Psychiatrist, Dr B

Registered Nurse, RN C

District Health Board

A Report by the Mental Health Commissioner

(Case 18HDC00178)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A was receiving care from community mental health and addiction services (CMHAS) in 2017. He was admitted to a public hospital for a five-day medical detoxification programme on 30 June 2017. The clinical notes documented that his current challenges included his relationship breakdown with his wife and the possible sale of his home/property.

2. Registered Nurse (RN) C, a community mental health nurse based at the public hospital, was the on-call crisis nurse from 1 to 3 July 2017 while Mr A was admitted. On 2 July 2017, Mr A self-discharged from the programme, and RN C assessed him prior to his self-discharge. They discussed and agreed on a safety plan, namely that RN C would make contact with him later in the day.

3. After Mr A self-discharged, RN C contacted Dr B, the on-call consultant psychiatrist at the public hospital, to discuss Mr A's self-discharge and the safety plan that had been put in place.

4. Later that day, RN C telephoned Mr A five to six times with no response. RN C contacted Dr B to inform her of this. Dr B told HDC that upon perusing Mr A's clinical notes in more detail, she identified factors that contribute very significantly to vulnerability of suicide risk, and therefore she and RN C decided to visit Mr A at home in order to assess his immediate risk of self-harm and his mental state (the risk assessment).

5. During the risk assessment at Mr A's house on 2 July 2017, a conversation about Mr A needing to sell his house occurred. Dr B recalled that Mr A stated that he needed to sell his house quickly owing to his relationship break-up.

6. Dr B did not have any further clinical contact with Mr A. RN C was involved in Mr A's care from 2 to 4 July 2017.

7. There is dispute as to who initiated the possible purchase of Mr A's house by Dr B; however, there is evidence that RN C entered into numerous communications about this with Mr A in July 2017. Dr B and RN C also attended a viewing of Mr A's house on or around 15 July 2017.

8. Dr B told HDC that on 27 July 2017, she received a text message from RN C telling her that the house was being offered to her, and the price. Dr B said that she accepted the price, and at that time involved her lawyers to deal with the purchase, as did Mr A and his ex-wife.

9. At some point in July 2017, Dr B informed her senior colleague about the possibility of looking at Mr A's house as a buyer, and the need not to be involved in his care going forward. However, Dr B did not disclose this information to the Service Manager. RN C informed her peers of her involvement in the sale of the house, but did not disclose this to her team leader.

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10. Mr A and his ex-wife sold their house to Dr B in 2017.

11. Mr A told HDC that he felt manipulated and pressured into selling his house. He believed that staff acted unprofessionally when he was in a vulnerable situation and under the care of their service. He advised that his house was never listed for sale publicly prior to the sale to Dr B, and he had not mentioned that his house was for sale to anyone other than Dr B and RN C during the risk assessment.

Findings

12. The Mental Health Commissioner found that Dr B and RN C did not provide Mr A with services that complied with legal, professional, ethical, and other relevant standards and, accordingly, that they breached Right 4(2)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

13. The Mental Health Commissioner made adverse comment about the DHB, in particular that it did not provide sufficient guidance to staff around maintaining professional boundaries, and around conflicts of interest.

14. This case has reinforced the importance of professional boundaries in a clinician–patient relationship and demonstrated how engaging in financial transactions with a patient can compromise the therapeutic relationship.

Recommendations

15. It was recommended that both Dr B and RN C provide a written apology to Mr A and complete relevant training.

16. It was recommended that the DHB provide a written apology to Mr A, consider how its codes of conduct and relevant guidelines may be improved, provide refresher training to mental health and addiction services staff on professional boundaries and conflicts of interest, and inform other DHBs of any changes it makes and the reasons for doing so, in a way that maintains the anonymity of the parties involved.

17. It was recommended that the Medical Council of New Zealand consider whether a review of Dr B's competence is appropriate, and that the Nursing Council of New Zealand consider whether a review of RN C's competence is appropriate.

18. In addition, the Medical Council of New Zealand, Nursing Council of New Zealand, and the New Zealand Medical Association were invited to consider reviewing current wording in standards and guidelines in relation to maintaining professional boundaries, in light of this case, to give clearer guidance on the ethics of financial transactions between consumers and providers.

[1] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Complaint and investigation

19. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Dr B and mental health nurse RN C at the DHB. The following issues were identified for investigation:

- *Whether the DHB provided Mr A with an appropriate standard of care in July and August 2017.*
- *Whether Dr B maintained professional boundaries in respect of the care provided to Mr A in July and August 2017.*
- *Whether RN C maintained professional boundaries in respect of the care provided to Mr A in July and August 2017.*

20. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

21. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	Provider/psychiatrist
RN C	Provider/registered nurse
Provider/District Health Board (DHB)	

22. Further information was received from:

Dr D	Psychiatrist at the DHB
RN E	Registered nurse at the DHB
RN F	Registered nurse at the DHB

23. Also mentioned in this report:

Ms G	Mr A's ex-wife

Information gathered during investigation

Background and risk assessment

24. This report focuses on the sale of Mr A's house to Dr B in 2017, and RN C's involvement in this financial transaction.

25. Mr A (in his forties at the time of the events) was receiving care from the CMHAS. Mr A's case manager, RN F, told HDC that Mr A had self-referred to CMHAS in May 2017.

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26. Mr A was admitted to the public hospital[2] for a five-day medical detoxification programme on 30 June 2017. The clinical notes documented that his current challenges included his relationship breakdown with his wife, the possible sale of his home/property, and other family-related matters.

27. RN C is a community mental health nurse based at the public hospital, and was the on-call crisis nurse from 1 to 3 July 2017 while Mr A was admitted to the medical detoxification programme. On 2 July 2017, Mr A self-discharged from the programme, and the clinical notes show that RN C assessed Mr A prior to his self-discharge.

