NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO:	**1298/Med22/554D**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**DIRECTOR OF PROCEEDINGS** designated under the Health and Disability Commissioner Act 1994
	Applicant
AND	**DR NELSON NAGOOR**, formerly of Invercargill, now of South Africa, Registered Medical Practitioner
	Practitioner

HEARING	Held in Invercargill 26 and 27 October 2022 and by AVL hearing on 23 November 2022
TRIBUNAL	Ms A J Douglass (Chair) Mr T Burns, Dr J McKenzie, Dr W Rainger and Dr K Good (Members)
IN ATTENDANCE	Ms D Gainey, Executive Officer
APPEARANCES	Ms J Herschell and Ms K Corbett for the Director of Proceedings Mr A Holloway for the Practitioner

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DECISION OF THE TRIBUNAL

Dated this 17th day of March 2023

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Introduction

[1] This case concerns the clinical care of Mr Joshua Linder by his General Practitioner (GP), Dr Nelson Nagoor between April and August 2019 regarding a melanoma skin cancer on Mr Linder's back.

[2] Dr Nagoor is a registered medical practitioner. He faces one Charge of professional conduct with four particulars (the Charge).

[3] At the time of these events during 2019 Dr Nagoor was working as a GP at a community practice in Invercargill, He Puna Waiora Wellness Centre (Ngā Kete).[1] Dr Nagoor has since returned to live in South Africa.

[4] The Director of Proceedings (the Director) says that Dr Nagoor failed in his care of Mr Linder following the removal of a lesion (mole) on Mr Linder's back. Despite receiving a histology report that the lesion was an invasive primary melanoma with superficial spreading and that the report recommended a wider excision, Dr Nagoor did not act on this report. The Director says that Dr Nagoor did not inform Mr Linder of the histology results, and that he did not perform a further excision or to make a referral to a specialist.

[5] Mr Linder did not become aware of his diagnosis until almost six months after his first consultation with Dr Nagoor. Sadly, Mr Linder died on 28 June 2022 as a consequence of the melanoma.

[6] The Director says that Dr Nagoor's omissions in the care of Mr Linder is conduct that is both negligence and / or malpractice in his scope of practice and that he has brought discredit to the medical profession under ss 100(1)(a) and (b) of the Health Practitioners Competence Assurance Act 2003 (the Act).

[1] Ngā Kete is the Ngā Kete Matauranga Pounamu Charitable Trust's He Puna Waiora Wellness Centre, a community primary care provider based in Invercargill.

[7] Dr Nagoor did not attend the hearing. However, he has filed an affidavit[2] and he was represented by counsel.

[8] Dr Nagoor now accepts that his conduct as described and that most of the particulars of the Charge amount to professional misconduct. Nonetheless, it is for the Tribunal to consider all of the evidence to determine whether the Charge of professional misconduct has been established.

[9] Following the liability hearing in Invercargill on 27 and 28 October 2022, the Tribunal reconvened by way of Audio-Visual Link (AVL) for a penalty hearing on 23 November 2022.

[10] The reasons for our decision in respect of liability and penalty are set out below.

The Charge

[11] The Charge and four particulars are set out in the Schedule to this decision.

[12] Particular 1 alleges that on or about 17 April 2019 Dr Nagoor failed in his care of Mr Linder in that he did not take steps to contact Mr Linder to advise him about the histology report and / or to arrange an in-person consultation with Mr Linder following the excision of the lesion in which the histology report included a diagnosis of "primary melanoma, invasive".

[13] Particular 2 alleges that on 30 April 2019 on a follow-up appointment with Mr Linder that Dr Nagoor failed to advise Mr Linder about the diagnosis contained in the histology report and to inform him that the lesion was cancerous (particular 2(a)). It goes further and alleges that Dr Nagoor advised Mr Linder that the lesion was not cancer (particular 2(b)), that Dr Nagoor failed to advise Mr Linder that a wider incision was recommended (particular2(c)) and that Dr Nagoor documented in Mr Linder's clinical notes that "At this stage no further excision to be done" despite the histology report and the applicable clinical guidelines recommending a wide incision (particular 2(d)). Dr Nagoor failed to refer Mr Linder for further specialist assessment, management and treatment in respect of his melanoma

[2] Document 9, Affidavit of Dr Nelson Nagoor dated 20 October 2022.

(particular 2(e)) and, in the alternative, if there was a discussion about such a referral then Dr Nagoor failed to document this discussion (particular 2(f)).

[14] In particular 3, the Director says that on or around 17 April 2019 and up until 2 August 2019 Dr Nagoor failed to adequately communicate to Mr Linder that he had an advanced aggressive form of melanoma cancer.

[15] Particular 4 concerns the review undertaken by Dr Nagoor on 2 August 2019 in which the Director says he failed in his care to refer Mr Linder for specialist assessment, reviews and clinical examinations, including performing a "top to toe" skin check.

Background facts

[16] The following summary of the background facts is taken from the affidavit evidence of Dr Nagoor, the Director's witnesses and the clinical notes.

[17] On 5 April 2019 Mr Linder presented to Ngā Kete for the first time.[3] At the time, Mr Linder was working full time at Farmers, Invercargill as a general sales assistant.

[18] Mr Linder was seen bya Nurse [Nurse E], who assessed a mole on Mr Linder's back that he was concerned about. Nurse [E] noted that it was a very suspicious lesion, documented that it might be a melanoma, and arranged for an urgent revision of the mole by a doctor the same day.[4]

[19] Later that day, Mr Linder was reviewed by Dr Nagoor. Mr Linder asked Dr Nagoor outright whether his mole was cancer.[5] Dr Nagoor wrote in a clinical note that the mole was large and dark in colour, and had grown rapidly. His working diagnosis was keratoacanthoma, a skin tumour that can occur on sun-exposed areas.[6]

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3 Bundle of documents (Bundle), Tab 5, pp 27-28.
4 Affidavit of [Ms E] at [9].
5 Affidavit of Joshua Linder at [11].
6 Keratoacanthoma is a common, rapidly growing, locally destructive skin tumour.

[20] During the appointment, they discussed having the mole removed. Dr Nagoor offered to remove the lesion at Ngā Kete. Mr Linder signed a "consent for minor surgery" form, and agreed to Dr Nagoor removing the mole.[7]

[21] On 12 April 2019 Mr Linder returned to Ngā Kete. Dr Nagoor undertook the surgery by excising the lesion. He was assisted by Nurse [E].[8]

[22] Later that day Dr Nagoor sent a request to the laboratory for histology of the lesion.

[23] On 15 April 2019, Mr Linder returned to Ngā Kete for a review of his wound and a dressing change, which was performed by Nurse [E].[9]

[24] On 17 April 2019, the histology report was received by Ngā Kete.[10] The report stated that the diagnosis was a primary melanoma, invasive, with a sub-type of superficial spreading melanoma. The report recommended that a wider excision be completed.[11]

[25] On 26 April 2019 Mr Linder returned to Ngā Kete as scheduled for removal of alternate sutures by Nurse [E]. Nurse [E] noted that the wound was healing very well.[12] She asked Mr Linder whether he had heard anything from Dr Nagoor about his results. He advised Nurse [E] he had not, she attempted to arrange for him to see Dr Nagoor that day and when that was not possible, made an appointment for Mr Linder with Dr Nagoor on 30 April 2019.[13]

[26] On 30 April 2019 Mr Linder returned to Ngā Kete. He was seen by Dr Nagoor who recorded that Mr Linder's wound looked clean and was healing well.[14]

[27] On 2 August 2019 Mr Linder attended Ngā Kete for a review of the wound by Dr Nagoor.

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7 Bundle, Tab 5, p 23.
8 Bundle, Tab 5, p 27.
9 Bundle, Tab 5, pp 26-27.
10 Bundle, Document 8, p 45, Screen shot received from Ngā Kete showing that Dr Nagoor was the last person to view Mr Linder's test results on 18 April 2019.
11 Bundle, Tab 5, p 30.
12 Bundle, Tab 5, p 26.
13 Affidavit of [Ms E] at [16].
14 Bundle, Tab 5, p 26.

[28] On 27 September 2019, Mr Linder attended Ngā Kete for a review of a lump in his right armpit, which had become painful three days earlier.[15] He was seen by Dr Sager Elsafty, another GP at the practice as Dr Nagoor was overseas.

[29] Dr Elsafty noted the April 2019 histology report diagnosing a superficial spreading melanoma and documented a possible diagnosis of a lymphoma[16] or some other pathology. Dr Elsafty urgently referred Mr Linder to Southland Hospital General Surgery Department for assessment of the lump.[17]

[30] At Southland Hospital samples were taken of the mass in Mr Linder's armpit which was also found to be cancerous. He was seen by the Southern DHB Consultant Surgeon, Dr Alice Febery on 4 November 2019.

[31] On 11 November 2019, an ACC Treatment Injury Claim was made to ACC which stated that Mr Linder had metastatic melanoma, potentially avoidable or more proactively managed with appropriate action.[18]

[32] In a letter dated 12 November 2019, Dr Sharon Patterson advised Dr Febery that Mr Linder had Stage IV melanoma.

[33] On 12 November 2019 Mr Linder's aunt complained to the Health and Disability Commissioner (HDC) about the treatment provided to Joshua Linder by Dr Nagoor.[19]

[34] After an initial assessment of the complaint, a formal investigation was commenced on 22 September 2020.[20]

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15 Bundle, Tab 5, p 25.
16 Cancer of the lymphatic system.
17 Bundle, Tab 5, p 25.
18 Bundle, Tab 5, p 38.
19 Bundle, Tab 2.
20 Bundle, Tab 3.

