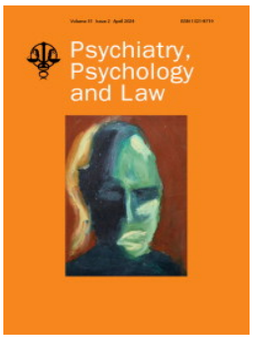

Psychiatry, Psychology and Law

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/tppl20

Case commentary: a 'merciful approach' to discipline for a New Zealand lawyer's misconduct

Kate Diesfeld, Marta Rychert, Lois J. Surgenor, Olivia Kelly & Kate Kersey

To cite this article: Kate Diesfeld, Marta Rychert, Lois J. Surgenor, Olivia Kelly & Kate Kersey (12 May 2024): Case commentary: a 'merciful approach' to discipline for a New Zealand lawyer's misconduct, Psychiatry, Psychology and Law, DOI: 10.1080/13218719.2024.2340098

To link to this article: https://doi.org/10.1080/13218719.2024.2340098

Psychiatry, Psychology and Law, 2024
Vol. 0, No. 0, 1–13, https://dx.doi.org/10.1080/13218719.2024.2340098

Case commentary: a 'merciful approach' to discipline for a New Zealand lawyer's misconduct

Kate Diesfeld[a], Marta Rychert[b], Lois J. Surgenor[c], Olivia Kelly[a] and Kate Kersey[d]

[a]*School of Public Health and Interdisciplinary Studies, Auckland University of Technology, Auckland, New Zealand;* [b]*SHORE and Whariki Research Centre, Masey University, Auckland, New Zealand;* [c]*Department of Psychological Medicine, University of Otago, Christchurch, New Zealand;* [d]*University of Auckland, Auckland, New Zealand*

A recent decision reveals how a New Zealand's disciplinary tribunal promoted justice for an unwell lawyer in a case of professional misconduct. In 2023, the Lawyers and Conveyancers Disciplinary Tribunal (LCDT) applied a 'merciful approach' when assessing the lawyer's misconduct and health issues. In *Auckland Standards Committee 3 v Ms W* [2023], the LCDT discussed the impacts of reproductive treatment in relation to the practitioner's conduct. This decision is the foundation to compare the disciplinary regime for legal and health practitioners in New Zealand. The article outlines New Zealand's framework for discipline of lawyers, noting the absence of a health pathway. The article discusses opportunities to resolve cases involving impaired lawyers outside the disciplinary system, including benefits and disadvantages of mandatory reporting. While focusing on the legal profession, the discussion is relevant to other professions and examines health-promoting regulatory strategies from other jurisdictions.

Keywords: disciplinary proceedings; health pathway; impairment; lawyers' discipline; mandatory reporting; name suppression; professional discipline; rehabilitation.

Article History: Received 15 December 2023; Accepted 2 April 2024

Introduction

Lawyers' associations and professional bodies are concerned about the health and well-being of their professions in many countries. International scholarship has reported high rates of depression, anxiety and substance dependence in the legal profession (Bergin & Jimmieson, 2014; Chan et al., 2014; Krause & Chong, 2019; Thiese et al., 2021). In New Zealand, lawyers' well-being is of enduring concern (Borissenko, 2014; Sim, 2014), and research is underway regarding diverse forms of distress experienced by New Zealand lawyers (Patel, 2023). The New Zealand Law Society recognises that 'the law is a fulfilling profession, but it can also be a stressful one' (New Zealand Law Society, 2024). In response, the Law Society created resources to support lawyers via the 'Practising Well' programme (see New Zealand Law Society, 2024). Yet the Lawyers and Conveyancers Disciplinary Tribunal (LCDT) observed in *Auckland Standards Committee 3 and Ms W* [2023] NZLCDT 35 (the *Ms W* decision) that some practitioners are unaware of, or feel unable to, express their health challenges.

Correspondence: Kate Diesfeld, School of Public Health and Interdisciplinary Studies, Auckland University of Technology, Private Bag 92006, Auckland 0627, New Zealand. Email: kate.diesfeld@aut.ac.nz
Accepted under the editorship of Professor Mark Nolan, Editor in Chief *Psychiatry, Psychology and Law*. Professor Kate Diesfeld was not involved in any editorial decisions regarding this manuscript.

New Zealand is not alone in assessing strategies to promote lawyers' well-being (Victoria Legal Services Board, 2020). For example, research from Victoria, Australia consistently revealed that rates of psychological distress are relatively high across the legal profession, with rates of depression appearing to be particularly high among law students, solicitors and barristers (Brady, 2019). 'There is also growing recognition that problems with depression, anxiety and burnout are not rare among legal professionals but instead are at very high levels and that these rates are driven by systemic factors within the profession itself' (Brady, 2019, p. 4). The effects are wide reaching for practitioners and potentially their families and clients (Brady, 2019; Krause & Chong, 2019).

This case commentary examines a recent example of how the LCDT managed discipline of an unwell practitioner. In the *Ms W* decision, the Tribunal explained how both physiological and mental health factors impacted the lawyer's performance and penalty. The commentary builds upon an analysis of New Zealand decisions regarding the health impairments of disciplined lawyers (Moore et al., 2015). It also explores the benefits of an explicit method to address practitioners' health impairments through a health pathway and notification requirements, with reference to New Zealand's Health Practitioners Competence Assurance Act 2003 (HPCAA).