28. RN C told HDC that during Mr A's pre-discharge assessment, he told her that he had separated from his wife recently and had multiple stressors. RN C said that they discussed strategies for Mr A to distract himself, and how to identify high-risk situations and challenging thoughts. They discussed and agreed on a safety plan, namely that RN C would make contact with him later in the day to discuss any situational factors that were of concern to him, any concerns regarding thoughts of self-harm, and a medication plan.

29. RN C told HDC that after Mr A self-discharged, she contacted Dr B, the on-call consultant psychiatrist at the public hospital, to discuss Mr A's self-discharge and the safety plan that she had put in place, which RN C reported was usual practice.

30. Later that day, RN C telephoned Mr A five to six times with no response. RN C contacted Dr B to inform her of this. Dr B told HDC that upon perusing Mr A's clinical notes in more detail, she identified that he did not have a clearly assigned therapist, that he lived alone in an isolated house, that he was expected to return to work immediately after his detoxification, and that he had gone through a recent divorce. Dr B told HDC that these factors contribute very significantly to vulnerability of suicide risk, and therefore she and RN C decided to visit Mr A at home in order to assess his immediate risk of self-harm and his mental state (the risk assessment).

Discussion during the risk assessment at Mr A's home on 2 July 2017

31. RN C told HDC that during the risk assessment, while talking and building a therapeutic relationship with Mr A, their conversation touched on various subjects.

32. Dr B and RN C told HDC that during the risk assessment, an "ice breaking" comment was made that Mr A had a nice home. Dr B recalled that in response, Mr A stated that unfortunately he needed to sell his house quickly owing to his relationship break-up.

33. RN C also recalled that Mr A disclosed his recent relationship break-up and having to sell the house, and that she made a comment that Dr B was looking for a house to buy.

34. Dr B and RN C told HDC that this was the extent of the conversation about the house during the risk assessment.

[2] The public hospital is part of the DHB.

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35. In his complaint to HDC, Mr A did not mention such a discussion having occurred. However, minutes from a meeting between the DHB and Mr A in October 2017 document Mr A stating: “They said what a nice house and then conversation [led] to selling it and wanting to purchase the house.”

36. Dr B told HDC that her risk assessment on 2 July 2017 found that Mr A was not depressed or suicidal, and was sober, keen to go back to work, and willing to get involved in regular counselling with Alcohol & Drug Services within that week. She noted that she did not think he had full insight into the extent of his alcohol problem, but that this was up to the addiction therapist to address.

Ongoing clinical care

37. Dr B told HDC that prior to the risk assessment on 2 July 2017, she had had no clinical contact with Mr A, and that following the risk assessment she had no further clinical contact with him.

38. The clinical notes show that RN C was involved in Mr A’s care from 2 to 4 July 2017, including attending a counselling appointment, and arranging matters such as a medical certificate and a prescription. The notes show that RN C also arranged a follow-up appointment for Mr A with Dr B for 14 July 2017, at Dr B’s request, to monitor his mood and risks. However, Mr A cancelled this appointment.

39. Dr D (Dr B’s senior colleague) told HDC that from 5 July 2017, RN F resumed care of Mr A, and no input from the crisis team and/or psychiatrist was needed, and this continued until 16 August 2017.

40. The clinical notes document a telephone conversation between a Clinical Nurse Manager and Mr A on 26 July 2017, where Mr A reported to the Clinical Nurse Manager that he had not been drinking for the past one and a half months, he was focused on recovery, and he declined the need for admission.

41. The clinical notes also record a conversation between RN F and Mr A, where Mr A reported maintaining abstinence, still having some relationship issues, and having agreed to sell his house and expecting to move to a rental property shortly.

Communication regarding house sale

42. RN C told HDC that on or around 12 July 2017, she telephoned Mr A to remind him of his doctor’s appointment, and that during the conversation, Mr A asked her whether Dr B was interested in buying his house, and reiterated that he needed to sell it because of his relationship break-up.

43. RN C said that she informed Mr A that she would ask Dr B and get back to him. The telephone conversation reminding Mr A about his appointment was not recorded in his clinical notes. RN C said that on 12 July 2017 she left a message on Mr A’s telephone informing him that Dr B may possibly be interested in looking at the home, and asking whether a kitchen cabinetmaker could look at the kitchen.

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44. However, Mr A told HDC that following the risk assessment, it was RN C who initiated discussions about whether he would be interested in selling his house. Mr A recalled advising her that his house was not for sale, but that she followed up with telephone calls and messages informing him that she was acting on Dr B's behalf, as Dr B was interested in buying his house.

45. RN C provided HDC with photographs of a number of text messages she exchanged with Mr A from 14 July 2017 onwards in relation to the house. The first text message from Mr A to RN C was on 14 July 2017. The photographs reflect the following communication between RN C and Mr A:

> "14 July 2017:
>
> [Mr A]: *Hi [RN C] I will not be able to make my appointment today can we reschedule. Also is there a time the kitchen person wants to come around? Or has that all stopped? [Mr A].*
>
> [RN C]: *Hi ya. No the kitchen man is still all go,* [cut off] …
>
> [RN C]: *Hi ya.. did u get my previous text?*
>
> [Mr A]: *Hi I will be down here with my sister for a few days but if the kitchen person wants have a look I can see if [Ms G] can let him in, then we can talk about price when I get back.*
>
> 17 July 2017:
>
> [RN C]: *Good morning [Mr A] u hope yr enjoying your family time.. yeap it's been blinkin cold up here but today's a nice day. .. r u able to tee up a time with [Ms G] re: kitchen man visit please. Give her my number if u want to. Cheers [RN C]*
>
> 19 July 2017:
>
> [RN C]: *Yes Friday morning is a definite. …. See u then.*
>
> 21 July 2017:
>
> [RN C]: *Hey can u give me a ring please*
>
> 22 July 2017:
>
> [RN C]: *Can we meet the middle of the week to talk about the house sale please? … never mind about the kitchen now.*
>
> 24 July 2017:
>
> [RN C]: *Hi r u getting these messages?*"

46. RN C was also in communication with Mr A's ex-wife about the house. RN C provided HDC with copies of these messages:

> *"…*
>
> *[RN C]: I have heard from [Mr A] this afternoon with [the price].. I have spoken to the dr and she has accepted the offer. Congratulations. We just need to start lawyer*

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contract details. I have left a message on [Mr A's] landline late this afternoon informing him of the Dr's accepting the offer.. I just thought I'd keep you in the loop if that's OK. [RN C]

[Ms G]: Hi—that's great news. I'll catch up with [Mr A] later this evening. Thanks [Ms G].