[35] On 25 June 2021 Deputy Commissioner, Rose Wall, released her report finding Dr Nagoor had breached Rights 4(1) and 6(1) of the Code of Health and Disability Services Consumers' Rights.

[36] The Deputy Commissioner referred Dr Nagoor to the Director of Proceedings, under s 45(2)(f) of the Health and Disability Commissioner Act 1994, who in turn laid the Charge before this Tribunal.

[37] On 28 June 2022, Mr Linder died as a consequence of the cancer. He was 31 years of age.

Relevant law

Professional misconduct

[38] The primary purpose of the Tribunal's disciplinary powers is the protection of the public by the maintenance of professional standards.

[39] Section 100 of the Act defines the grounds on which the health practitioner may be disciplined. Dr Nagoor has been charged with professional misconduct under both s100(1)(a) and/or (b) of the Act as follows:

> 100 Grounds on which health practitioner may be disciplined
>
> (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—
>
> (a) the practitioner has been guilty of professional misconduct because of 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 that the conduct occurred; or
>
> (b) the practitioner has been guilty of professional misconduct because of 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 that the conduct occurred;

[40] The Tribunal and the Courts have considered the term "professional misconduct" under s 100(1)(a) on many occasions. In *Collie v Nursing Council of New Zealand,*[21] Gendall J described negligence and malpractice as follows:

> Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.

[41] "Malpractice" is defined in the *Collins English Dictionary* as:[22]

> The immoral, illegal or unethical conduct or neglect of professional duties. Any instance of improper professional conduct.

[42] Malpractice is defined in the New Shorter Oxford English Dictionary:[23]

> 1. Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer … 2. Gen. A criminal or illegal action: wrongdoing, misconduct.

[43] Section 100(1)(b) of the Act creates another route by which a finding of professional misconduct may be made. This is where the practitioner's conduct has or is likely to bring discredit on the particular health profession. In *Collie v Nursing Council of New Zealand*, Gendall J considered the meaning of conduct likely to bring discredit on the nursing profession as follows:[24]

> To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard with 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.

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21 [2001] NZAR 74.
22 Collins English Dictionary (2nd Edition).
23 Shorter Oxford English Dictionary (1993 ed), as cited in *Dr E* 136/Med07/76D at [12]–[14].
24 *Collie v Nursing Council of New Zealand* [2001] NZAR at [28].

Burden and standard of proof

[44] The burden of proof is on the Director. This means that it is for the Director to establish that the practitioner is guilty of professional misconduct.

[45] The Director must produce evidence that establishes the facts on which the Charge is based to the civil standard of proof; that is, proof which satisfies the Tribunal that on the balance of probabilities the particulars of each Charge are more likely than not. The Tribunal must apply a degree of flexibility to the balance of probabilities taking into account the seriousness of the allegation and the gravity of the consequences flowing from a particular finding.[25]

Threshold test for disciplinary sanction

[46] There is a well-established two-stage test for determining professional misconduct in this jurisdiction.[26] The two steps are:

(a) First, did the proven conduct fall short of the conduct expected of a reasonably competent health practitioner operating in that vocational area? This requires an objective analysis of whether the health practitioner's acts or omissions can reasonably be regarded as being negligence and/or malpractice or, having brought or are likely to bring discredit to the practitioner's profession; and

(b) Secondly, if so, whether the departure from acceptable standards has been significant enough to warrant a disciplinary sanction for the purposes of protecting the public and / or maintaining professional standards?

[47] In *Martin v Director of Proceedings*[27] the High Court has said that the threshold should not be regarded as "unduly high" but that "a notable departure from acceptable standards"

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[25] *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1 (SC) at [112].

[26] *PCC v Nuttalll* 08 Med 04/03P; *F v Medical Practitioners Disciplinary* Tribunal [2005] 3 NZLR 774 (CA), as applied in *Johns v Director of Proceedings* [2017] NZHC 2843 at [78].

[27] [2010] NZAR 33.

is required; and that the threshold is to be reached with care, having regard to both the purpose of the Act and the implications for the practitioner.[28]

Relevant professional standards and guidelines

[48] There are several professional standards to which medical practitioners are required to adhere. These include the Medical Council's general standards as well specific guidelines for the diagnosis, care and treatment of patients with melanoma skin cancer.

[49] The New Zealand Medical Council's (Medical Council) *Good Medical Practice*[29] requires doctors to refer patients to another practitioner or service when it is in the patient's best interests, and to keep clear patient records that report options discussed, decisions made, and the reasons for them.

[50] In relation to the specific guidelines for the management of melanoma skin cancer the following professional standards are relevant:

(a) Australasian Cancer Network Melanoma Guidelines Revision Working Part's "*Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand*".[30] These Guidelines recommend referral to a specialist melanoma centre when patients have deeper invasive melanomas (> 1mm thick) and follow-up intervals of three-monthly or four-monthly when patients have Stage II or III disease; and

(b) Community HealthPathways Southern*, Melanoma (Cutaneous) (HealthPathways)*[31] (the HealthPathways Guidance). The HealthPathways Guidance sets out the recommended management various types of situations, including diagnosed invasive melanoma, where referral for wide local excision should occur, and the recommended follow-up procedures for confirmed melanoma.

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[28] Martin v Director of Proceedings [2010] NZAR 33, Courtney J at [32].
[29] Medical Council of New Zealand, *Good Medical Practice*, December 2016.
[30] Cancer Council Australia / Australian Cancer Network / Ministry of Health New Zealand (2008).
[31] Community Health Pathways Southern, *Melanoma (Cutaneous)* September 2015.

[51] Right 4 - the right to receive services of an appropriate standard, and Right 6 - the right to informed consent, in the Code of Health and Disability Consumer Services' Rights (HDC Code) are relevant to the Tribunal's overall assessment of the disciplinary charge.

[52] Rights 4(1) and 6 of HDC Code provide:

> Right 4
>
> (1) Every consumer has the right to have services provided with reasonable care and skill.
>
> Right 6
>
> (1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including—
>
> (a) an explanation of his or her condition; and
>
> (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
>
> (c) advice of the estimated time within which the services will be provided; and
>
> (d) notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
>
> (e) any other information required by legal, professional, ethical, and other relevant standards; and
>
> (f) the results of tests; and
>
> (g) the results of procedures.
>
> (2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
>
> (3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about—
>
> (a) the identity and qualifications of the provider; and

(b) the recommendation of the provider; and

(c) how to obtain an opinion from another provider; and

(d) the results of research.

(4) Every consumer has the right to receive, on request, a written summary of information provided.

Evidence and witnesses

[53] To prove the Charge, the Director provided a Bundle of Documents (Bundle) and an affidavit from Ms Isabelle Mackay setting out the investigation undertaken by the HDC. [32]

[54] Although the Commissioner's opinion was not before the Tribunal, some of the evidence that was gathered for the purpose of the investigation was provided by the Director in the Bundle. These included the relevant clinical notes for Mr Linder from 29 March 2019 to 4 December 2019 and the correspondence between the HDC and Dr Nagoor.

[55] The Bundle also included a photo of Joshua Linder's mole taken on 12 April 2019 by his mother.[33]

[56] The clinical notes included the histology report received by Ngā Kete on 16 April 2019.[34]

[57] Each of the Director's witnesses provided affidavits as follows:

(a) Mr Joshua Linder, the health consumer / patient in this case.[35] Mr Linder directly observed and experienced events that are the subject of the Charge.[36] Mr Linder describes his appointments with Dr Nagoor at Ngā Kete, including that he specifically asked if the lesion was cancer and he was told it was not, that he was never given a referral for specialist assessment or treatment and that had he been,

[32] Document 3, Affidavit of Isabelle Mary Mackay.
[33] Bundle, p 68.
[34] Document 8, Screenshot.
[35] Document 4, Affidavit of Joshua Linder dated 20 May 2022. As Mr Linder died before the hearing, his evidence is a hearsay statement and is admitted by the Tribunal pursuant to s 18 of the Evidence Act 2006. The Tribunal accepts that the circumstances relating to Mr Linder's affidavit is reliable.
[36] Document 4, Affidavit of Joshua Linder dated 20 May 2022.

he would have taken it. His affidavit sets out the subsequent events after discovering that he had cancer, and how this affected him and his family.

(b) [Ms R],[37] is Joshua Linder's [family member]. The key aspect of her evidence is that after Joshua came home from his appointment with Dr Nagoor on 30 April 2019, he told her that he did not have cancer. She also took a photo of the mole / lesion onJoshua's back.[38] MsR described the impact of the cancer onJoshua and their family.

(c) [Ms E],[39] was at the time of events aNurse at Ngā Kete. She initially assessed Joshua when he first presented at Ngā Kete and arranged for him to see Dr Nagoor on the same day. She also reviewed Mr Linder on several other occasions after his mole was excised.

(d) Ms Isabelle Mackay[40] is a senior investigator at the HDC. She was assigned as the responsible investigator on this case. Ms Mackay has provided the information gathered during the HDC process, and HDC's communication with Dr Nagoor during this process and his responses.