Examination of Tribunal decisions reveals how disciplinary bodies administer justice and offer rich data regarding practitioners' health impairments and needs (Moore et al., 2015). More broadly, the decisions may inspire regulatory and legislative reform (Schulz et al., 2022), for example creation of a health pathway, to assist unwell lawyers, prevent substandard practice and protect the public.

The *Ms W* decision and her health conditions

This decision involved a practitioner's deceptive conduct from August 2019 to February 2021. To conceal her professional inaction, the practitioner lied to her client and other lawyers. She admitted that she made nine false statements to her client and the opposing lawyers between August 2019 and February 2021. For example, the practitioner suggested to her client that the court and opposing lawyers were at fault for delays. To the opposing lawyers, she attributed delays to her client's health issues. The LCDT found that the practitioner knew the statements were false. She admitted that this qualified as conduct that would reasonably be regarded by lawyers of good standing as disgraceful or dishonourable [Lawyers & Conveyancers Act 2006 (NZ), s 7(1)(a)(i); LCA].

In a foreshadowing of the outcome, the LCDT's introduction to the decision reported: 'If there was no basis for a merciful approach, (the conduct) would amount to a gross breach of her duty to her client and her duty of candour to other parties in the proceeding' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). The justification for a compassionate approach related to the practitioner's ill health. The LCDT described Ms W's lengthy reproductive difficulties and treatment, which spanned periods when the majority of the incidents occurred.

Two experts explained the effect of these factors upon the practitioner. A specialist adult psychiatrist reported on the 'medically induced state of physiological stress' that accompanied multiple miscarriages (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). He commented: 'She felt unable to disclose these personal upheavals to colleagues, while fulfilling professional and community tasks' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). A clinical psychologist reported on the effects of in vitro fertilisation upon the practitioner during the relevant period. The inter-related physical and mental issues included high anxiety, palpitations, fatigue and compromised concentration. In addition to grief and severe depression, the clinical psychologist noted that the

practitioner's 'thinking and memory' were impacted by the health events that occurred 'over the period she forgot to attend to the [client's] cases' (*Auckland Standards Committee 3 v Ms* [2023] NZLCDT 35).

The LCDT discussed Ms W's diminished responsibility with reference to the concept of infanticide within the Crimes Act 1961 (NZ) (s 178):

> While by no means a perfect analogy, the criminal law itself recognises the effect on the mental health of a woman not having fully recovered from the effect of giving birth to a child – the position must be (at least) equally so when a woman has gone through IVF for some five years. . . . (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35).

The expert clinical psychologist adduced evidence that 'the hormonal response of the body after miscarriage is the same as after a full-term delivery' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). Thus, the LCDT suggested a similarity between the primary stressors experienced by Ms W and the factors that may give rise to the recognition of diminished responsibility.

The LCDT observed that the cumulative effects of the practitioner's health conditions explained, but did not excuse, her conduct. Additional COVID-19 related stressors included home-schooling her child, coping with the failure of her husband's business and the death of her relative abroad. The LCDT accepted that although the practitioner could not 'avoid all responsibility, she was not totally rational in these panicky behaviours' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35) and did not accept the Standards Committee's view that her actions were calculated. The Tribunal concluded that she 'acted in an irrational manner out of an increasing level of panic' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35).

Additional matters influenced the LCDT. The practitioner's deception occurred over 18 months but only related to one file. In her previous two decades of practice, the practitioner had no disciplinary history. She had made many positive contributions to her profession and constructively engaged with the disciplinary process. After Ms W was 'firmly confronted with her wrongdoing', she 'promptly made peace with her former client' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35) and compensated him $75,000, which demonstrated 'her basic integrity' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). Subsequently, the client did not pursue his complaint.

Orders

The LCDT had a range of penalty options, including: striking the practitioner off the roll or suspending the person from practice for a period not exceeding 36 months (LCA, s 242(1)(c)-(f)); prohibiting the person from practising on their own account (LCA, s 242 (1)(g)); imposing a fine not exceeding $30,000 (LCA, s 241(i)-(j)); issuing an order to provide restitution or compensation (LCA, s 156(1)(d)-(h)); issuing an order of a supervisory or educational nature (LCA, s 156(1)(j)-(m)); and reprimanding or censuring the practitioner (LCA,s 156(1)(b)). The LCDT may make orders that the Standards Committee can make (LCA, s 242(1(a)), for example an order that the person apologise to the complainant (LCA, s 156(1)(c)).

The LCDT's approach to penalties in the *Ms W* decision

The LCDT clearly expressed its rationale for lenient penalties:

> Although the misconduct calls for condemnation, we regard this as an appropriate case to extend a merciful approach. Her misconduct was not borne out of desire to harm the client, nor to advance her own interests beyond the immediate embarrassment of accepting she had been failing in her work (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35).

The practitioner's conduct was the result of 'overwhelming stress, rather than the

disclosure of a basic flaw in her professionalism' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). However the LCDT acknowledged the nature and duration of her problematic conduct:

> Despite the desperation we recognise in the narrative, the misleading conduct extended over a long period, and it requires condemnation. The misleading falsehoods had an apparent measure of coherence and consistency which adds to their pernicious nature (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35).