…

[Ms G]: Hi [RN C]. [Mr A] asked that I text our names & house sale price to you. [Mr A] & [Ms G]. Amount […]. Our legal representation is […]. Is […] writing up the sale agreement? Thanks [Ms G]

…

[Ms G]: Hi [RN C]—can you please let me know where things are at with the property purchase. Cheers [Ms G]

[RN C]: As far as I know the sale of purchase has been completed and there has been contact too and fro between the lawyers. I think some paperwork got signed today by the Dr but I'm not sure what. I've been flat out at work and I've not had time to catch up with the Dr properly.

[Ms G]: Ok thanks for the update — I will check in with our lawyer tomorrow. I ran into […] today — so good to see her again after a couple of months!

…

[RN C]: Hi ya.. just wanting an update. I hope your week has been grand…. mine has been a blinkin busy nightmare grr. Everything has been signed at this end (on Tuesday) and just wondering if you guys have signed yet? ..."

47. Dr B said that approximately two weeks after the risk assessment, Mr A texted RN C that they should come to see the house properly if Dr B was really interested.

48. Dr B and RN C told HDC that they attended a viewing of Mr A's house on or around 15 July 2017. They both recalled Mr A being happy to accommodate them and show them around.

49. RN C recalled Mr A telling them that he had had two independent real estate agents value his house recently, and that he would speak to his ex-wife and get back to them with a price. RN C recalled Dr B stating that she was only too willing to work with a real estate agent, but that Mr A wanted a private sale due to the cost of the real estate agent commission fees. RN C recalled Mr A telling Dr B that he was happy to have and work with independent lawyers if the sale of the house eventuated.

50. Dr B said that at the end of the house viewing, she stated that she could be interested, although it was obvious that the house required a lot of work. She said that she and Mr A agreed that if the price was acceptable and the move could happen on the [final date to leave her rental accommodation], the purchase was a possibility.

51. Dr B told HDC that the house viewing was the only private contact she had with Mr A.

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52. Dr B told HDC that she received a text message from RN C offering her the house. Dr B said that she understood that RN C had been in regular contact with Mr A and his ex-wife. Dr B said that she accepted the price, and at that time involved her lawyers to deal with the legal aspects of the purchase, as did Mr A and his ex-wife.

53. Mr A and his ex-wife sold their house to Dr B in 2017.

Disclosure to colleagues

54. Dr B told HDC that a "few days" after the risk assessment at Mr A's house, she spoke to her senior colleague, Dr D, a consultant psychiatrist and clinical head of department, about the possibility of looking at Mr A's house as a buyer, and the need not to be involved in his care in any capacity going forward. Dr B also told HDC that it was at the point of the house viewing that it became clear to her that if in future Mr A required treatment, she must arrange for her colleague to become involved, to which Dr D agreed.

55. Dr D told HDC that during a handover meeting "very soon" after the weekend of 1–2 July 2017, she learned of Dr B's interest in a property that might become available for purchase. Dr D recalled that when it became apparent that Dr B had formally made an offer to purchase the property, approximately 2–3 weeks later, Dr B casually told her about it. Dr D recalled that Dr B said that she would not be able to meet with Mr A again as a client, as that would constitute a conflict of interest, and Dr D agreed immediately.

56. Dr D said that "every individual working in the service was aware of the possibility that [Dr B] had maybe found a house (several people were involved previously — offering suggestions of possible properties for purchase)", and on more than one occasion other staff members had accompanied Dr B to house viewings. Dr D also said that "everyone [was] aware there was some urgency in obtaining alternative accommodation, as [Dr B's] [existing tenancy] was to be terminated".

57. RN E told HDC:

> "I am confident that I recall [RN C] talking about a 'potential house' for [Dr B] to buy after they saw a client [Mr A] in Crisis over the weekend as she made reference to [Mr A] wanting to sell his property which may be perfect for [Dr B]. I believe this discussion was very soon after the Crisis call out and within the dates of 4th–14th July 2017."

58. RN E also said:

> "I was asked along with [a colleague] by [Dr B] if we were able to support her on the day she moved into the home … Both myself and [my colleague] took a day off work on [date] and went [to] the property as agreed at approximately 0900hrs."

Subsequent events — Mr A's complaint to the DHB

59. The DHB became aware of the sale and purchase of Mr A's house via the on-call crisis team. RN F told HDC that in September 2017, Mr A telephoned CMHAS and reported that he was drinking again, and was depressed, experiencing anxiety attacks, sleeping poorly, and losing weight. RN F telephoned back, and Mr A told him that he had resumed drinking.

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RN F said that Mr A sounded depressed, tearful, and overwhelmed, and described panic attacks. RN F stated that his questioning led him to conclude that Mr A was a potential risk for suicide, so he requested that the Crisis Assessment and Treatment Team (CATT) staff attend for assessment, and asked weekend duty staff to visit and support him over the weekend.

60. As mentioned above, in October 2017 a meeting occurred in relation to the sale and purchase of Mr A's house, and the attendees were Mr A, RN F, and the Service Manager of the region's mental health and addiction services. The minutes from this meeting document that Mr A stated that during the risk assessment, "[t]hey said what a nice house and then conversation [led] to selling it and wanting to purchase the house".