(e) Dr Phillip Keith Monnington[41] provided expert evidence (Dr Monnington's opinion). He is a registered medical practitioner with over 40 years' experience in general practice. For the last 15 years, he has specialised in primary skin cancer medicine. Dr Monnington's report is referred to in our assessment of the particulars of the Charge. He gave his expert opinion on the ways in which Dr Nagoor departed from the standards of care and accepted practice when providing treatment to Mr Linder.

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37 Document 6, Affidavit of [Ms R].
38 Bundle, Tab 13, Photo of Joshua Linder's mole taken on 12 April 2019.
39 Document 5, Affidavit of [Ms E].
40 Document 3, Affidavit of Isabelle Mackay. Ms Mackay was excused by the Tribunal from giving evidence in person, although she was available by phone should any questions arise.
41 Document 7, Affidavit of Dr Phillip Keith Monnington.

[58] Dr Nagoor filed an affidavit shortly prior to the hearing.[42] In his affidavit Dr Nagoor apologised to the family. He outlines his initial response to the HDC on 1 March 2022. More recently, he has read the clinical notes as well as Mr Linder's affidavit, and he has provided a detailed response to each of the particulars of the Charge.

[59] The parties agreed that all affidavit evidence would be received and taken as read. Dr Nagoor through his counsel did not seek to cross-examine the available witnesses.

[60] Dr Monnington's expert evidence was not challenged by the practitioner. He gave oral evidence to clarify the usual process and timing for sending and receiving histology reports from a laboratory. He interpreted the computer records of when the histology report was received by Ngā Kete and when Dr Nagoor accessed the report.

Liability – Tribunal's consideration of the Charge

[61] The issue for determination by the Tribunal in respect of all four particulars of the Charge is whether, on the balance of the probabilities, each particular (and sub-particular) of the Charge is established separately and/or cumulatively as conduct that has departed from the professional and ethical standards expected of doctors and if so, whether this conduct amounts to professional misconduct that warrants a disciplinary sanction. [43]

[62] The Charge essentially relates to two aspects of Dr Nagoor's care of Mr Linder in relation to the histology report: first, Dr Nagoor's failure to acknowledge the diagnosis of the melanoma cancer and to inform his patient of this; and secondly, his failure to act on the recommendations that a wider excision be made and that Mr Linder be referred for specialist assessment and treatment.

[63] Mr Holloway, counsel for the practitioner, submitted that there was substantial overlap with the particulars as set out in the Charge and that this tended to amplify the alleged breach of the professional standards.

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[42] Document 9, Affidavit of Nelson Nagoor dated 20 October 2022.

[43] Health Practitioners Competence Assurance Act 2003, ss 100(1)(a) and 100(1)(b).

[64] To the extent that there is some overlap between the particulars we have considered these particulars individually and in our overall assessment, cumulatively, to determine whether the Charge of professional misconduct has been made out.

[65] We now turn to consider each particular of the Charge.

Particular 1: Failure to inform Mr Linder about the histology report

[66] On 12 April 2019 following excision of the mole on Mr Linder's back, Dr Nagoor ordered a histology report on the excised tissue.

[67] On or around 17 April 2019 the histology report was received by the practice management system at Ngā Kete.[44] The Inbox shows that Dr Nagoor accessed the histology report on 18 April.

[68] The histology report included the following diagnosis:[45]

> Diagnosis: primary melanoma, invasive.
>
> Subtype: SUPERFICIAL SPREADING MELANOMA
>
> Tumour Thickness (Breslow): 8.9mm
>
> Level of invasion (Clark): III
>
> Dermal mitotic rate: 4 per mm^2
>
> …
>
> A wider excision is recommended …
>
> SUMMARY: Skin mid back – primary cutaneous (of the skin] melanoma, invasive, superficial spreading.
>
> M stage (AJCC8th ed.): $pT4bpNx2^2$

[44] Document 8, Bundle, p 45, Screenshot of Ngā Kete Inbox.
[45] Bundle, p 27.

[69] The histology report was received five days after the specimen was sent to the laboratory. Given the histology report's diagnosis, we agree with Dr Monnington's opinion that accepted practice would have been for Dr Nagoor to empathetically inform Mr Linder of the results in a face-to-face situation, preferably with a support person present, as soon as practicable.

[70] Dr Nagoor states that he cannot remember when he received and read the histology report. He accepts however that a doctor receiving such a report should review it reasonably promptly and, after reviewing it, ask for the patient to be booked reasonably promptly for a consultation to discuss the results.[46]

[71] Initially Dr Nagoor said that while his memory was "very sketchy given that the time has passed" and that he could only comment on the "broadest terms", that he would have "communicated the seriousness to the patient".[47]

[72] In Dr Monnington's opinion a two-week delay in advising a patient a test result is greater than ideal.[48]

[73] Dr Nagoor's failure to take steps to contact Mr Linder immediately after receiving the histology report is against a backdrop whereby Nurse [E] had herself made an initial query diagnosis of melanoma and noted this possible diagnosis. She had requested a plan for urgent review by Dr Nagoor at the initial consultation. Her notes read:[49]

> Plan for urgent RN today with Dr NN as ? very suspicious lesion ? melanoma [sic].

[74] Subsequently on 26 April, Mr Linder returned to Ngā Kete for suture removal. Nurse [E] noted that the wound was healing well and that there were no signs of infection present.

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[46] Document 9, Affidavit of Dr Nelson Nagoor at [22].
[47] Bundle, p 67, Email from Dr Nagoor to Health and Disability Commissioner dated 2 March 2021.
[48] Document 7, Dr Monnington's report at [30].
[49] Bundle, p 28, Clinical notes.

[75] Nurse [E] then recorded that she could see Mr Linder's results had returned showing they were abnormal melanoma. She questioned him if he had heard from Dr Nagoor regarding his results. He advised that he had not heard anything.

[76] We accept Nurse [E]'s evidence that the policy for these kind of test results is for the doctor to disclose the results to the patient so that a treatment plan can be formed, and it is not for the nurse to disclose the results or refer to specialists. Nurse [E] did however then proceed to tell Mr Linder that he needed to see the doctor for these results and she booked him in to see Dr Nagoor on 30 April.

[77] The relevant professional standards for a GP presented with a patient with a suspicious skin lesion includes the Medical Council *Good Medical Practice*:[50]

> Caring for patients
>
> 2. When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:
>
> - adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate
> - providing or arranging investigations or treatment when needed
> - taking suitable and prompt action when needed, and referring the patient to another practitioner or service when this is in the patient's best interests.
>
> …
>
> Keeping records
>
> 5. You must keep clear and accurate patient records that report:
>
> - relevant clinical information
> - options discussed

[50] Medical Council of New Zealand, *Good Medical Practice*, December 2016.

- decisions made and reasons for them
- information given to patients
- The proposed management plan
- any medication or any other treatment prescribed.

[78] We are satisfied on the balance of probabilities that Dr Nagoor failed to take any steps to advise Mr Linder about the histology report. We find that there was no communication at all from Dr Nagoor to Mr Linder regarding the histology report nor were there any arrangements made by Dr Nagoor to actively set up a consultation with Mr Linder to advise him about the diagnosis.

[79] Particular 1 is established.

Particulars 2(a) and 2(b): Failing to explain the diagnosis and advising that the lesion was not cancer on 30 April 2019

[80] Particular 2 relates to the consultation by Dr Nagoor with Mr Linder on 30 April 2019. The Director says there were a number of failures by Dr Nagoor despite having received the histology report.

[81] Dr Nagoor's clinical notes for 30 April 2019 state as follows:[51]

> Post excision rev and disc of histology
>
> Wound looks clean and healing well
>
> All sutures to come out today
>
> Advised re histology
>
> At excision when one of the margins recognised to be close to edge additional sliver of tissue removed and included in specimen
>
> At this stage no further excision to be done

[51] Bundle, Clinical notes, p 26.

Will be reviewed in three months

Both axillae checked and free of glands.

[82] Dr Nagoor says that as the clinical notes record "Advised re histology", he believes that he did discuss the results with Mr Linder. He suggests that the most likely explanation is that, at the time, he misread the results.

[83] Mr Linder says that during the appointment on 30 April 2019, Dr Nagoor did not tell him he had cancer and instead told him it was not cancer. We accept Mr Linder's account of this consultation as the issue of whether his mole was cancer had been high on his mind during the consultation. The first thing he did at the initial consultation on 5 April 2019 was to point out the mole and ask Dr Nagoor directly "Is this cancer?".

[84] At the consultation with Dr Nagoor on 30 April, Mr Linder says:[52]

> 29. As soon as I walked into this appointment, Dr Nagoor was smiling at me. He said he had got the results and there was no cancer, or something along those lines. I wanted to double check that I had heard him correctly, so I asked 'No cancer?' and he replied 'No cancer'. I was extremely happy and relieved to hear this. I'm absolutely certain about him saying 'No cancer'. It was top of my mind because I knew right from the first appointment that it could have been cancer.
>
> 30. Dr Nagoor said nothing about needing any more treatment or seeing a specialist. He looked at the stitching of the wound and commented that it was a beautiful scar (which was untrue, because he'd made a real mess of it). At this check-up Dr Nagoor checked my lymph nodes by pushing his fingers into my armpits. I remember him telling me he was checking my glands as a routine check-up, if anything else popped up. I did not have any other pain or discomfort at this time …

[85] Mr Linder's evidence is supported by that of his [family member]. When Mr Linder arrived home that day Ms [R] says:[53]

> 6. When Josh got home from work he told me that Dr Nagoor had said he did not have cancer. I had been really worried about the mole because it looked so bad. I was surprised when Josh said that he had been told it was not

[52] Affidavit of Joshua Linder at [29]-[30].
[53] Affidavit of [Ms R] at [6].