The LCDT explained the precedents that guided their decision-making, preferring LCDT decisions 'where medical factors and compassion affected the outcome' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35), including *Auckland Standards Committee 3 v Anderson* [2022] LCDT 25 and *Auckland Standards Committee 1 v Latton* [2017] NZLCDT 14. Their influence was reflected in the LCDT's penalty decision:

> When we consider what happened in light of physiological and mental ill-health, we are inclined to take a merciful view on penalty. This does not mean a permissive approach, but the response must not only match the misconduct but must also conform to our assessment of the practitioner and our assessment of negligible risk to the public (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35).

Ms W was not struck off. She was censured, suspended from practice for two months and prohibited from practising on her own account unless authorised by the LCDT to do so. She was ordered to pay the Standards Committee costs of $12,890 and reimburse the New Zealand Law Society for the LCDT costs of $3713. These penalties took account of the extensive, private and sensitive health challenges she had experienced. The decision provides a robust foundation to explore disciplined practitioner's well-being and strategies for their restoration to practice.

New Zealand's legislative framework for lawyers' regulation and discipline

The LCA provides the regime for regulating lawyers who hold a current practising certificate, such as Ms W. However, the LCA does not have a clear pathway for health impairment notifications and in this respect differs from the regime of registered health practitioners under the HPCAA.

The disciplinary framework for lawyers is organised between the New Zealand Law Society (NZLS) as the regulator and two statutory bodies – the Legal Complaints Review Officer (LCRO) and the LCDT. In most instances the disciplinary process begins with a complaint to the NZLS Lawyers Complaint Service. The matter is then referred to a Standards Committee that consists of practitioners and lay members (LCA, s 129). The Standards Committee enquires into, and investigates, complaints (LCA, s 130) and may initiate an investigation of its own motion (LCA, s 130 (c)). It may make final decisions on the complaint or bring charges before the Tribunal (LCA, s 130 (e) and (f)). This committee has broad discretion to take no further action (LCA, s 138(2)).

The LCRO (a non-lawyer) independently reviews decisions of the Standards Committee. It has broad powers to confirm, modify or reverse the Standards Committee's decisions (LCA, s 192). Decisions to refer to the Tribunal may be challenged through the LCRO (LCA, s 193). The LCRO may frame the charge or direct the Standards Committee to do so (LCA, s 212). The Tribunal consists of lawyer and lay members (LCA, s 228). For a quorum for a hearing, the panel consists of the chairperson or deputy chairperson and an even number of other members that is no less than four (LCA, s 234(1) and (2)). Half of those members must be lay members (LCA, s 234(3)). Members are not renumerated.

Disciplinary charges

The charges that may be brought before the LCDT are that the practitioner has been guilty of: misconduct (LCA, s 241(a)), unsatisfactory conduct (LCA, s 241(b)) or negligence or incompetence in a professional capacity (LCA, s 241(c)). The remaining charge is that the practitioner has been convicted of an offence punishable by imprisonment, and the conviction reflects on the practitioner's fitness to practice or tends to bring the practitioner's profession into disrepute (LCA, s 241(d)).

Misconduct is conduct that occurs at a time when the practitioner is providing regulated services and 'that would reasonably be regarded by lawyers of good standing as disgraceful or dishonourable' (LCA, s 7(1)(a)(i)) or is 'wilful or reckless contravention of any provisions of this Act or of any regulations or practice rules made under the Act' (LCA, s 7(1)(a)(ii)). Ms W was found guilty of professional misconduct pursuant to LCA s 7(1)(a)(i).

In contrast, unsatisfactory conduct occurs when the practitioner is providing regulated services and is conduct that 'falls short of the standard of competence and diligence that a member of the public is entitled to expect of a reasonably competent lawyer' (LCA, s 12(a)) or that would be regarded by 'lawyers of good standing as being unacceptable' (LCA, s 12(b)), including 'unbecoming' (LCA, s 12(b)(i)) or 'unprofessional' (LCA, s 12(b)(ii)). Additional guidance regarding misconduct or unsatisfactory conduct is contained with the Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care) Rules 2008.

The interrelationship between legal practice and lawyers' health

Lawyers, like other individuals, may suffer from a constellation of health issues that result in discipline. The *Ms W* decision was distinctive regarding its discussion of the impact of a lawyer's reproductive and mental health upon her practice. Analysis of past New Zealand LCDT decisions also revealed examples of diverse impairments that had bearing on misconduct, including: mental health issues such as anxiety, depression, personality disorders and cognitive impairment; physical health conditions; substance misuse such as alcohol or drug dependence; and problem-gambling (Moore et al., 2015). Similarly, studies of impaired physicians revealed that their health is key to their professional functioning (Bradfield et al., 2023; Kiel, 2013).

In some instances lawyers' ill health and their legal practices are interrelated (Medlow et al., 2011). Several disciplinary decisions remark on how legal practice impacts upon lawyers' health (e.g. *Auckland Standards Committee 4 v Lynette O'Boyle,* 2021, NZLCDT 27). High workloads, the lack of work–life balance, high turnover levels (Bergin & Jimmieson, 2014), burnout (Nickum & Desrumaux, 2023) and the impact of secondary trauma (Iversen & Robertson, 2021) contribute to the stressful nature of lawyers' work. Often legal practice is competitive and adversarial and involves extended work hours (Moore et al., 2015).

In some decisions the ill health is depicted as a private matter (i.e. not directly arising from the nature of lawyers' work). Ms. W's physiological and psychological conditions were depicted as 'personal material' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35) that influenced her professional functioning and the LCDT's decision regarding protection of her privacy.