61. The meeting minutes record that Mr A stated that he "felt steam rolled, taken advantage [of] exploited in my darkest hours, used". The meeting minutes documented the following:

> "I [Mr A] feel I was taken advantage of [by] [Dr B] and [RN C]."
>
> "[T]he house deal was fast forwarded."
>
> "Looking back what a mug (himself), being in the most vulnerable position I was in, in my life.
>
> If that was me in a professional position I would not have talked about the house, the whole thing was wrong, reach out for help … felt totally 'shat on'.
>
> Mentally I was not in the right frame of mind; [RN C] said 'we won't quibble over a couple of thousand dollars'.
>
> There was not a lot of professional help going on. The speed and the enormity, what the hell just happened, had to think out it [sic] very clearly. I have lost everything, my marriage, my home, I know I have addiction issues.
>
> [RN C] said 'no real estates involved, probably better to not go to the real estate agency, because it will cost more money'."
>
> "[RN C] was bugging his ex-partner and phoned him on numerous occasions wanting a price."

62. The meeting minutes documented that Mr A's "closing comment was 'when I am feeling better I might get a Real Estate agent to value the house. If I need [to] I will take further action.'"

The DHB's policies and procedures

63. When asked for relevant policies and procedures relating to the management of potential conflicts of interests, professional boundaries, and/or financial transactions between clinical staff and consumers, and disciplinary, misconduct, and employment investigations,

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the DHB told HDC that it relied on professional guidelines and codes of conduct, as well as the DHB's Code of Conduct to guide staff.

64. The DHB's Code of Conduct (2016) provides:

> "The State Services Commission's Standards of Integrity and Conduct provide the over arching principles for the … Code of Conduct …
>
> …
>
> **Standards of Integrity and Conduct**
>
> As a crown entity, [the DHB] and its employees must comply with the State Services Commission's **Standards of Integrity and Conduct** (Appendix 1). These standards seek to reinforce a spirit of service and set common standards of behaviour required from the diverse range of people and roles across the State Services.
>
> …
>
> **Meeting Expectations**
>
> …
>
> It details the standards of behaviour required of employees to ensure practical application of the organisation's Values in the day-to-day actions of its employees. It also seeks to meet the State Services Commission's expectation with regard to standards of integrity and conduct.
>
> It does not provide an exhaustive list of circumstances that would be deemed to breach the Code, as it is impossible to foresee every possible situation that may arise. However, the Code of Conduct does define minor and serious misconduct.
>
> …
>
> **Required Standards of Conduct**
>
> …
>
> 10. Maintain proper standards of integrity and concern for the public interest through being honest and conscientious in performing duties, responsibilities and undertakings given.
>
> …
>
> 12. Ensure that individual's actions do not bring the organisation into disrepute.
>
> …
>
> 14. Maintain Annual Practicing Certificate, Registration and professional development activities or requirements and notify the organisation of any discrepancies.

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15. To not engage in any private activity, without the employer's prior agreement which could have an effect on their ability to carry out their duties as an employee.

Appendix 1 State Services Commission's **Standards of Integrity and Conduct**

…

FAIR

We must:

Treat everyone fairly and with respect

Be professional and responsive

Work to make government services accessible and effective

Strive to make a difference to the well-being of New Zealand and all its people.

…

RESPONSIBLE

We must:

Act lawfully and objectively

Use our organisation's resources carefully and only for intended purposes

Treat information with care and use it only for proper purposes

Work to improve the performance and efficiency of our organisation.

TRUSTWORTHY

We must:

…

Ensure our actions are not affected by our personal interests or relationships

Never misuse our position for personal gain

Decline gifts or benefits that place us under any obligation or perceived influence

…"

Further information — Mr A

65. Mr A reported that he felt manipulated and pressured into selling his house. He told HDC that he believes that staff acted unprofessionally when he was in a vulnerable situation and under the care of their service.

66. Mr A told HDC that his house was never listed for sale publicly prior to the sale to Dr B. He said that he did not mention that his house was for sale to anyone other than Dr B and RN C.

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67. Mr A said that, at the time of events:

> "I did feel pressured and taken advantage of especially in the mental state I was in and this was known by those staff members. There were numerous texts and calls asking about timing for people to come and look at the kitchen so they could see how much the cost would be to rebuild before buying. There were other communications with pressure about coming up with a price for the property."

Further information — Dr B

68. Dr B apologises to Mr A if he felt offended in any way, as this was not her intention. She noted that this was not the impression she had throughout their contact, and that she does not feel that she has crossed any professional boundaries.

69. Dr B told HDC that at the time of contact with Mr A, she had been in negotiations with three agents, and had been looking for a house for months, with the help of almost all the nurses from her clinic. She said that at that stage, she had been looking at available houses for sale daily, and most of the nurses were showing her places to consider. She said that the final date to leave her rental accommodation was fast approaching, and it became the most important factor in her decision-making, as she did not want to move twice, i.e., into a second temporary accommodation arrangement and thereafter taking occupation of the premises to be purchased.

Further information — RN C

70. RN C recognises that the well-being of Mr A was paramount in providing his crisis care and treatment, and that possibly she should have managed this differently. She said that she did not intentionally cross or violate any professional boundaries. She stated:

> "[T]he seductiveness of a helping role, community influences, have, in hindsight, been interrupted [sic] as blurring professional boundaries. If for any reason I am faced with the same situation, I would discuss immediately with my manager and supervisor to ensure there were no professional, personal issues that could be misinterpreted by any member of the public or my peers."

Further information — the DHB

71. The DHB conducted its own internal investigation into these events. Its preliminary findings included the following, based on interviews with staff:

- "I [Service Manager] was advised that each party had their own solicitor ([Mr A] and his ex-wife had a solicitor and [Dr B] had a solicitor). I was provided with the name and details of the solicitor who had assisted [Dr B].

- I was advised that [Mr A] had determined the sale price, purportedly based on 2 local estate agent valuations — there was no haggling over price, [Mr A] had stated a price to [RN C], who advised [Dr B], whom accepted the price.