> cancer and so I asked him if he was sure that was what Dr Nagoor had said. Josh was adamant that that was what Dr Nagoor had said. I felt so relieved.

[86] Dr Nagoor says that given this account from Mr Linder he thinks it is most likely that he mistakenly told Mr Linder that the lesion did not require further treatment. He now accepts Mr Linder must have understood his explanation as meaning "Not cancer".[54]

[87] We are satisfied on the balance of probabilities that Mr Linder's account of the 30 April 2019 consultation is reliable and an accurate account of this discussion between the doctor and the patient.

[88] All that can be taken from the clinical notes from this appointment is that Dr Nagoor noted, "Advised re histology". This entry is inadequate as it is unclear as to what precisely Mr Linder was advised about the histology.

[89] We find that Mr Linder was not told he had an advanced aggressive melanoma requiring wider excision as detailed in the histology report. The absence of a discussion on such a critical topic is consistent with Dr Nagoor's subsequent actions and clinical notes where he recorded that no further excision was to be done at this stage, when that was exactly what the histology report advised.

[90] We therefore accept Mr Linder's recollection that he was not advised that he had cancer. We concur with Dr Monnington's opinion that this is a significant departure from accepted standards by Dr Nagoor.[55]

[91] Particulars 2(a) and (b) are established.

Particulars 2(c) and 2(d): Failure to advise Mr Linder that a wider excision was recommended and contrary documentation

[92] The pathologist documented in the histology report that a wider excision was recommended.

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[54] Affidavit of Nelson Nagoor at [22].
[55] Dr Monnington's report at [31].

[93] Dr Monnington has confirmed that this advice is consistent with the relevant clinical guidelines regarding further management of this particular type of melanoma, namely that a wide local re-excision with a margin of two centimetres is indicated in order to reduce the risk of local recurrence.[56]

[94] Dr Nagoor has accepted this particular as "most likely".[57]

[95] The Australasian Guidelines for the Management of Melanoma state:[58]

> 7. Histopathological reporting of cutaneous melanoma
>
> The aim of the histopathology report on primary cutaneous melanoma is to provide the clinician with the information necessary for the optimum management of the patient. The most important components of the report are the correct diagnosis of primary melanoma …, the microscopic assessment of completeness of excision and the microscopic measurement of tumour thickness (Breslow), the single most important prognostic factor for primary melanoma.
>
> …
>
> 11. Treatment of primary melanoma
>
> The standard treatment for primary melanoma is wide local excision (WLE) of the skin and subcutaneous tissues around the melanoma. The aim is complete surgical excision of all in situ and invasive melanoma components.
>
> …
>
> 11.2 Good practice points
>
> …
>
> - Melanoma (i) is a risk factor for new primary melanoma(s) and (ii) also has the potential to recur or metastasise. Patients should be appropriately managed and followed-up for these aspects as discussed elsewhere in these Guidelines.
>
> …

[56] Dr Monnington's report at [32].
[57] Affidavit of Dr Nelson Nagoor at [22].
[58] Cancer Council Australia / Australian Cancer Network / Ministry of Health New Zealand (2008).

- For patients with deeper invasive melanomas (> 1mm thick), referral to a specialised melanoma centre should be considered to ensure that best practice is implemented and for the collection of national outcome data.

…

19. Follow up

19.2 Undertaking follow-up

…

Recommendation

1. Self-examination by patients is essential and they should be taught the process …

19.3 Follow up intervals and tests

…

Recommendation

2. Follow-up intervals are preferably six-monthly or five years for patients with Stage I disease, three-monthly or four-monthly for five years for patients with Stage II or III disease and yearly thereafter for all patients. [Mr Linder had Stage 3].

[96] The *Health Pathways*[59] section on "Melanoma (Cutaneous)" states:

Management

…

2. Managing increased risks situations or after excision or biopsy

Diagnosed invasive melanomas

[59] Community HealthPathways Southern, Melanoma (Cutaneous), Bundle, pp 145-6.

> Refer all diagnosed invasive melanomas for wide excision even where general practitioners are capable performing the excision. It is important that invasive melanoma are removed by a specialist to ensure:
>
> - discussion of sentinel mode biopsy, where relevant.
> - The appropriate margin is taken, which depends on several variables, not just Breslow thickness.
> - Comprehensive patient management information is provided.
> - Any suitable patient trials are considered, e.g. treatments, vaccines.
>
> Follow-up of confirmed melanoma:
>
> - Stage II disease (1-2mm thick and ulcerated, or > 2mm thick (4-6 monthly for five years. …
> - Stage III (node or metastasis): specialist follow-up for variable number of years then by agreement.

[97] We are satisfied that Dr Nagoor did not act on this advice or in accordance with the clinical guidelines and had instead documented that "At this stage no further excision to be done".

[98] We agree with Dr Monnington's opinion that this is a severe departure from accepted standards of care by Dr Nagoor.

[99] Particulars 2(c) and 2(d) are established.

Particulars 2(e) and 2(f): Failure to refer Mr Linder for further specialist assessment and treatment and/or document discussion

[100] Once again there is some overlap with particular 2(c). Dr Nagoor has accepted that his failure to refer Mr Linder to specialist care was "most likely".

[101] Dr Nagoor initially said that he remembered Mr Linder conveying to him that he did not want to go for any further assessment if he did not have to as he was concerned about taking time off work. We find Dr Nagoor's recollection unreliable and contrary to Mr Linder's own

evidence where he makes it quite clear that his anxiety around a potential diagnosis of cancer was such and that:

> If Dr Nagoor had said that it was cancer or anything like it, I would have made sure that I had any further treatment quickly.[60]

[102] Dr Monnington has also raised the question of whether, upon receipt of the histology report, Dr Nagoor should have referred and / or recommended a sentinel node biopsy (SNB).[61] In Dr Monnington's opinion, if Mr Linder had presented again to Ngā Kete five months post-surgery with clinically enlarged axillary lymph nodes, he considers it is highly likely that the SNB would have been positive if it had been carried out in or around the time that Dr Nagoor received the histology report in April 2019.

[103] In Dr Monnington's opinion if a referral for an SNB had occurred:[62]

> … it would have allowed Mr Linder access to earlier surgical and oncology opinions (ideally via a multi-disciplinary team), and possible earlier enrolment in a clinical trial … the fact that Mr Linder was not afforded the opportunity to undergo an SNB in April or May and as a result suffered an approximate 5 month delay in diagnosis of Stage III disease is a direct consequence of the failure to appropriately refer him.

[104] We are satisfied that it is incumbent upon a GP who undertakes the management of malignant skin lesions to be aware of the relevant guidelines and, unless there are extenuating circumstances, to follow them. For Dr Nagoor to record that further excision was not indicated and to not refer Mr Linder into specialist care following receipt of the histology report is a severe departure from the accepted standard of care.[63]

[105] If there was a discussion between Dr Nagoor and Mr Linder about Mr Linder declining further referral and being happy to be monitored in the practice, as initially suggested by Dr Nagoor, there is no documentation by Dr Nagoor of this important discussion in Mr Linder's clinical notes.

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[60] Affidavit of Joshua Linder at [35].

[61] Removal and examination of the sentinel nodes (the first lymph nodes to which cancer cells are likely to spread from a primary tumour).

[62] Dr Monnington report at [34].

[63] Dr Monnington report at [36].

[106] A patient's clinical record is the ultimate record of whether something happened or not. If it is not documented, it is reasonable to assume that it did not happen. There is some ambiguity around the note, "Advised re histology" as it does not give the specifics of what the patient was advised. If it is documented then this is considered robust evidence that is what occurred. For example, the notes record on 30 April 2019, "At this stage no further excision will be done".[64]

[107] We are satisfied on the balance of probabilities that Dr Nagoor failed to refer Mr Linder for further specialist assessment, management and treatment in respect of his melanoma in accordance with the guidelines above.

[108] As particular 2(e) is established it is not necessary for the Tribunal to find in the alternative that if there was a discussion of a referral, then there was a failure to document this discussion. Accordingly, particular 2(e) is established and particular 2(f) in the alternative, is not.

Particular 3: 17 April 2019: 2 August 2019: failure to adequately communicate to Mr Linder that he had an advanced aggressive form of melanoma cancer

[109] On 2 August 2019 Mr Linder returned for a check-up with Dr Nagoor. Dr Nagoor's clinical notes record "Here for rev of wound 3mm after excision. Superficial spreading melanoma R lower back".

[110] We accept Mr Linder's evidence that Dr Nagoor again did not advise him about the histology results. The clinical notes go on to record that Dr Nagoor advised a further review in six months' time and "If OK", three-yearly thereafter.[65]

[111] For the reasons set out in established particulars 2(a)-(e) inclusive we are satisfied there was an ongoing failure by Dr Nagoor to adequately communicate to Mr Linder that he had an advanced aggressive form of melanoma cancer. Failure by Dr Nagoor to inform Mr Linder that the lesion was skin cancer and that a specialist referral was warranted is a breach of Right 4(1) and the right to reasonable care and skill, and Right 6(1) of the HDC Code as Mr Linder was

[64] Bundle, p 26.
[65] Bundle, pp 25 and 26, clinical notes.

not provided with information that a reasonable consumer in his circumstances would expect to receive.