Name and health information suppression

The LCDT is permitted to order non-publication where it is deemed to be appropriate (LCA, s 24). The LCDT's compassionate approach in the *Ms W* decision extended to suppressing her identity. (Also, the names of her client, other lawyers referenced in the proceedings and her employer were not disclosed.) Part of the rationale was that she

posed a negligible public risk, and her 'underlying character and practice' were satisfactory (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). She had made considerable contributions to the profession and had 'taken every step (the LCDT) could recommend, to make her practice safe' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). But another justification for name suppression seemed linked to the nature of her health issues.

The LCDT has a range of approaches to protecting practitioners' health information and identities. For example, strenuous privacy protection regarding health information was afforded to a trust account administrator who had 'several stressors that explained the context of her conduct', namely the theft of $2750 from her employer (*Auckland Standards Committee 2 v Name Suppressed* [2021] NZLCDT 17). The health details were contained in the decision's addendum that was fully suppressed, as was her name and the name of her former employer.

In another decision the practitioner's identity was disclosed while his 'grave health problems' were not detailed although they were directly relevant to his misconduct (*Auckland Standards Committee 2 v Mark William Miller,* 2020, NZLCDT 24). The LCDT reasoned that the practitioner's circumstances warranted a 'compassionate and proportionate response' regarding suppression of his health status but the LCDT reported that the decision 'cannot be treated as any precedent that benchmarks a more tolerant approach' (*Auckland Standards Committee 2 v Mark William Miller* [2020] NZLCDT 24). In contrast, a practitioner's name was revealed, and his alcohol problems were described but his other medical concerns were not disclosed because the LCDT did not deem them of concern to the public in *Nelson Standards Committee v Craig Peter Stevenson* (2020) NZLCDT 42, redacted decision 9 April 2020.

In the *Ms W* decision the LCDT discussed its decision regarding how much information to reveal. On the one hand, the LCDT reported: 'In this case, it would be inappropriate to publish the detail of the practitioner's medical and stress-related matters. She is entitled to the dignity of privacy' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). On the other hand, the LCDT justified disclosure of several details of the Ms W's health history: 'By approaching the case in this way, we hope to provide a salutary reminder to members of the profession about the impact of undue stress on the way in which they undertake their business' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). The LCDT continued that there is a 'the need for lawyers to recognise when they are not coping, and to call for assistance (whether from a colleague or other professional), and to ensure the client is always informed and advised' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35).

The case illustrates the tension that tribunals, and researchers, face when attempting to protect practitioners' privacy while providing adequate, relevant details in the public interest (Diesfeld et al., 2016). The decision raises awareness for regulatory bodies and tribunals regarding the complex health issues that sometimes accompany reproductive treatment, pregnancy and miscarriage. It also expresses the need for impaired players to be self-aware of their health status and to seek assistance. Access to a health pathway may respond to this concern.

Absence of a health pathway for legal practitioners

Perhaps the LCDT adopted a merciful approach towards Ms W because compassionate intervention is *not* delivered through a lower level intervention within the lawyers' disciplinary scheme. The absence of a health pathway under the LCA was specifically noted in a 2020 decision involving a lawyer with alcohol problems:

It is accepted that a very sad feature of this case is that the practitioner is, as described by his counsel, 'in the grips of addiction'.

Counsel for the Standards Committee concedes that this seriously complicates the assessment of a proper penalty for such serious charges.

> *The legislation (the LCA), unlike that for disciplinary processes for health practitioners, does not have specific provisions for dealing with a practitioner who is impaired in some way* (*Nelson Standards Committee v Craig Peter Stevenson* [2020] NZLCDT 42, redacted decision 9 April 2020) (emphasis added).

If a lower level pathway for therapeutic intervention was available to lawyers, some cases potentially would not progress to the LCDT.

International examples of a health pathway

In other jurisdictions increasing attention has been directed at the relationship between professionals' misconduct and their ill health, including substance dependence. In some jurisdictions regulators have adopted a dual-pathway regime to distinguish between practitioners' deficits in competence, in contrast with their health-related impairments (Moore et al., 2015). Often health professions led this reform, for example in Australia (Moore et al., 2015), Canada and the United States (Freckelton & Bennett, 2015; Freckelton & Molloy, 2007). This framework exists for health practitioners, but not lawyers, in New Zealand.

New Zealand registered health practitioners' health pathway

In New Zealand health practitioners may be subject to review if they are incapable of safely practising. The HPCAA includes a reporting process for those who are unable to perform the functions required for the practice of their professions because of relevant mental or physical condition (HPCAA, s 45(3)). The duty of the Registrar in this regard is defined (HPCAA, s 47), and the relevant authority may direct practitioners to submit themselves for examination or testing by an assessor at the expense of the authority (HPCAA, s 49(1)). The authority must consult with the practitioner about the assessor who will undertake the examination or test (HPCAA, s 49(3)). The assessor then reports to the Registrar (HPCAA, s 49(6)). The authority may order suspension (HPCAA, s 50(3)) or conditions upon practice (HPCAA, s 50(4)).

This intervention offers a potentially therapeutic response and may prevent misconduct (and formal discipline) for health practitioners. In effect, there are health-related filters that might avert discipline. Firstly, the matter may be deemed as primarily a fitness to practise or health issue and not be referred for investigation by a Professional Conduct Committee (PCC). Secondly, and even if investigated by a PCC, the PCC may recommend that the regulatory authority review the practitioner's fitness (HPCAA s 80(2)(b)) instead of, or as well as, the matter progressing to the HPDT.