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- Neither [RN C] nor [Dr B] were concerned whether he chose to sell the house by using an estate agent or not, since their view was that costs of the sale would be borne by the seller not the purchaser."

72. Based on the preliminary findings, it was considered that there was no evidence of malice, ill-intent, or manipulation.

73. The DHB told HDC that RN C should have managed her potential conflict of interest more professionally by advising her team leader, but did not do so. It noted: "[RN C] took advice from her peers, in particular [RN E], but neither appeared to have thought the Team Leader should have known." It stated that Dr B did inform her senior colleague, but also should have informed the Service Manager of mental health and addiction services.

74. As a result of the DHB's internal investigation, the providers were reminded of their need to manage potential conflicts of interest better by declaring all relevant issues of potential conflict of interest to their respective managers as soon as they become relevant.

75. The DHB told HDC that at the time of the events, MHAS was in the process of improving its policy, procedure, and guideline framework, and had commissioned an expert consultant. MHAS has identified a gap in the framework, and is developing an additional guideline with regard to professional boundaries and potential conflicts of interest. It will clarify expectations of steps staff should follow for conflicts of interest.

76. The DHB has recognised that rural communities face challenges more frequently, and anticipates that a local DHB guideline will improve recognition, active reflection, and seeking of senior guidance.

Responses to provisional decision

Mr A

77. Mr A was given an opportunity to comment on the "information gathered" section of the provisional decision, but did not provide a response.

Dr B

78. Dr B was given an opportunity to respond to the provisional decision, and advised that she accepted the findings and recommendations.

RN C

79. RN C was given an opportunity to respond to the provisional decision, and advised that she did not wish to provide a response and accepted the recommendations.

DHB

80. The DHB was given an opportunity to respond to the provisional decision and, where relevant, its comments have been incorporated into this report.

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Relevant standards

Standards for doctors

81. The Medical Council of New Zealand's (MCNZ's) *Good Medical Practice* (2016) outlines the standards that the public and the profession expect a competent doctor to meet. It is not intended to be exhaustive, and it acknowledges that there may be obligations or situations that are not expressly provided for. In such circumstances, a doctor's first priority should always be the care of his or her patient.

82. Under the heading "Professionalism", the standard provides:

> "Make the care of patients your first concern.
>
> ...
>
> Be honest and open when working with patients; act ethically and with integrity by … never abusing your patients' trust in you or the public's trust of the profession.
>
> ...
>
> Work cooperatively with, and be honest, open and constructive in your dealings with managers, employers ..."

83. Under the heading "Financial and Commercial dealings", the standards state that doctors are to be honest and open in any financial or commercial dealings with patients, employers, insurers, or other organisations or individuals.

84. Under the heading "Conflicts of interest", the standard provides: "[I]f you have a conflict of interest, you must be open about the conflict, declaring your interest."

85. The Principles of Ethical Behaviour in the New Zealand Medical Association Code of Ethics (2014)[3] (the NZMA Code of Ethics) recognises that given the complexities of doctor–patient relationships, no set of guidelines can cover all situations. It sets out a number of recommendations designed to convey an overall pattern of professional behaviour consistent with the NZMA Code. These behaviours include:

> "Doctors should ensure that all conduct in the practice of their profession is above reproach … the trust embodied in the doctor–patient relationship must be respected."
>
> "Doctors, like a number of other professionals, are involved in relationships in which there is a potential or actual imbalance of power …"

86. The NZMA Code of Ethics sets out that medical practitioners will consider the health and well-being of the patient to be their first priority.

[3] Recognised by the Medical Council of New Zealand as the key source of advice on ethics for the medical profession, according to the Medical Council of New Zealand's *Good Medical Practice* (2016).

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87. The Royal Australian and New Zealand College of Psychiatrists'[4] Code of Ethics (2010) (the RANZCP Code of Ethics), which was in effect at the time of the events, provided:

> "2.1 … the trust embodied in the doctor–patient relationship must be respected.
>
> 2.2 Psychiatrists are involved in professional relationships in which there is an imbalance of power."

Standards for nurses

88. The Nursing Council of New Zealand's "Code of Conduct for Nurses" (2012) (the Nursing Council Code of Conduct) is a set of standards defined by the Council describing the behaviour or conduct that nurses are expected to uphold. The Code of Conduct provides guidance on appropriate behaviour for all nurses, and can be used by health services consumers, nurses, employers, the Nursing Council, and other bodies to evaluate the behaviour of nurses.

89. One of the values underpinning professional conduct in the Nursing Council Code of Conduct is trust. The Nursing Council Code of Conduct states:

> "Nurses are privileged in their relationships with consumers … Health consumers need to be able to trust nurses to be safe and competent, and not harm them and to protect them from harm. They need to trust nurses to work in the interests of their health and well-being, and promote their interests."

90. Standard 5.2 of the Nursing Council Code of Conduct states that nurses should "treat as confidential information gained in the course of the nursing–health consumer relationship and use it for professional purposes only".

91. Principle 7 refers to acting with integrity to justify health consumers' trust, and provides:

> "7.5 Act in ways that cannot be interpreted as, or do not result in, you gaining personal benefit from your nursing position.
>
> …
>
> 7.10 Declare any personal, financial or commercial interest which could compromise your professional judgement.
>
> …
>
> 7.13 Maintain a professional boundary between yourself and the health consumer and their partner and family, and other people nominated by the health consumer to be involved in their care."

92. The Nursing Council of New Zealand also has a guideline entitled "Guidelines: Professional Boundaries *A nurse's guide to the importance of appropriate professional boundaries*" (2012). It has been developed to provide advice to nurses and the public on nurses

[4] Dr B holds affiliate membership with the Royal Australian and New Zealand College of Psychiatrists.

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maintaining appropriate professional relationships with consumers. It acknowledges that it is not possible to provide guidance for every situation, and that nurses must develop and use their own professional and ethical judgement, and seek advice when issues arise in relationships with health services consumers.

