication of his name and reduced by 20 per cent the contribution to costs he would otherwise be expected to make.[61] While the point may be taken that the consequences of publication became relevant to the Tribunal's consideration of costs, not its assessment of penalty, I think any such point becomes technical and without merit in light of the fact Dr Liston did not seek any order for permanent name suppression when interim orders lapsed.

Frequency of misdiagnoses

[57] The argument is that the Tribunal unfairly rejected, and therefore failed to take into consideration, an important mitigating factor regarding the prevalence of the type of mistake Dr Liston made.

[58] During the Tribunal hearing Dr Liston produced a paper referring to the frequency of outpatient diagnostic errors in the United States. The paper was published in the British Medical Journal. Apparently, statistics from the report were argued by Dr Liston as supporting the submission that his failure in this case could not be characterised as unusual and that, in fixing penalty, the Tribunal should take account of the frequency of misdiagnoses. In its decision the Tribunal stated: [62]

> The Tribunal has not had any help from that article. It was written in the Unites States situation. Even if there may have been a frequency of misdiagnosis that does not excuse Dr Liston in this circumstance. The individual particulars and facts must be taken into account. There is [a] significant difference between strict misdiagnosis on the one hand and

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60 *J v Director of Proceedings* HC Auckland CIV-2006-404-2188, 17 October 2006 at [52].
61 *Director of Proceedings v Liston*, above n 1, at [49].
62 At [27].

> negligent reading of biopsy results and failure to advise adequately on the other.

[59] Mr Waalkens submitted the Tribunal gave no reason why it regarded the article as unhelpful and submitted the Tribunal was wrong to put the article to one side. The paper was fully peer reviewed. It behoved the Tribunal to recognise that mistakes do happen.

[60] Ms Preston critically considered the article. The studies looked at diagnostic errors significantly different from those before the Tribunal. The studies were focused on primary health care providers, not specialists, and related to misdiagnoses based on symptomology and 'red flags', not in the face of a clear diagnosis provided in a report, such as occurred, twice, in Dr Liston's case. The error rate for misdiagnosis in the cancer studies was well below 0.05 per cent. In addition, there was no indication of misdiagnosis on two separate occasions.

[61] The first point is that the Tribunal did state its reasons for not finding the paper to be of assistance. But the key point is that the paper's focus was on misdiagnoses. Dr Liston's professional misconduct involved repeated and fundamental failures to read and act on clear and concise pathology results and diagnostic findings. Dr Liston's lapses did not involve diagnostic error.

[62] Even without Ms Preston's assiduous analysis Mr Waalkens has not shown the Tribunal was wrong to dismiss the paper as unhelpful to the circumstances before it and the assessment it was required to make.

Deterrence and the punitive nature of a fine

[63] Mr Waalkens submitted the imposition of a fine, in addition to other penalties, had the erroneous purpose of punishing Dr Liston. Mr Waalkens reiterated the point he made to the Tribunal: "registered practitioners hardly need to be deterred from making diagnostic errors" by the imposition of penalty orders additional to censure and costs.

[64] Putting to one side (again), that the malpractice in this case did not involve diagnostic error, the factors relevant to a consideration of an appropriate penalty are

those which Collins J drew from the authorities which he discussed in *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand*.[63]

[65] Regarding the "punitive" nature of penalties Collins J said:[64]

> …it is also important to recognise that penalties imposed by the Tribunal may have a punitive function. I accept that punishment is often reviewed as a by-product of the penalties imposed by the Tribunal and that protecting the public and setting professional standards are the most important factors for the Tribunal to bear in mind when setting a penalty. However, where the Tribunal imposes a fine or censure it normally does so in order to punish the health professional.

[66] Collins J's recognition of a punitive aspect to the imposition of penalties was discussed in *Singh v Director of Proceedings*[65] in which Ellis J expressed reservation about the correctness of the summary in *Katamat*.[66] On Ellis J's reading of *Roberts* "Collins J did not say that punishment was a necessary focus of the disciplinary penalty exercise".[67]

[67] In my view the key point about the punitive dimension in penalties ordered against practitioners is that a punitive component is somewhat inherent. In a sense, that is signalled by the heading to s 101 of the HPCAA. Section 101 is headed "Penalties" (not some more neutral heading such as "Orders").

[68] More importantly, however, it is widely accepted that disciplinary proceedings necessarily have a punitive effect notwithstanding the overarching purpose of the HPCAA, which is the protection of the public.[68]

[69] In the immediate case the Tribunal was not intending to punish Dr Liston through the imposition of a fine. That is plain from its decision. The significant acts and omissions and misconduct were said to "bring significant discredit" to the dental

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63 *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand*, above n 42, at [44]–[51.

64 At [46].

65 *Singh v Director of Proceedings* [2014] NZHC 2848.

66 *Katamat v Professional Conduct Committee*, above n 43, in which the "*Roberts* factors" were summarised. See [34] above.

67 At [57].

68 See for example *Johns v Director of Proceedings*, above n 50, at [146].

profession and "there must be a deterrent factor built into the penalties ordered not only for Dr Liston but also for the whole of this profession".[69]

[70] I have found helpful as well the transcript of the hearing and the delivery of the Tribunal's decision on penalty. The Chair expressed to Dr Liston the Tribunal's concerns for his predicament and said it was "mindful" of the consequences for him. While there would be no order for suspension –

> … the message needs to be sent to the public and to the profession, and indeed to Dr Liston himself, that this behaviour is not acceptable so there will be an order that he pay a fine of $5,000. That may not sound like much to the public or to you, Mr Hindson, having regard to what is perceived to be the income received from dental practitioners, but that is a sum which has regard to all of the factors including the maximum fine order that could be made and including all of the other cases that have been taken into account.