In contrast, lawyers with impairments do not have this opportunity, and the LCDT is itself mindful of this gap through rehabilitative penalties, as evident in *Auckland Standards Committee 1 v Brett Dean Ravelich* [2020] NZLCDT 22.

New Zealand's challenge is how to develop sound, autonomy promoting and pro-therapeutic measures for legal practitioners. The optimum strategy protects the public by intervening early through support for struggling lawyers, thereby averting tribunal proceedings where appropriate circumstances exist. This would require legislative reform and perhaps a cultural shift in the legal profession.

Mandatory reporting of mental or physical issues impairing practice

The *Ms W* decision described a distressed practitioner who did not reveal her health conditions. According to the LCDT: 'Like a person with hypothermia, she attempted to soldier

on, not seeking help when she was very unwell, not even alerting those around her of her plight' (*Auckland Standards Committee 3 v Ms W* [2023] NZLCDT 35). Although controversial, reform of the mandatory reporting scheme could aid practitioners like Ms W who cannot, or do not, seek assistance.

Mandatory reporting is one means to protect the public because regulators are able to access information regarding practitioners' performance and, in relevant circumstances, health information. However, opponents argue that this strategy 'deters help-seeking and drives practitioners underground' (Bismark et al., 2016, p. 2). These schemes need to have very clear guidance regarding when this duty is triggered and how reports are handled, with fair and timely responses (Leslie & Nelson, 2018). The following discussion reflects upon such schemes for health and legal practitioners in New Zealand, with reference to international schemes.

Health practitioners

Mandatory reporting exists for health practitioners in New Zealand. It applies to practitioners who are unable to perform their required functions due to mental or physical conditions. Ninety percent of the submissions to the Ministry of Health supported such mandatory reporting, and 80% supported mandatory reporting of incompetence (Cull, 2001, p. 72). In the year ending 30 June 2022, there were 51 notifications regarding doctors' ability to perform due to mental or physical conditions reported (Medical Council of New Zealand, 2022, p. 31), suggesting that this requirement is exercised.

The legislation provides that health practitioners *may*, but are not required to, report another practitioner's *incompetence* (HPCAA, s 34). In contrast, for *health impairments* there is a mandatory requirement to make a notification, including self-notification, under the HPCAA s 45. If one of the designated people 'has reason to believe that a health practitioner is unable to perform the functions required for the practice of his or her profession because of some mental or physical condition', the person must notify the Registrar (HPCAA, s 45(2)). A mandated reporter is a person who: is in charge of an organisation that provides health services; is a health practitioner; is an employer of health practitioners; or is a medical officer of health (HPCAA, s 45(1)(a)-(d)). Those who report are protected from civil and disciplinary proceedings, unless they acted in bad faith (HPCAA, s 45 (6)). Additionally, 'any person' with these beliefs regarding the practitioner may notify the Registrar (HPCAA, s 45(3)).

In New Zealand it is expected that most notifications of this nature result in undertakings to limit the health practitioners' practices, although few are the result of mandated reports. For example, in the most recent Medical Council Annual Report, of the notifications regarding doctors' inability to perform their functions, 22 were about mental health, 10 about physical health and 4 about substance use (Medical Council of New Zealand, 2022, p. 33). Just under 40% were reported by the doctors themselves (Medical Council of New Zealand, 2022, p. 33). But no notifications resulted in conditions or in interim or full suspensions (Medical Council of New Zealand, 2022, p. 33).

The Health Committee approach was explained by the Committee's Chair, Dr Pamela Hale: 'We carefully balance any risks to patient safety with compassionate management of the doctor, encouraging and facilitating treatment of their health condition' (Medical Council of New Zealand, 2022, p. 32). The emphasis on humane responses was echoed in the LCDT's decision regarding *Ms W*.

Other jurisdictions also have mandatory reporting in respect of *health* practitioners. Many states within the United States have mandatory reporting statutes that require physicians and other health care professionals to report to appropriate authorities those physicians whose ability to practise is impaired by

alcohol or drug use, or by physical or mental illness (DesRoches et al., 2010). A comparative analysis of schemes in Australia and Ontario, Canada also provides insights on reporting of impaired health practitioners (Leslie & Nelson, 2018).

Lawyers

There is a distinction between New Zealand's approach to reporting of impaired health practitioners and of legal practitioners. There is a narrower approach for reporting lawyers' health conditions. In considering whether a lawyer can be admitted, the LCA requires legal practitioners to self-report any 'mental or physical health condition' that renders them 'unable to perform the functions required for the practice of the law' (LCA, s 55(1)). The ongoing mechanism for self-reporting is on the annual renewal of a lawyer's practising certificate. The lawyer is prompted to declare any mental or physical health condition as part of a series of 'fit and proper person' declarations. There is an ongoing requirement to disclose any matter that may affect continuing eligibility to hold a practising certificate, including any fit and proper person considerations (Lawyers and Conveyancers Act (Lawyers: Practice Rules) Regulations 2008, Cl 8). Any non-disclosure or false declaration has the potential to become a disciplinary matter (LCA s 7(1)(a)(ii)).