93. Under the heading "The importance of maintaining boundaries in professional relationships", the guideline references Standard 7.13 of the Nursing Council Code of Conduct, and provides:

> "Professional relationships are therapeutic relationships that focus on meeting the health or care needs of the health consumer. Nurses must be aware that in all their relationships with health consumers they have greater power because of their authority and influence as a health professional, their specialised knowledge, access to privileged information about the health consumer and their role in supporting health consumers and those close to them when receiving care. The health consumer does not have access to the same degree of information about the nurse as the nurse does about the health consumer thereby increasing the power imbalance.
>
> …
>
> The power imbalance is increased when the health consumer has limited knowledge, is made vulnerable by their health circumstances or is part of a vulnerable or marginalised group. Some particularly vulnerable consumers are … those with a mental illness … Health consumers must be able to trust nurses to protect them from harm and to promote their interests. Nurses must take care to ensure that their own personal … needs are not influencing interactions between themselves and the health consumer.
>
> …
>
> The nurse has the responsibility of knowing what constitutes appropriate professional practice to maintain his or her professional and personal boundaries. The health consumer is in an unfamiliar situation and may be unaware of the boundaries of a professional relationship … There is a professional onus on nurses to maintain a relationship based on care plans and goals that are therapeutic in intent and outcome."

94. Under the heading "Social media and electronic forms of communication", the guideline states:

> "Keep your personal and professional life separate as far as possible …
>
> Nurses must be aware of professional boundaries and ensure that communication via text is not misinterpreted by the health consumer or used to build or pursue personal relationships."

95. Under the section "Preventing Boundary Transgressions", the guideline provides:

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"This section focuses on boundary issues that arise when a nurse becomes **over involved** with a health consumer … The nurse may believe she/he is helping the health consumer … However these boundary crossings have the potential to harm the health consumer by changing the focus from the therapeutic needs of the health consumer to meeting the nurse's own needs … They have the potential to harm the health consumer by increasing their vulnerability … and could be detrimental to their health outcomes by compromising the nurse's objectivity and professional judgment. The harmful consequences may not be recognised or experienced until much later.

Nurses can reduce the risk of boundary transgressions by:

- Maintaining the appropriate boundaries of the nurse–health consumer relationship, and helping health consumers understand when their requests are beyond the limits of the professional relationship …
- Recognising that there may be an increased need for vigilance in maintaining professionalism and boundaries in certain practice settings e.g. rural and remote locations …
- Consulting with colleagues and/or the manager in any situation where it is unclear whether behaviour may cross a boundary of the professional relationship …

Signs of over involvement in a nurse–health consumer relationship:

- Texting or using forms of social media to communicate in a way that is not clinically focused."

96. Under the heading "Financial transactions", the guidelines state:

"Financial transactions between a nurse and a health consumer (other than in a contract for provision of services) may compromise the professional relationship by resulting in monetary, personal or other material benefit, gain or profit to the nurse. Nurses have access to personal and confidential information about health consumers under their care that may enable them to take advantage of situations that could result in personal, monetary or other benefits for themselves or others. A nurse could also influence or appear to coerce a health consumer to make decisions resulting in benefit to the nurse or personal loss to that health consumer and it is unacceptable for nurses to take such actions …

All transactions must occur within acceptable organisational policy …"

97. The New Zealand Nurses Organisation (NZNO) Standards of Professional Practice outline what the profession expects of its members, and aim to promote, guide, and direct professional nursing practice. Standard Three, "Relationships", provides:

"Nurses establish and maintain respectful, collaborative, therapeutic and professional relationships …

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Nurses:

3.1 adhere to professional standards of behaviour and conduct with clients, family, whānau members, colleagues and society as outlined in the Nursing Council of New Zealand Code of Conduct (NCNZ, 2012) at all times.

…

3.5 use professional judgment in determining the appropriate boundaries of a therapeutic relationship with each client. The nurse — not the client — is responsible for establishing and maintaining boundaries."

Opinion: Introductory comment

98. Maintaining professional boundaries between consumers and providers is an important part of the provision of healthcare services. Trust is fundamental to this relationship, in ensuring that the consumer is assured that the provider is acting with the consumer's best interests in mind.

99. The power dynamic in favour of the provider in this relationship is well established and recognised. The New Zealand Medical Association's "Code of Ethics" (2014) outlines the potential or actual imbalance of power, and the Royal Australian and New Zealand College of Psychiatrists' "Code of Ethics" (2010) outlines that the trust embodied in the doctor–patient relationship must be respected.

100. The Nursing Council's Guidelines on Professional Boundaries similarly outlines the need for nurses to be aware that in all relationships with health consumers, nurses have greater power because of their position as a health professional, their knowledge, their access to information about the consumer, and their role in supporting the consumer when the consumer is receiving care.

101. This report focuses on whether professional codes of ethics and standards were maintained in respect of the sale of Mr A's home to Dr B. The legality of the sale and purchase of the house is not in question. I have also not examined the standard of clinical care provided to Mr A by Dr B and RN C.

Factual findings

102. As is evident from the "information gathered" section of this report, there is disagreement about whether Mr A's house needed to be sold at the time of his risk assessment on 2 July 2017.

103. RN C and Dr B recall Mr A advising them that he needed to sell his house due to his relationship break-up during their risk assessment on 2 July 2017. However, in his complaint to HDC, Mr A asserted that his house was not for sale at this time.

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104. The clinical notes from Mr A's admission on 30 June 2017 show that Mr A indicated that his home/property may need to be sold as part of his relationship break-up. Dr B's and RN C's recollection of events is also consistent with the minutes from Mr A's meeting with the DHB in October 2017.

105. Overall I am satisfied that during the risk assessment at Mr A's house on 2 July 2017, a conversation about Mr A needing to sell his house occurred.

106. In relation to the other disputed facts, I do not consider it necessary to make findings on those issues. As outlined below, they are not material to my decision.