[71] I am satisfied the Tribunal's imposition of the $5,000 fine:

(a) was directed towards protection of the public;[70]

(b) was intended to emphasise the importance of professional standards;[71]

(c) reserved the maximum penalty for the worst offences;[72]

(d) was the least restrictive penalty in the circumstances;[73] and

(e) was fair reasonable and proportionate in the circumstances.[74]

[72] I turn now to Mr Waalkens final head of argument.

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69 *Director of Proceedings v Liston*, above n 1, at [47].
70 *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand*, above n 42, at [44].
71 At [45].
72 At [49].
73 At [50].
74 At [51].

Third head of argument: consistency with comparable cases

[73] The primary submission is that the decision to impose a fine was inconsistent with other cases referred to the Tribunal involving similar conduct. The further submission is that the Tribunal did not refer to, or adequately consider, any of the cases which counsel for either party had submitted were relevant or undertake any comparison. Had it done so, it would have been "abundantly clear" that a fine in all the circumstances, was excessive.

[74] I have considered the 13 cases summarised in Mr Waalkens' written submissions.[75] All but three of the cases were summarised in an appendix of comparable cases which counsel for the Director of Proceedings handed to the Tribunal during the penalty hearing.[76] The Tribunal noted its attention had been "helpfully" drawn to comparable cases and that the Director suggested a fine in the range of $5000–$7,500 was considered appropriate in comparable cases.[77] As well, the transcript shows that when the Tribunal gave its decision and addressed Dr Liston the Chair said the $5,000 sum was reached having regard to all factors including the maximum fine for which an order could be made and including "all of the other cases that have been taken into account".

[75] The only other reference in the Tribunal's decision to cases is at [49]. There, in considering costs, the Tribunal records its consideration of the cases referred to by the parties. To the extent Mr Waalkens submits that, on its face, the Tribunal's decision does not reveal specific engagement with comparable cases, Mr Waalkens is correct. From my review of the decisions referred to me, however, that seems to be par for the

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75 *Director of Proceedings v Bhatia* NZHPDT 77/Med06/39D, 12 February 2007.
Director of Proceedings v S NZHPDT 50/Med06/28D, 31 August 2006.
Director of Proceedings v Johri NZHPDT 54/Med06/33D, 25 July 2006.
Director of Proceedings v H NZHPDT 946/Med17/378D, 5 February 2018.
Director of Proceedings v Vatsyayann NZHPDT 428/Med10/170D, 21 December 2011.
Director of Proceedings v S NZHPDT 809/Med15/318D, 16 May 2016.
Director of Proceedings v Parry 139/00/62D, 31 October 2000.
Perera v Medical Practitioners Disciplinary Tribunal DC Whangarei MA94/02, 10 June 2004
Professional Conduct Committee v White NZHPDT 525/Opt12/220P, 8 April 2013.
Director of Proceedings v Harrild NZMPDT 176/01/70D, 26 October 2001.
Martin v Director of Proceedings [2010] NZAR 333 (HC).
Professional Conduct Committee v U NZHPDT 699/Med14/298P, 4 April 2015.
Professional Conduct Committee v Goff NZHPDT 890/Mid16/373D, 30 May 2017.

76 The appendix was also included in the Agreed Bundle of Documents prepared for this appeal.

77 *Director of Proceedings v Liston*, above n 1, at [25].

course. Ideally, the Tribunal's decisions would reveal something of the comparative exercise in which it has engaged to ensure comparability of penalties in comparable circumstances but in the resource-stretched world in which such bodies operate that is an unrealistic expectation. The real task for the Tribunal is to "strive to ensure" comparability of penalties in comparable circumstances.[78]

[76] An appeal court will be concerned to assess parity for itself notwithstanding the Tribunal's own approach to comparability which may or may not be apparent from its decision. I am satisfied that the imposition of the fine itself, and its quantum, was not out of step with penalties imposed in similar circumstances.

[77] The Tribunal's decisions reveal, unsurprisingly, innumerable differing circumstances: whether in the gravity of the offending; the presence of mitigating factors; the utility of particular orders under the HPCAA; the period of time over which the practitioner exercised responsibility in respect of a patient; whether the practitioner was part of a team or acted alone; the nature of the detriment to a patient from the professional misconduct; and so on.

[78] Fines of a similar or identical amount to that which Dr Liston was ordered to pay have been imposed in circumstances which may suggest more egregious conduct than Dr Liston's, or more serious outcomes, but the fines were imposed under a statutory regime that allowed a maximum fine of $20,000.[79]

[79] In other cases, which Mr Waalkens submits reflect a complete lack of care by the professional, there has been an order for costs and censure but no fine. I note, however, in *Director of Proceedings v S* the Tribunal said the doctor was not to be criticised for failing to diagnose a notoriously difficult cancer.[80] I regard that case as dissimilar to the present case in which Dr Liston was criticised for repeatedly failing to take appropriate steps after being provided with clear histological results.

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78 *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand*, above n 42, at [48].

79 For example, *Director of Proceedings v Harrild* NZMPDT 176/01/70D, 26 October 2001 and *Director of Proceedings v Bhatia* NZHPDT 77/Med06/39D, 12 February 2007.

80 *Director of Proceedings v S* NZHPDT 50/Med06/28D, 31 August 2006 at [3].

[80] Dr Liston has not shown that the imposition of a $5,000 fine in the context of his professional misconduct lacked parity with comparable cases.

Result

[81] The appeal is dismissed.

[82] The Director of Proceedings is entitled to costs on a 2B basis. If the parties are unable to agree costs, memoranda may be filed. Memoranda should be brief and focused.

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Karen Clark J

Solicitors:
DLA Piper, Wellington for Appellant