New Zealand does not have a provision for mandatory reporting of lawyers by others specifically on the basis of the lawyer's *health*. The lawyer's duty to report colleagues applies to the most serious or obvious breaches of professional obligations. Rule 2.8 of the Lawyers: Conduct and Client Care Rules 2008 places a mandatory duty to report 'misconduct' as defined in LCA (s 7). 'A lawyer who has reasonable grounds to suspect that another lawyer may have engaged in misconduct must make a confidential report to the Law Society at the earliest opportunity'. Rule 2.9 is more permissive and relates to the reporting of the 'unsatisfactory conduct', which is less egregious, and defined in LCA (s 12). Thus, there is no formal mechanism for reporting on the basis of ill health.

In some cases it may be difficult to assess the impact of lawyers' health on their practice, both for external parties and for the practitioners themselves. Perhaps a legal requirement for expanded mandatory reporting may trigger beneficial interventions by the regulatory body. Perhaps even the spectre of being the subject of a notification may prompt practitioners to self-report, although admittedly this is a coercive rationale for reform.

New Zealand's initiatives in the legal sector

In 2009, New Zealand established an initiative to support lawyers' well-being. The New Zealand Law Society's 'Practising Well' website offers general information to promote health and mentoring (New Zealand Law Society, 2024). Up to six free, confidential counselling sessions are available. Also, for those who 'need a break for recreational or health reasons and to provide short cover for short term absences', a Locum Panel list of approved lawyers is provided (New Zealand Law Society, 2024). Through the Law Care Service, legal professionals can confidentially discuss sensitive matters. It serves legal professionals who have experienced, witnessed or been affected by sexual assault, sexual harassment or other unacceptable behaviour. The National Friends Panel offers confidential communication with another lawyer for advice related to personal and professional matters. Also, a lawyer through the Complaints Advisory Service may be confidentially contacted by practitioners who are subject to a complaint.

Complementary strategies for lawyers' well-being

From Australia, we see recommendations for additional support for lawyer well-being; the

Victoria Legal Services Board and Commissioner's Lawyer Wellbeing Report offers a spectrum of strategies (Brady, 2019). These included: increased promotion of counselling and debriefing programmes; reforms to court practices; improved management training; the incorporation of a well-being focus with the continuing professional development requirements; and increased collaboration with researchers.

International research has inquired whether professional regulation can better attend to practitioners' well-being through more humane processes. Scholars asked whether there are methods to incorporate kindness into regulatory processes, to reduce the stress, shame and ill health that may result from professional discipline (Biggar et al., 2022). An example is the implementation of risk assessment process to differentiate complaints regarding relatively minor or single errors or omissions from 'serial incompetence or gross misconduct' (Biggar et al., 2022, p. 1).

Scholars who have examined relatively more humane doctors' disciplinary schemes from Australia and New Zealand provide additional insights that may contribute to reform on behalf of impaired New Zealand lawyers. These include training of the relevant professions regarding mandatory reporting duties; integration of specialist clinicians into health services (e.g. addiction medicine specialists) within the regulatory pathway; and promotion of a more pro-therapeutic approach by regulators (Bradfield et al., 2023).

Concluding reflections upon the power of penalties to promote lawyers' well-being

The *Ms W* decision is one of several cases that signal the LCDT's willingness to adopt a compassionate approach to impaired lawyers. This orientation may promote lawyers' health and thereby assist with their return to practice. The LCDT stated its 'compassionate and proportionate response' in *Auckland Standards Committee 2 v Mark William Miller* [2020] NZLCDT 24. Similarly, the LCDT referred to the 'compassionate and sensible approach by counsel of the Standards Committee' in *Auckland Standards Committee 1 v Brett Dean Ravelich* [2020] NZLCDT 22. The penalty included a plan to manage the practitioner's alcohol dependence and rehabilitation, noting that the alcohol dependence was linked with his misconduct.

The LCDT has expressed that it has a role in promoting lawyers' well-being. In *Auckland Standards Committee 4 v Lynette O'Boyle* [2021] NZLCDT 27, the LCDT referred to the practitioner's family law practice and her inability to 'develop healthy ways of managing stress' (*Auckland Standards Committee 4 v Lynette O'Boyle* [2021] NZLCDT 27). According to the LCDT: 'Were we simply to suspend Ms. O'Boyle from practice, we would be leaving the job largely undone' (*Auckland Standards Committee 4 v Lynette O'Boyle* [2021] NZLCDT 27). The LCDT further noted that 'in appropriate cases, rehabilitation will be an important component of the Tribunal's response' (*Auckland Standards Committee 4 v Lynette O'Boyle* [2021] NZLCDT 27). A targeted, direct intervention involving 'rehabilitative supervision' was ordered for the management of Ms O'Boyle's personal and profession stress (*Auckland Standards Committee 4 v Lynette O'Boyle* [2021] NZLCDT 27).

The LCDT's attention to rehabilitation was evident in additional cases. For example, the LCDT observed:

> The purpose of penalty proceedings is not a punitive one, it is to protect the public and the reputation of the profession by upholding professional standards. Further purposes can be rehabilitation and deterrence, both specific and general [*Otago Standards Committee v Simon Nicholas Claver* (2019) NZLCDT 8].

Thus, LCDT decisions have acknowledged that rehabilitative penalties can be designed for restoration to practise in appropriate

circumstances. Development of a rehabilitation theory to guide disciplinary proceedings may have manifold benefits for lawyers and other registered practitioners (Surgenor et al., 2023).