[112] Particular 3 is established.

Particular 4: failures with follow-up care

[113] The consultation on 2 August 2019 when Dr Nagoor reviewed Mr Linder, was a further missed opportunity of his care. We are satisfied that Dr Nagoor failed to check his understanding of the histology report if in some way he had "misread" the histology report as he suggests.

[114] The Practice Management System shows that Dr Nagoor only accessed the histology report once, on or about 17 April 2019, at the time it was received by Ngā Kete.

[115] If Dr Nagoor had made the appropriate referral, it is possible the specialist team would have taken over Mr Linder's management in that Dr Nagoor would not have been involved in repeat follow-up appointments. However, as Dr Nagoor did not make the appropriate and urgent referral, it was incumbent on him to ensure Mr Linder received adequate follow-up.

[116] We agree with Dr Monnington's opinion that Dr Nagoor's follow up with Mr Linder was inadequate. There was no record of Dr Nagoor examining Mr Linder's lymph node basins, nor is there any documentation of a skin check being performed, at the three month follow up appointment on 2 August 2019.

[117] Dr Nagoor suggests that he believes he actually advised Mr Linder that he should be reviewed at one month, three months and five months, yet he cannot explain why he recorded six-monthly reviews. Mr Linder did return on 2 August for a "3 month" review, which took place three and a half months post-operatively. After that appointment, six months follow-up was recommended.

[118] Dr Nagoor accepts that he failed to examine Mr Linder's lymph node basins and to perform a "top-to-toe" skin check of Mr Linder.

[119] We are satisfied that these failures to examine the patient for a lymph node enlargement following diagnosis of an advanced, aggressive melanoma is a significant departure from accepted standards of care.

[120] Dr Nagoor's failure to provide services with reasonable care and skill is in breach of Right 4(1) of the HDC Code. Mr Linder was not provided with information that a reasonable consumer in his circumstances, would expect to receive and Dr Nagoor's conduct is also in breach of Right 6(1) of the HDC Code.

[121] Particular 4, including sub-particulars (a)-(d) inclusive, are established.

Is the disciplinary threshold met?

[122] The Tribunal is satisfied that the established conduct set out in Particulars 1-4 (and each of the sub-particulars) each fall short of the conduct expected of a reasonably competent medical practitioner working in general practice.

[123] On an objective analysis the Tribunal is satisfied that the conduct established in the four Particulars each, separately and cumulatively, amount to negligence. These failures fall well short of the standards expected of a general practitioner.

[124] Reasonably minded members of the public would consider Dr Nagoor's conduct to be unacceptable and is such a serious departure from appropriate standards of care that his conduct has brought and is likely to bring discredit to the medical profession.

[125] There were two important omissions in Mr Linder's care: firstly, Dr Nagoor's failure to communicate the diagnosis of melanoma, and secondly, to act on the recommendations for further excision and referral for specialist care.

[126] We accept that it is possible that Mr Linder presented late with an already advanced lesion which, in the opinion of Dr Monnington, had almost certainly metastasised prior to his presentation in April 2019, and that earlier referral would not have altered the ultimate outcome. Notwithstanding this, Dr Nagoor failed to follow the widely accepted best practice clinical guidelines for the diagnosis, treatment and care of patients with advanced melanoma.

[127] We agree with Dr Monnington's assessment that as a result, Mr Linder was done a disservice in the form of an approximate five-month delay, and an opportunity for early intervention was missed. Importantly, this patient was not aware immediately following the surgery that he had potentially life-threatening cancer which required urgent referral to specialist care.

[128] Dr Nagoor neither advised Mr Linder of the result at the time of the suture removal on 30 April 2019 nor did he document his intention with respect to informing Mr Linder of the results.

[129] On 30 April 2019 he documented that no further excision was required when the histology report clearly recommended a wider excision, and he did not recommend or offer referral to a specialist.

[130] Devastatingly for Mr Linder's family, Dr Nagoor failed to inform Mr Linder that the lesion was a melanoma skin cancer.

[131] Furthermore, the frequency of follow-up reviews advised by Dr Nagoor was inconsistent with reasonable and accepted practice set out in the Australasian Guidelines for the Management of Skin Cancer. This resulted in a missed opportunity for recognising and correcting the earlier failure to arrange for a specialist review.

[132] There was a serious failure of communication by Dr Nagoor to inform Mr Linder of the melanoma diagnosis and the seriousness of the histology results. Mr Linder was not aware of the results immediately following the surgery that he had potentially life-threatening cancer which required urgent referral for specialist care.

[133] There was an opportunity for an earlier intervention which was missed and fell well below an appropriate and reasonable standard of care.

[134] Dr Nagoor referred to his "heavy" workload at the time he provided care to Mr Linder, that he felt under pressure, there were risks involved in "skimping on time and forcing me to

rush work", and there were issues with his management as he felt he "was not listened to and definitely not respected". [66]

[135] The practitioner's personal circumstances at the time of the events in question, including the subjective reasons for their conduct, are not relevant to the Tribunal's decision about the disciplinary threshold, but instead go to the question of penalty.[67] This is because the personal circumstances of the practitioner are secondary to the overriding purpose of the Act, being to protect the public and maintain appropriate standards.

[136] In terms of the second step of our assessment, the Tribunal is satisfied that each of the four particulars, separately and cumulatively, are departures from acceptable standards and the Charge is established as professional misconduct under sections 100(1)(a) and (b) of the Act. These departures are significant enough to warrant a disciplinary sanction for the purposes of protecting the public and maintaining professional standards.

Penalty

[137] In relation to the Charge of professional misconduct that has been established, the Tribunal must go on to consider the appropriate penalty under s 101 of the Act. The penalties may include:

(a) Cancellation of the practitioner's registration;

(b) Suspension of the registration for a period not exceeding three years;

(c) Censure;

(d) An order that the practitioner may only practise with conditions imposed on employment or supervision or otherwise;

(e) A fine up to $30,000; and

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[66] Affidavit of Dr Nelson Nagoor at [9], [13] and [14].

[67] *McKenzie v MPDT* [2004] NZAR 47 at [71]; *Cole v PCC* [2017] NZHC 1178, [128]-[130]; *Paltridge* 382/Med11/172P at [118].

(f) An order as to costs of the Tribunal and the Director of Proceedings to be met in part or in whole by the practitioner.

[138] The Tribunal adopts the principles contained in *Roberts v Professional Conduct Committee,*[68] where Collins J identified the following eight factors as relevant whenever the Tribunal is determining an appropriate penalty. In particular, the Tribunal should always consider the penalty that:

(a) most appropriately protects the public and deters others;

(b) facilitates the Tribunal's important role in setting professional standards;

(c) may punish the practitioner, though this is not the objective of any penalty;

(d) allows for the rehabilitation of the health practitioner;

(e) promotes consistency with penalties in similar cases;

(f) reflects the seriousness of the misconduct;

(g) is the least restrictive penalty appropriate in the circumstances; and

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

[139] In *Singh v Director of Proceedings*[69] Ellis J held that the power to discipline must be exercised in light of and consistently with the principal purpose of the Act, namely 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:

> As s 3 makes clear, it is the protection of the public's health and safety by ensuring that the health practitioners are competent and fit to practise that must be the principal focus of disciplinary action. That object has primacy over any punitive

[68] [2012] NZHC 3354, per Collins J at [44]-[51].
[69] [2014] NZHC 2848, per Ellis J.

> purpose. So while, for example, it has been long recognised that de-registration or suspension necessarily has a punitive effect, that should not be the principal purpose (or effect) of making such an order.

[140] The Tribunal's role is to determine the appropriate penalty, given the nature of the conduct, to ensure that both the public interest and the integrity of the profession are maintained.

Submissions on penalty

[141] Ms Herschell, counsel for the Director submitted that the appropriate penalty in this case is censure, cancellation of the practitioner's registration and a minimum fine of $5,000 as a deterrent signal.

[142] Ms Herschell submitted, as in the case of *PCC v Houlding,*[70] that should the Tribunal be minded to order cancellation or suspension, this was a case where neither cancellation nor suspension alone would have a deterrent consequence on Dr Nagoor given his stated retirement.

[143] Mr Holloway, counsel for the practitioner, submitted that censure of Dr Nagoor and conditions (together with an award of costs) would be an appropriate penalty. Mr Holloway submitted that without taking away the significance of these events for Mr Linder and his family, it is nevertheless relevant that this is a Charge about a single clinical error – the misreading of a histology report.

[144] Mr Holloway submitted that soon after what happened Dr Nagoor retired from medical practice and he no longer lives in New Zealand. Dr Nagoor does not present any ongoing risk to the public.

[145] Dr Nagoor has, by way of an affidavit, apologised for his actions and accepted that they amounted to professional misconduct under s 100(1)(a) and (b) of the Act.

[70] 1061/Phys19/461P at [91]-[93].

Comparable cases

[146] The Tribunal was referred to several cases dealing with professional misconduct for clinical negligence. These cases show that the Tribunal has imposed a wide range of penalties in a similar circumstances – from censure and conditions – to cancellation or suspension of the practitioner from practice.

[147] In *Director of Proceedings v Liston,*[71] Dr Liston was an oral and maxillofacial surgeon charged in relation to failing to inform his patient that a lesion on his tongue was cancer, despite having received results confirming the diagnosis following an excisional biopsy. In similar circumstances to the current case, Dr Liston told his patient incorrectly that his condition was dysplasia and "definitely not cancer". The Tribunal found that his conduct was unquestionably negligent in his reading of the biopsy reports and his failure to refer the patient to a multidisciplinary team for review.