Opinion: Dr B — breach

Introduction

107. Any relationship between a service user and a healthcare provider is likely to involve a power imbalance and a degree of vulnerability on the part of the service user, and trust on the part of the service user that this vulnerability will not be abused. This report focuses on whether professional codes of ethics and standards were maintained in respect of the care provided to Mr A in July and August 2017.

Discussion

108. Mr A was in a vulnerable position when Dr B visited him at his home on 2 July 2017. He was particularly vulnerable as a mental health service user who was receiving treatment for alcohol addiction, and was facing family issues. At the time of events, he was going through a marriage break-up, and this resulted in him needing to sell his house. Dr B was fully aware of the difficulties Mr A was experiencing and the vulnerabilities that this created. She was aware that he had been admitted for a five-day medical detoxification programme, and undertook a risk assessment at his home, soon after his self-discharge, due to his risk factors for suicide.

109. Whilst I acknowledge that Dr B's clinical involvement in Mr A's care was limited and brief, it is clear that a doctor–patient relationship between Dr B and Mr A existed, and that Dr B was in a position of trust in relation to Mr A that needed to be respected. I note the sensitive nature of the clinical interaction she had with Mr A.

110. In the course of their doctor–patient relationship, Dr B obtained knowledge that Mr A needed to sell his house as a result of his marriage break-up. Had she not been in this doctor–patient relationship, she may not have obtained this information. Using this information, Dr B entered into private dealings with Mr A, and purchased his home, which benefitted her personally and materially.

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111. Although Dr B advised the clinical head of her department of this conflict of interest, she did not declare this conflict to her manager, nor did she obtain prior agreement from her manager before entering into the transaction with Mr A.

112. Mr A has told HDC that in looking back on these events, they occurred during his "darkest hours", and he does not think he was "mentally in the right frame of mind". He expressed feeling a sense of loss: "I have lost everything, my marriage, my home."

Conclusion

113. Professional boundaries must be managed well by health professionals. In this case, they were not. It was Dr B's responsibility to comply with relevant professional and ethical standards and maintain professional boundaries. After careful consideration, it is my view that the action of Dr B was ill considered and unwise, and clearly led to significant distress for Mr A.

114. I acknowledge that at the time of the events there was no Code or Standard that set out in detail the public's and the profession's expectations of how Dr B ought to have acted in this situation.

115. I also acknowledge that these events occurred in a rural community where there may be increased opportunities for professional and personal relationships to overlap. This does not remove the need to manage professional boundaries, but requires greater ethical guidance from the DHB. If the DHB had provided such guidance in this case, it may well have prevented the considerable distress a number of the parties affected by this complaint have experienced subsequently. I acknowledge the steps that Dr B did take to declare her conflict of interest, and it was appropriate that she identified the need to cease involvement in Mr A's care.

116. Furthermore, the evidence I have available to me does not suggest a deliberate intent to take advantage of Mr A or exploit his situation. There is evidence that Mr A and Dr B received independent legal advice about the sale and purchase of the property, and that Mr A had received recent valuations for the property. When Mr A advised Dr B of the sale price, Dr B accepted the price without further negotiation.

117. Notwithstanding the above, in my opinion Dr B fell short of meeting several professional and ethical standards when she decided to engage in a personal and financial transaction to buy Mr A's home.

118. Specifically, I find that Dr B did not comply with the following relevant professional and ethical standards. The MCNZ's Good Medical Practice Standards, NZMA's Code of Ethics, and the RANZCP's Code of Ethics require doctors to:

- Never abuse a patient's trust;
- Respect the trust embodied in the doctor–patient relationship;
- Make the care of patients the first priority;

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- Be open in financial dealings with patients;
- Declare a conflict of interest; and
- Ensure that all conduct in the practice of their profession is above reproach.

119. The DHB's Code of Conduct also stipulates that without the employer's prior agreement, staff are not to engage in any private activity that could affect their ability to carry out their duties as an employee.

120. In my opinion, Dr B abused Mr A's trust (although unintentionally) when she used the information he disclosed to her in a clinical context (mental health risk assessment) to achieve a personal gain. A financial transaction occurred between Dr B and Mr A, namely the sale and purchase of Mr A's house, as a result of the clinical relationship. By blurring the lines of her professional boundary with Mr A, Dr B did not respect the trust embodied in her doctor–patient relationship with Mr A.

121. There is evidence that Dr B urgently needed to find accommodation, and that Mr A was particularly vulnerable at this time, having recently self-discharged from a detoxification programme. Mr A's vulnerability was known to Dr B. In this context, I do not consider that she made Mr A's care her first priority.

122. Dr B did not disclose her purchase of Mr A's house to her employer, and did not adhere to the DHB's Code of Conduct, as she did not seek prior approval before engaging in the sale and purchase transaction with Mr A. As such, Dr B was not adequately open in her financial dealings with Mr A, and did not declare her conflict of interest to Mr A or her employer.

123. Dr B therefore did not provide Mr A with services that complied with legal, professional, ethical, and other relevant standards and, accordingly, I find Dr B in breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).

124. This case has reinforced the importance of professional boundaries in a doctor–patient relationship and demonstrated how engaging in financial transactions with a patient can compromise the therapeutic relationship.

Opinion: RN C — breach

Introduction

125. Any relationship between a service user and a healthcare provider is likely to involve a power imbalance and a degree of vulnerability on the part of the service user, and the trust that this vulnerability will not be abused. I note that the Nursing Council's guidelines on professional boundaries specifically recognises that some particularly vulnerable consumers are those with mental health issues. This report focuses on whether

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professional codes of conduct and standards were maintained in respect of the care provided to Mr A in July and August 2017.