However, the LCDT does not always craft penalties to address the practitioner's health issues. In *Auckland Standards Committee v Jesse Seang Ty Nguy* [2021] NZLCDT 26, the practitioner's mental health concerns were not deemed to be an excuse for his misconduct. Medical opinions reported that he was 'prone to anxiety and depression' (*Auckland Standards Committee v Jessie Seang Ty Nguy* [2021] NZLCDT 26) and raised the mental health impact of the effects of the disciplinary process itself. According to the LCDT:

> This is not surprising, as the (processes) concern Mr Nguy's deliberate acts of dishonesty involving large sums of money. It is common for practitioners to feel stressed by disciplinary processes, especially at the more grave level like this case (*Auckland Standards Committee v Jessie Seang Ty Nguy* [2021] NZLCDT 26).

The practitioner was struck off for the misapplication of funds in excess of $1 million held by him on trust, with no mention of a compassionate disposition. Thus, there is variation in LCDT decisions, regarding who is afforded compassion.

Insight can be derived from how other tribunals demonstrated compassion through rehabilitative conditions. For example, rehabilitation featured in the HPDT's discipline of an impaired pharmacist (*Professional Conduct Committee v Mr S,* Pharm 09/126 P, 23 March 2017). Mr S had become fixated on the belief that his hair was falling out and resorted to stealing Propecia from a pharmacy. He was convicted of eight charges of theft. The HPDT pro-therapeutic orders included: cognitive behavioural therapy as recommended by a specified psychologist; reports from that clinician to the Pharmacy Council; assessment by Council's Health Committee; formalisation of his relationship with his Council-appointed mentor; development of his networks with other members of the pharmacy profession; and annual reports to the Council regarding these contacts.

The HPDT embraced an explicitly rehabilitative approach for Mr S, with detailed conditions to support his return to safe practice. Similar pro-therapeutic penalties may assist unwell practitioners from other professions, including lawyers.

Conclusion

The *Ms W* decision illustrates the LCDT's 'merciful' approach to a lawyer suffering from multiple, inter-related health concerns. The LCDT may have adopted this orientation because there is not a health pathway available under the LCA to support impaired lawyers. Given this gap, the task may be addressed in some instances by the LCDT through compassionate penalties. Examination of the health pathway for health practitioners under the HPCAA may be informative because it contains a relatively pro-therapeutic, health--promoting orientation. Also, expansion of the Practising Well Programme could be informed by constructive strategies such as Victoria's Lawyer Wellbeing programme and exploration of models for promoting lawyers' wellbeing (Cipriano, 2023). This combination of strategies may afford New Zealand lawyers greater supports, similar to those that their colleagues within the registered health professions enjoy. This spectrum will offer additional, humane responses for lawyers who face complaints and professional discipline.

Ethical standards

Declaration of conflicts of interest

Kate Diesfeld has declared no conflicts of interest.

Marta Rychert has declared no conflicts of interest.

Lois J. Surgenor has declared no conflicts of interest.
Olivia Kelly has declared no conflicts of interest.
Kate Kersey has declared no conflicts of interest.

Ethical approval

This article does not contain any studies with human participants or animals performed by any of the authors.

ORCID

Kate Diesfeld http://orcid.org/0000-0002-8117-551X
Lois J. Surgenor http://orcid.org/0000-0002-1972-598X

References

Bergin, A. J., & Jimmieson, N. L. (2014). Australian lawyer well-being: Workplace demands, resources and the impact of time-billing targets. *Psychiatry, Psychology and Law*, *21*(3), 427–441. https://doi.org/10.1080/13218719.2013.822783

Biggar, S., Fletcher, M., Van Der Gaag, A., & Austin, Z. (2022). Finding a place for kindness: Public protection and health professional regulation. *International Journal for Quality in Health Care*, *34*(3), 1. https://doi.org/10.1093/intqhc/mzac057

Bismark, M. M., Mathews, B., Morris, J. M., Thomas, L. A., & Studdert, D. M. (2016). Views on mandatory reporting of impaired health practitioners by their treating practitioners: A qualitative study from Australia. *BMJ Open*, *6*(12), e011988. https://doi.org/10.1136/bmjopen-2016-011988

Borissenko, S. (2014, November 21). Dealing with mental illness. LawTalk, 855, 5.

Bradfield, O., Jenkins, K., Spittal, M., & Bismark, M. (2023). Australian and New Zealand doctors' experiences of disciplinary notifications, investigations, proceedings and interventions relating to alleged mental health impairment: A qualitative analysis of interviews. *International Journal of Law and Psychiatry*, *86*, 101857. https://doi.org/10.1016/j.ijlp.2022.101857 accessed 5 December 2023.

Brady, M. (2019). *VLSB + C Lawyer Wellbeing Project Report on legal professionals' reflections on wellbeing in the legal profession and suggestions for future reforms*. https://www.lsbc.vic.gov.au/lawyers/practising-law/lawyer-wellbeing/lawyer-wellbeing-report

Chan, J., Poynton, S., & Bruce, J. (2014). Lawyering stress and work culture: An Australian study. *University of New South Wales Law Journal*, *37*, 1062.

Cipriano, T. (2023). *The thriving lawyer: A multidimensional model of well-being for a sustainable legal profession*. Taylor & Francis.

Cull, H. Q. (2001). *Review of processes concerning adverse medical events*. Ministry of Health.