[148] In *Liston*, the Tribunal did not consider that cancellation or suspension from practice was justified. Dr Liston was censured and fined $5,000. In discussing the appropriate penalty, the Tribunal made allowances for the pressures and stresses Dr Liston was under and the limited resources he had available to him for the correct interpretation of biopsies and proper performance of his professional duties.

[149] The Tribunal considered that conditions were not necessary as Dr Liston had completed a recertification programme already and supervision was not necessary to address a one-off situation. Dr Liston was ordered to pay 30% contribution towards costs totalling $21,000.

[150] On appeal to the High Court,[72] the Court upheld the Tribunal's decision and dismissed the appeal. Clark J found that the Tribunal did not overstate the seriousness of Dr Liston's misconduct, properly considered mitigating factors and imposed a penalty that was consistent with comparable cases noting that the Tribunal had made significant allowance for Dr Liston's circumstances.[73]

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[71] 940/Den17/387D
[72] *Liston v Director of Proceedings* 2018 [NZHC] 2981.
[73] Ibid at [53].

[151] In *PCC v White,*[74] Mr White was an optometrist charged with failing to refer his patient in a timely manner to an ophthalmologist for the assessment and / or treatment of an abnormality which he had identified in the patient's right eye. The Tribunal found that there was professional misconduct.

[152] The Tribunal in its discussion of penalty considered the failures to make a diagnosis and the delay in referral was serious and detrimental so could not be dismissed as an administrative error. The Tribunal imposed suspension of Mr White's practice for a period of six months (even though Mr White was not currently practising) and imposed conditions for a period of 18 months including supervision in order to satisfy the Board that he could demonstrate competence in his practice. The Tribunal did not impose a fine due to the suspension and Mr White's limited financial means. The Tribunal imposed 25% costs to reflect the early guilty plea and an Agreed Summary of Facts.

[153] In *Director of Proceedings v Dr Johri,*[75] a pregnant patient was referred by her midwife to her GP with a sore breast lump, who treated her with antibiotics for an infected duct. Dr Johri intended to refer her to a specialist if the lump did not respond to the antibiotics. There were subsequent failures to record the breast examination and to refer the patient to a specialist and it was confirmed the lump was cancerous. The patient gave birth and died seven months later.

[154] While noting several mitigating factors, including a long and exemplary record and outstanding contribution to the community, the Tribunal also accepted that Dr Johri was one of a number of health professionals managing the patient at the time and it was accepted that the patient may not have been monitored as carefully as she should have been as a result of that. Dr Johri was censured and ordered to pay 30% costs.

[155] In *Director of Proceedings v Dr Martin,*[76] Dr Martin failed to undertake an adequate examination of her 41 year old patient, who presented at multiple appointments. Dr Martin diagnosed irritable bowel syndrome and did not refer the patient for a colonoscopy or barium

[74] 525/Opt12/220P.
[75] 54/Med06/33D (25 July 2006).
[76] 58/Med05/15D (31 August 2006).

enema in order to exclude bowel cancer. The patient then saw a different doctor who discovered the patient's grandfather died at 43 of bowel cancer and drew to Dr Martin's attention the need to take further steps to investigate. However, Dr Martin failed to take appropriate steps to thoroughly investigate the patient's condition despite seeing her on a number of occasions. The patient subsequently was diagnosed with bowel cancer and died aged 43 years.

[156] The Tribunal had no issue with Dr Martin not diagnosing bowel cancer over the first three appointments, but considered Dr Martin should have begun to seriously question her diagnosis of irritable bowel syndrome by the fourth appointment and for not responding in a way which would reasonably be expected of a GP.[77]

[157] The Tribunal considered that Dr Martin's steps to be at the lower end of offending. She was censured, fined $5,000 in relation to the Tribunal's findings for some of the charge and $5,000 in relation to the Tribunal's finding to another aspect of the charge and ordered to pay costs of $20,000. On appeal, the High Court dismissed the appeal as to the substantive finding of professional misconduct accepting that a reasonably competent practitioner would have recognised the need for further investigation in that Dr Martin's persistent failure in the face of three opportunities to take steps to exclude bowel cancer must be regarded as serious.[78] However, the High Court modified the penalty order and reduced the fines (the $5,000 fine was reduced to $3,000 and the $10,000 was reduced to $7,000).

[158] In *Director of Proceedings v Bhatia,*[79] a consultant neurologist, failed to adequately and appropriately respond to his patient's condition knowing that she had squamous cell carcinoma in the bladder and / or taking into account the size of the tumour in the bladder, he failed to perform a total cystectomy instead undertaking a partial cystectomy. The Tribunal was satisfied that he had an obligation to ensure a procedure which offered the best chance of survival and was in accordance with accepted urological practise. The charge of professional misconduct was established noting that Dr Bahtia reached this decision as to how to treat the patient without reference to any urologist. The penalty imposed conditions on

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77 Ibid at [138].
78 *Martin v Director of Proceedings* [2010] NZAR 333 at [102].
79 77/Med 06/39D.

Dr Bahtia as he was practising on his own as a private practitioner, he was fined $5,000, censured and ordered to pay 30% costs.

[159] In *Re Dr H*,[80] Dr H was charged in relation to care she provided to a male patient in his fifties over the course of four consultations. The patient had difficulty swallowing, a sore throat, pain in his chest and stomach and weight loss. The Tribunal found that the charge of professional misconduct was established as it was satisfied that Dr H's failure to refer the patient for an endoscopy or to a specialist despite his presentations cumulatively amounted to misconduct. Dr H was censured and ordered to pay 30% of total costs of the Director of Proceedings and Tribunal.

[160] In *Re S,*[81] Dr S failed to undertake / record an adequate assessment of a patient on four occasions. The patient presented to Dr S with a bloated stomach and suffering abdominal discomfort. Dr S was not charged with failing to diagnose the subsequent cyst that was ultimately removed, rather the focus of the charge was the alleged inadequate examinations and steps taken by Dr S when consulted by his patient. Having found professional misconduct, Dr S was censured, conditions imposed requiring professional development and a requirement to pay $15,000 towards the costs incurred by the Director of Proceedings and $7,000 towards the Tribunal's costs.

Aggravating and mitigating factors

[161] The Tribunal has considered the aggravating and mitigating factors in this case.

[162] We accept Mr Hollway's submissions that three of the four aggravating factors identified by the Director go to the heart of the Charge that has been brought against Dr Nagoor. These factors relate to Dr Nagoor's misreading of the histology report and the cumulative effect of failing to act on Mr Linder's melanoma and referral for urgent specialist care.[82]

[80] 946/Med17/378D.
[81] 50/Med06/28D.
[82] Document 10, Penalty Submissions for Director of Proceedings, at 4.1(a), (b) and (c).

[163] We consider the primary aggravating factor is Dr Nagoor's lack of engagement with the HDC in response to Mr Linder's complaint and a lack of substantive and meaningful engagement with the disciplinary process.

[164] Mr Holloway, on behalf of Dr Nagoor recognised that his lack of engagement at times during the process would not be looked on favourably. However, it was submitted that the practitioner has not obstructed the disciplinary process.[83] While Dr Nagoor was tardy in his response to the HDC he ultimately engaged counsel and took responsibility for his actions in the disciplinary process.

[165] By way of mitigation, counsel for the practitioner submitted that Dr Nagoor was afflicted by various personal issues. He has suffered post-traumatic stress disorder because of his experiences in South Africa. At the time of these events in his workplace at Ngā Kete, he felt bullied and demeaned at work and experienced depression as a result. Dr Nagoor identified issues with both his physical and mental health.

[166] The difficulty the Tribunal has with this submission is that there is no opinion from a medical doctor in New Zealand of Dr Nagoor's health status and the extent to which he was suffering mental distress and the matters raised in his affidavit.[84]

[167] In his affidavit Dr Nagoor's apologised to the family as follows:

> … I want to say sorry for my actions. It was my role to:
>
> …
>
> 6.1 Understand the histology report which identified Mr Linder's melanoma;
>
> 6.2 Make sure Mr Linder understood the seriousness of that diagnosis; and
>
> 6.3 Provide Mr Linder with care advice about the best course of action and encourage him to take that advice.

[83] See for example *Kora* 432/Nur11/192P at [102.4].
[84] Document No.9 Affidavit of Dr Nelson Nagoor dated 20 October 2022 at [4], [13]-[16].

> 7. As I will explain, I accept that I must have made a mistake. Because of this, approximately five months passed before Mr Linder received treatment for his melanoma. I also accept that this delay may have reduced the likelihood of treatment being successful.
>
> 8. I also want to apologise for finding it so difficult to manage the HDC process. I understand this may have delayed the HDC's investigation which would have been distressing for Mr Linder and his family …"[85]

[168] We do not consider that this apology in Dr Nagoor's affidavit for the purposes of the disciplinary hearing is a mitigating factor. This statement came too late and after Mr Linder died. Mr Linder said in his affidavit that he would die wondering if Dr Nagoor's conduct towards him was something personal, something he had said or done to Dr Nagoor.[86]

[169] The Tribunal was advised that the HDC communicated several times with Dr Nagoor following the lodgement of Mr Linder's complaint.