DesRoches, C. M., Rao, S. R., Fromson, J. A., Birnbaum, R. J., Iezzoni, L., Vogeli, C., & Campbell, E. G. (2010). Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA*, *304*(2), 187–193. https://doi.org/10.1001/jama.2010.921

Diesfeld, K., Surgenor, L. S., Ip, M., & Kersey, K. (2016). Name suppression practices of New Zealand's Health Practitioners Disciplinary Tribunal 2004–2014. *Journal of Law and Medicine*, *24*(2), 504–515. PMID: 30137718.

Freckelton, I., & Bennett, B. (2015). Regulating professional practice. In Y. Joly & B. M. Knoppers (Eds.), *Routledge handbook of medical law and ethics* (p. 147). Routledge.

Freckelton, I., & Molloy, P. (2007). The health of health professionals: Remedial programs, regulation and the spectre of the law. *Journal of Law and Medicine*, *15*(3), 366.

Iversen, S., & Robertson, N. (2021). Prevalence and predictors of secondary trauma in the legal profession: A systematic review. *Psychiatry, Psychology, and Law: An Interdisciplinary Journal of the Australian and New Zealand Association of Psychiatry, Psychology and Law*, *28*(6), 802–822. https://doi.org/10.1080/13218719.2020.1855270

Kiel, H. (2013). Regulating impaired doctors: A snapshot from New South Wales. *Journal of Law and Medicine*, *21*(2), 429–440.

Krause, C. A., & Chong, J. (2019). Lawyer well-being as a crisis of the profession. *South Carolina Law Review*, *71*(2), 203.

Leslie, K., & Nelson, S. (2018). Mandatory reporting of health professional incompetence and incapacity: Is it time to adopt the Australian regime? *Nursing Leadership*

(Toronto, Ont.), *31*(3), 8–18. https://doi.org/10.12927/cjnl.2018.25682
Medical Council of New Zealand. (2022). *Annual Report ending 2022*. https://www.mcnz.org.nz/assets/Publications/Annual-Reports/MCNZ-Annual-Report-2022.pdf
Medlow, S., Kelk, N., & Hickie, I. (2011). Depression and the law: Experiences of Australian barristers and solicitors. *Sydney Law Review*, *33*(4), 771.
Moore, J., Buckingham, D., & Diesfeld, K. (2015). Disciplinary tribunal cases involving New Zealand lawyers with physical or mental impairment, 2009 - 2013. *Psychiatry, Psychology and Law*, *22*(5), 649–672. https://doi.org/10.1080/13218719.2015.1055624
New Zealand Law Society. (2024). *Practising well*. https://www.lawsociety.org.nz/professional-practice/practising-well/
Nickum, M., & Desrumaux, P. (2023). Burnout among lawyers: Effects of workload, latitude and mediation via engagement and over engagement. *Psychiatry, Psychology, and Law: An Interdisciplinary Journal of the Australian and New Zealand Association of Psychiatry, Psychology and Law*, *30*(3), 349–361. https://doi.org/10.1080/13218719.2022.2035840
Patel, G. (2023, February 19). Law in distress: How are lawyers impacted by work-related stress?. In *Professional tribunals: Research, practice and new directions conference*. *Auckland University of Technology*.
Schulz, J. S., Forster, C., & Diesfeld, K. (2022). The discipline of, and failure to sanction, sexual misconduct by Australian legal practitioners. *Legal Ethics*, *25*(1–2), 88–108. https://doi.org/10.1080/1460728x.2022.2146965
Sim, E. (2014, November 21). It's a stressful profession. LawTalk, 855, 8.
Surgenor, L. J., Diesfeld, K., & Rychert, M. (2023). Practitioner rehabilitation following professional misconduct: A common practice now in need of a theory? *Laws*, *12*(3), 59. https://doi.org/10.3990/laws12030059
Thiese, M. S., Allen, J. A., Knudson, M., Free, K., & Petersen, P. (2021). Depressive symptoms and suicidal ideation among lawyers and other law professionals. *Journal of Occupational and Environmental Medicine*, *63*(5), 381–386. https://doi.org/10.1097/JOM.0000000000002127
Victoria Legal Services Board. (2020). *Lawyer wellbeing*. https://www.lsbc.vic.gov.au/lawyers/practising-law/lawyer-wellbeingicotria

Cases

Auckland Standards Committee 1 v Latton [2017] NZLCDT 14 (8 June 2017)
Auckland Standards Committee 1 v Brett Dean Ravelich [2020] NZLCDT 22 (16 July 2020)
Auckland Standards Committee 2 v Mark William Miller [2020] NZLCDT 24 (7 August 2020)
Auckland Standards Committee 2 v Name Suppressed [2021] NZLCDT 17
Auckland Standards Committee 2 v Jessie Seang Ty Nguy [2021] NZLCDT 26 (21 October 2021)
Auckland Standards Committee 3 v Anderson [2022] NZLCDT 25 (22 July 2022)
Auckland Standards Committee 3 v Ms W [2023] NZLCDT 35 (17 August 2023)
Auckland Standards Committee 4 v Lynette O'Boyle [2021] NZLCDT 27 (29 October 2021)
Nelson Lawyers Standards Committee v Craig Peter Stevenson [2020] NZLCDT 42 (15 December 2020)
Otago Standards Committee v Simon Nicholas Claver [2019] NZLCDT 8 (29 March 2019)
Professional Conduct Committee v Mr S, Pharm 09/126P (23 March 2017) https://www.hpdt.org.nz/portals/0/886HP16377P.pdf

Legislation

Lawyers and Conveyancers Act 2006 (NZ)
Health Practitioners Competence Assurance Act 2003 (NZ)