[170] The initial account of his clinical interactions with Mr Linder provided by Dr Nagoor in an email to the HDC on 1 March 2021 could not be considered an apology. At that time, Dr Nagoor did not acknowledge, as he did subsequently, that he failed to inform his patient of the histology and to refer him for specialist advice. He does state:

> I am truly sorry about the subsequent course of clinical events and about any distress experienced by the patient.[87]

[171] Subsequently in May 2021, the Commissioner recommended a formal apology. However, there was no further acknowledgement of the clinical events by Dr Nagoor until after he instructed counsel and provided an affidavit for this disciplinary hearing.[88]

[172] While it is positive that Dr Nagoor ultimately instructed counsel to appear on his behalf and has now appropriately acknowledged that his conduct amounts to professional misconduct, this engagement has occurred very late in the piece and cannot be considered a mitigating factor.

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85 Affidavit of Nelson Nagoor dated 20 October 2022.
86 [Ms R] affidavit at [15]. Joshua Linder affidavit at [44].
87 Affidavit of Dr Nelson Nagoor dated 20 October 2022 at [10].
88 Affidavit of Dr Nelson Nagoor dated 20 October 2022.

[173] Overall, we are not satisfied that there are any significant aggravating or mitigating factors over and above the finding of professional misconduct for Dr Nagoor's failures in the standard of care that he provided to Mr Linder.

Tribunal findings on penalty

[174] The Tribunal has considered the relevant penalty principles, the comparative cases and the aggravating and mitigating factors in reaching a decision on the appropriate penalty that is tailored to our finding of professional misconduct by Dr Nagoor.

[175] In assessing the appropriate penalties, The Tribunal is mindful of the overarching objectives of the Act for the protection of the public and to maintain high professional standards.

[176] Punishment of the practitioner is a secondary purpose of the Tribunal's assessment of an appropriate penalty.

[177] In *Dr N,*[89] the Tribunal made the point that unlike the term "negligence" in the common law, there is no requirement under a disciplinary charge for the Director to prove that damage or harm has been suffered by the patient and that such harm was caused by the practitioner's breach of their duty of care owed to the patient.

[178] Instead, a disciplinary charge of clinical negligence under s 100(1)(a) of the Act focuses on the practitioner's breach of their duty in a professional setting.[90] So, 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 s 100(1)(a) of the Act.[91]

[179] Nonetheless, we have found Dr Nagoor's omissions in Mr Linder's care as a serious departure from professional standards reasonably to be expected of a medical practitioner

[89] *Dr N* 58/Med05/15D.
[90] *Dr N* 58/Med05/15D at [24]-[25].
[91] *Dr N* 58/Med05/15D at [26].

working in general practice. Any penalty to be imposed must also act as a deterrent and send a strong message to the medical profession of the unacceptable conduct by this practitioner.

[180] The finding of clinical negligence also takes into account the discredit that Dr Nagoor has brought to the medical profession. It is important for the Tribunal to maintain public confidence in the medical profession and for the accountability of Dr Nagoor. This point was made in the following way by Eichelbaum CJ in *Dentice v Valuers Registration Board:*[92]

> Disciplinary hearings exist to enforce a high standard of propriety and professional conduct; to ensure that no person unfitted because of his or her conduct should be allowed to practise the profession in question; to protect both the public and the profession itself against persons unfit to practise; and to enable the profession or calling, as a body, to ensure that the conduct of members conforms to the standards generally expected of them.

[181] There has been a serious departure by Dr Nagoor from his clinical responsibilities in the treatment and care of Mr Linder.

[182] Cancellation of a practitioner's registration is reserved for the most serious of cases. Both counsel acknowledge that to impose cancellation in this case would be out of step with the comparative cases of clinical negligence referred to above.

[183] Despite this agreed position, Ms Herschell submitted that cancellation should be imposed as suspension is not an appropriate alternative given Dr Nagoor's stated intention to retire. An order must have some consequences of significance for a practitioner as otherwise it is meaningless.

[184] In support of this submission, Ms Herschell referred to *Professional Conduct Committee v Houlding,*[93] where the Tribunal considered whether a period of suspension could suffice. However, it decided that suspension was not open to it because of Mr Houlding's stated retirement from practice. Conversely, however, an order for cancellation would not have a

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92 *Dentice v Valuers Registration Board* [1992] 1 NZLR 720 (HC) at 724, as cited by Collins J in *Roberts v Professional Conduct Committee* [2012] NZHC 3354 [44]-[51].

93 1061/Phys19/461P at [89].

deterrent consequence on Mr Houlding himself and the Tribunal suggested that this would be a pyrrhic outcome.[94]

[185] Counsel for the Director submitted that to impose suspension, as opposed to cancellation, was not appropriate as suspension is more apt where there is some condition affecting a practitioner's fitness to practice which may or may not be amendable to cure.[95]

[186] Dr Nagoor has stated that he has retired and does not have a current Practising Certificate and he does not currently live in New Zealand. Rehabilitation is not relevant to his circumstances. This is not a case where the practitioner has already responded to measures as a response with the intention of continuing to practise.[96]

[187] We observe that the practitioner has neither provided a written undertaking to the Medical Council nor can the Tribunal be satisfied with the practitioner's statement, and it remains open for Dr Nagoor to recommence practice in New Zealand.

[188] In *PCC v Beer,* [97] for example, in reliance of Dr Beer's undertaking to not practice again, the PCC withdrew its request for cancellation or suspension of Dr Beer's registration and the Tribunal imposed instead censure and a fine of $7,500 following a finding of clinical negligence. The Tribunal noted that if Dr Beer were to breach the undertaking that this would be another matter which could result in a further charge.

[189] We are satisfied that the appropriate penalty in this case is censure, the practitioner's suspension from practice for a period of three months, conditions should he resume practice, and a fine of $5,000.

[190] A term of three months' suspension from practice reflects the seriousness of the offending and will act as a deterrent to other practitioners. Conditions with supervision addressing the practitioner's competency and health concerns will be imposed for the

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[94] Ibid at [92]-[93].

[95] *A v Professional Conduct Committee* HC CIV-2008-404-2927, Keane J at [80]-[81], cited with approval in *Singh v Director of Proceedings* [2014] NZHC 2848 at [55]-[59].

[96] *A v Professional Conduct Committee* at [81]-[82].

[97] *PCC v Beer* 1025/Den18/428P at [15].

purpose of the protection and safety of the public should Dr Nagoor return to practice in New Zealand.

[191] In relation to the imposition of a fine, we have taken into account Dr Nagoor's financial circumstances as set out in his affidavit. We consider there is insufficient financial evidence to suggest that Dr Nagoor is unable pay a fine. A fine of $5,000 will be imposed.

[192] These penalties are consistent with the *White and Liston* cases involving clinical negligence by a practitioner.

[193] In *White*,[98] suspension was imposed even though Mr White, an optometrist was not currently practising.

[194] In *Liston,* suspension was not imposed, Dr Liston was censured and fined $5,000. There was a significant mitigating factor, as deposed by expert evidence, that Dr Liston was under significant pressure and stressors and was working for an under-resourced District Health Board. Further, as Dr Liston was the only oral and maxillofacial surgeon in the community, his role was critical to the operation of the hospital and suspending him would deprive the DHB and public the service he could offer.

[195] When imposing a fine as an alternative to suspension and conditions, the Tribunal stated it would be "Sending the wrong message for the Tribunal simply to censure without conditions on practice or any suspension".[99] The Tribunal considered that conditions including supervision were not necessary as Dr Liston had already completed a recertification programme.

[196] In 2019, Dr Nagoor abandoned his practice and simply left the country. Although Dr Nagoor did communicate with the HDC investigation, he did not substantially engage with the HDC or show insight into his professional responsibility to genuinely address this clinical error and communicate effectively with his patient.

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[98] 525/Opt 12/220P

[99] The Tribunal's decision was upheld on appeal to the High Court: *Liston v Director of Proceedings* [2018] NZHC 2981, Clark J.

[197] A penalty of suspension from practice for a period of three months and conditions with ongoing supervision will address the Tribunal's responsibility to protect the public and in all the circumstances, is fair, reasonable and proportionate.

[198] These penalties signal that when practitioners make a clinical error that falls below the appropriate standard of care, it is their professional and ethical responsibility to face up to these errors: The medical profession and the public would expect nothing less.

Costs

[199] The Tribunal may order the practitioner to pay part or all of the costs and expenses of and incidental to the HDC investigation and prosecution in respect of the Charge, and the cost of the hearing by the Tribunal.[100]

[200] When ordering the appropriate amount of costs, the Tribunal must consider the need for the practitioner to make a proper contribution towards the costs. In doing so, the Tribunal takes 50% of the total reasonable costs as a starting point.[101] An award of costs is not intended to be punitive and the practitioner's means, if known, should be considered.[102]

[201] An order for costs in any professional disciplinary proceeding involves the judgement as to the proportion of the costs that should be properly borne by the profession (being responsible for maintaining standards and disciplining its own profession) and the proportion which should be borne by the practitioner who has caused the costs to be incurred.

[202] In this case, the Director has capped the Commissioner's costs of the investigation at $2,000. The total costs submitted by the Director is $39,321.20.[103]

[203] The Tribunal's estimated costs of hearing is $34,133.32, a combined total of $73,454.52.[104]

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[100] Health Practitioners Competence Assurance Act 2003, s 101(1)(f).
[101] *Cooray v Preliminary Proceedings Committee,* HC Wellington, AP23/4, Doogue J, 14 September 1995.
[102] *Vatsyayann v PCC* [2012] NZHC 1138.
[103] Document 10, Penalty Submissions for Director of Proceedings, Appendix "A".
[104] Document 11, HPDT Estimate of Costs.

[204] Counsel for the Director submitted that while Dr Nagoor appropriately acknowledged professional misconduct in his affidavit filed shortly before the hearing, that he could have taken this position at the outset and saved the time and work to prepare the case on the basis of formal proof. Counsel appropriately acknowledged that with the cooperation of Dr Nagoor's counsel the hearing time was reduced significantly in that the evidence was taken as read and the penalty hearing was adjourned to be heard by way of an audio visual link, with submissions filed in advance.

[205] Counsel submitted that this was not an agreed matter in the traditional sense and would typically attract a contribution of 30%. In light of Dr Nagoor's lack of engagement until recently, counsel for the Director submitted that a 40% contribution is appropriate in the circumstances.

[206] Mr Holloway, counsel for the practitioner submitted that costs orders should not be punitive and that how Dr Nagoor has conducted himself is a factor for consideration regarding penalty, not costs. Counsel submitted that Dr Nagoor has acted responsibly, instructing counsel, not challenging the substance of the prosecution evidence and accepting the Charge and liability and that he should be given credit for this.

[207] Mr Holloway submitted that whether Dr Nagoor has professional indemnity, as he was represented by senior counsel, is not a relevant consideration in determining a costs award – it is Dr Nagoor's own means that are to be considered. As set out in his affidavit, he is unemployed and has no work-related income. He receives the equivalent of about $1,200 per month from an investment and the entirety of his income is spent on medical insurance, transport and co-payments for medicines and medical services not covered by insurance.

[208] In these circumstances counsel for the practitioner submitted that a costs order of 35% would ordinarily be warranted in recognition of Dr Nagoor's degree of cooperation.

[209] Based on Dr Nagoor's affidavit and that he did not make himself available to attend his disciplinary hearing, the Tribunal is not in a position to fully assess Dr Nagoor's financial means as there has not been a comprehensive statement of his financial position or the opportunity to test that position.

[210] the Tribunal orders that there should be a reduction of costs to take into account Dr Nagoor's cooperation, albeit belated, with the disciplinary process and his substantial admission to the Charge of professional misconduct. The hearing was able to proceed over two days in person without cross-examination of the Director's witnesses[105] and with a half day penalty hearing by way of AVL.

[211] The practitioner was also successful in an interlocutory hearing on objections to the evidence intended to be produced by the Director for the penalty hearing.[106]

[212] Balancing all of these factors, there will be a contribution by the practitioner of 35% of the estimated total costs of the Director and the Tribunal of $73,454.52, to be fixed at $26,000.

[213] The Tribunal is satisfied that these total costs to be paid by the practitioner is just and proportionate to the overall costs of the Director's investigations and the disciplinary hearing.

Permanent non-publication orders

[214] Interim non-publication orders were made in respect of two of the Director's witnesses: [Ms R], Mr Linder's[family member] and [Ms E], a Nurse at Ngā Kete. Each of these witnesses provided an affidavit in support of their application for permanent name suppression.[107]

[215] There was no opposition from counsel for the practitioner in respect of these applications witnesses.

[216] The starting point in any consideration of name suppression is the fundamental principle of open justice, a principle which is reflected in s 95(1) of the Act. The Tribunal's power to order non publication is governed by s 95(2) of the Act. The test under s 95(2) requires the Tribunal to be satisfied that it is desirable to make one or more of the orders listed.

[105] The only exception was Dr Monnington who gave oral evidence to assist the Tribunal for clarification of the laboratory evidence.

[106] Med 22/554D Tribunal orders on Application by Practitioner Objecting to Evidence dated 18 November 2022.

[107] Affidavit of [Ms R] and Affidavit of [Ms E] in support of application for permanent non-publication orders.

[217] There has been considerable media interest in this matter regarding the circumstances of the care provided by Dr Nagoor to Mr Linder.

[218] For the reasons, they have provided, we are satisfied that the permanent non-publication order for suppression of the names and identifying details of Ms[R] and Ms [E] is desirable as their private interests outweigh any public interest in identifying them.

Result and orders

[219] The Charge of professional misconduct including particulars 1 to 4 are established as negligence pursuant to s 100(1)(a) of the Act and conduct that has brought and is likely to bring discredit to the medical profession pursuant to s 100(1)(b) of the Act is established.

[220] The Tribunal makes the following orders pursuant to s 101 of the Act:

(a) The practitioner's registrations is suspended for a period of three months from the date of this decision pursuant to s 101(1)(b) of the Act;

(b) An order that the following conditions apply should Dr Nagoor return to medical practice in New Zealand pursuant to s 101(1)(c) of the Act:

(i) Dr Nagoor will be required to practice under supervision with an approved supervisor for a period of 18 months as directed and set by the Medical Council. The cost of supervision is to be met by Dr Nagoor;

(ii) Dr Nagoor is required to undertake a performance assessment to determine his competency as directed by the Medical Council;

(iii) Dr Nagoor is not to practise as a sole practitioner for a period of three years from the date of this order; and

(iv) Dr Nagoor is to be referred to the Health Committee of the Medical Council for an assessment and monitoring of his health and fitness to practice.

(c) The practitioner is censured to mark the Tribunal's disapproval of the practitioner's failure to provide an appropriate standard of care to his patient and his failure to engage adequately with the investigation into his practice and the patient pursuant to s 101(1)(d) of the Act;

(d) The practitioner will be fined $5,000 pursuant to s 101(1)(e) of the Act;

(e) The practitioner is to make a contribution of 35% of the total costs of the Director of Proceedings and the Tribunal estimated at $73,454.52 to be fixed at $26,000 pursuant to s 101(1)(f) of the Act.

[221] There will be a permanent non-publication order of the name and identifying details of the Director's witnesses [Ms E] and [Ms R] pursuant to s 95 of the Act.

[222] The Tribunal recommends that the Registrar of the Medical Council notify this decision and orders to the relevant medical council in South Africa where the practitioner resides.

[223] Pursuant to s 157 of the Health Practitioners Competence Assurance Act 2003 the Tribunal directs the Executive Officer:

(a) To publish this decision and a summary on the Tribunal's website; and

(b) To request the Medical Council to publish either a summary of, or reference to, the Tribunal's decision in its professional publications to members, in either case including a reference to the Tribunal's website to enable interested parties to access the decision.

DATED at Dunedin this 17th day of March 2023

A J Douglass
Chair
Health Practitioners Disciplinary Tribunal

SCHEDULE

PARTICULARS OF CHARGE

TAKE NOTICE that pursuant to sections 91 and lO0(l)(a) and lO0(l)(b) of the Health Practitioners Competence Assurance Act 2003, the Director of Proceedings has reason to believe that a ground exists entitling the Tribunal to exercise its powers against you and charges that between 5 April 2019 and 2 August 2019, whilst caring for your patient Mr Joshua Linder you, being a registered medical practitioner, acted in such a way that amounted to professional misconduct.

IN PARTICULAR:

1. On or around 17 April 2019, after you received Mr Linder's histology report (in respect of a lesion you excised) which included the diagnosis "Primary melanoma, invasive. Subtype: Superficial spreading melanoma. Tumour thickness (Breslow): 8.9 mm. Level of invasion (Clark): III. Dermal mitotic rate: 4 per mm2", you failed in your care of Mr Linder, in that you did not take steps to contact Mr Linder to advise him about the histology report and/or to arrange an in-person consultation with Mr Linder to advise him about the histology report;

AND / OR

2. On 30 April 2019, during and/or following an appointment with Mr Linder and despite having received the histology report referred to in the first particular, you failed in your care of Mr Linder, in that you:

    (a) failed to advise Mr Linder about the diagnosis contained in the histology report and/or inform him that the lesion was cancerous and/or a melanoma; and/or

    (b) advised Mr Linder that the lesion was not cancer; and/or

    (c) failed to advise Mr Linder that a wider excision was recommended; and/or

(d) documented in Mr Linder's clinical notes that "at this stage no further excision to be done" despite the histology report recording and/or the clinical guidelines recommending a wider excision; and/or

(e) failed to refer and/or recommend referral of Mr Linder for further specialist assessment, management and/or treatment in respect of his melanoma; and/or

(f) in the alternative to (e), failed to document any discussion of such a referral to a specialist and/or recommendation and/or any decline of a referral by Mr Linder.

AND/OR

3. On or around 17 April 2019 and up until and including 2 August 2019 you failed to adequately communicate to Mr Linder that he had an advanced aggressive form of melanoma cancer;

AND/OR

4. On 2 August 2019, when you reviewed Mr Linder, you failed in your care of Mr Linder, in that you:

(a) Failed to refer and/or recommend referral of Mr Linder for further specialist assessment, management and/or treatment in respect of his melanoma; and/or

(b) recorded six-monthly reviews when three-monthly reviews would have been more appropriate; and/or

(c) failed to examine Mr Linder's lymph node basins; and/or

(d) failed to perform or document performing a "top-to-toe" skin check of Mr Linder.

The conduct alleged in the above four particulars separately or cumulatively amounts to professional misconduct. The conduct is alleged to amount to malpractice and/or negligence and/or conduct that brings discredit to the medical profession under sl00(l)(a) and slO0(l)(b).

DATED at Wellington this 19th day of May 2022