Discussion

126. Mr A was in a vulnerable position when RN C visited him at his home on 2 July 2017. He was particularly vulnerable as a mental health service user who was receiving treatment for alcohol addiction and was facing family issues. At the time of the events, he was going through a marriage break-up, and this resulted in him needing to sell his house. RN C was fully aware of the difficulties Mr A was experiencing, and the vulnerabilities that this created. She was aware that he had been admitted for a five-day medical detoxification programme, and undertook a risk assessment at his home soon after his self-discharge, due to his risk factors for suicide.

127. In the course of their nurse–patient relationship, RN C obtained knowledge that Mr A needed to sell his house owing to his marriage break-up. Had she not been in this relationship, she may not have obtained this information. Using the information obtained through the nurse–patient relationship, RN C was able to assist her colleague, Dr B, to purchase Mr A's home.

128. RN C entered into numerous private communications with Mr A and his ex-wife, via text message and telephone calls, in relation to Dr B's purchase of the house. It is clear that RN C was communicating with Mr A and his ex-wife on Dr B's behalf and on a non-clinical matter. RN C also attended the house viewing with Dr B.

129. RN C did not consult with any colleagues and/or her manager about whether her actions were within organisational policy and/or crossed professional relationship boundaries.

130. RN C accepts that she could have managed this differently, and that she did not intentionally cross or violate any professional boundaries. Mr A has told HDC that when looking back on these events, they occurred during his "darkest hours", and he does not think he was "mentally in the right frame of mind". He expressed feeling a sense of loss: "I have lost everything, my marriage, my home."

Conclusion

131. Professional boundaries must be managed well by health professionals. In this case, they were not. It was RN C's responsibility to comply with relevant professional and ethical standards and maintain professional boundaries. After careful consideration, it is my view that the actions of RN C were ill considered and unwise, and clearly led to significant distress for Mr A.

132. I acknowledge that these events occurred in a rural community where there may be increased opportunities for professional and personal relationships to overlap. This does not remove the need to manage professional boundaries, but requires greater ethical guidance from the DHB. If this had occurred in this case, it may well have prevented the considerable distress a number of the parties affected by this complaint have experienced subsequently.

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133. The evidence I have available to me does not suggest a deliberate intent to take advantage of Mr A or exploit his situation. There is evidence that Mr A received independent legal advice about the sale and purchase of the property, and that Mr A had received recent valuations for the property.

134. I note also that RN C did not have any personal or financial gain from this financial transaction.

135. Notwithstanding the above, in my opinion RN C fell short of meeting several professional and ethical standards when she decided to involve herself in her colleague's purchase of Mr A's home.

136. Specifically, I find that RN C did not comply with the following relevant professional and ethical standards. The Nursing Council's Code of Conduct, the Nursing Council's Guidelines on Professional Boundaries, and NZNO's Standards of Professional Practice require nurses to:

- Maintain professional boundaries;
- Be aware that there is a power imbalance in the nursing–health services consumer relationship, which is increased with particularly vulnerable consumers, and that health services consumers must be able to trust nurses to protect them from harm and to promote their interests;
- Use confidential information gained in the course of the nursing–health services consumer relationship for professional purposes only;
- Consult with colleagues and/or managers in any situation where it is unclear whether behaviour has crossed a boundary of the professional relationship; and
- Be aware that any financial transactions must occur within acceptable organisational policy.

137. The DHB's Code of Conduct also stipulates that without the employer's prior agreement, staff are not to engage in any private activity that could affect their ability to carry out their duties as an employee.

138. In my opinion, by engaging in frequent contact with Mr A on a range of matters to progress the sale and purchase of Mr A's home, RN C did not maintain professional boundaries, and showed a lack of awareness of the power imbalance between herself and Mr A. There was intermingling of clinical and personal matters, evident by the text communications where both clinical and personal matters were discussed at the same time. RN C also contacted Mr A's ex-wife in relation to the purchase of the house, which further blurred the professional boundaries.

139. When Mr A disclosed to RN C that he needed to sell his house during a mental health clinical risk assessment, RN C used this as an opportunity to further her colleague's personal interest of needing to find a new home. As such, RN C did not use the confidential

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information gained in the course of her nursing–health services consumer relationship with Mr A for professional purposes only.

140. RN C also did not disclose her private involvement with Mr A to her manager, and did not adhere to the DHB's Code of Conduct, as she did not seek prior agreement from her employer before engaging in private activity with Mr A. While she did discuss the purchase of Mr A's house with some of her colleagues, this was not in the context of consulting her peers as she was unclear whether her behaviour had crossed professional boundaries.

141. RN C therefore did not provide Mr A with services that complied with legal, professional, ethical, and other relevant standards and, accordingly, I find RN C in breach of Right 4(2) of the Code.

Opinion: DHB — adverse comment

142. As a healthcare provider, the DHB is responsible for ensuring that its staff provide services in accordance with the Code.

143. I consider that the guidance provided by the DHB to support staff, in relation to managing professional boundaries and conflicts of interest, was insufficient. This is evident in RN C and Dr B engaging in private activity (the sale and purchase of a property) with a vulnerable consumer, Mr A, and not demonstrating awareness of the DHB's requirements about prior approval and disclosure of conflicts of interests.

144. Furthermore, I note that a number of other staff members were aware of private activity occurring between two clinicians and a consumer of the DHB's service, but did not consider it prudent to raise the issue with the clinicians or seek guidance from their relevant managers or escalate matters appropriately. While not a criticism of these other staff members, I consider this to be further evidence of a lack of guidance provided by the DHB, as it appears that these staff members did not recognise the significance of this private activity in relation to professional boundaries and the DHB's organisational requirements.

145. Rural communities face the challenges of maintaining professional boundaries more frequently. I consider that the DHB should have had stronger and clearer guidance in its Code of Conduct prior to these events. I note that the DHB identified a gap in its framework about being clearer about expectations of the steps that staff should follow if they are concerned that they have a conflict of interest in any interactions with a consumer or past consumer. I consider that there is a need for clear guidance and a strict requirement for proactive prior written disclosure to, and approval from, senior managers before any discussion about a property or financial transaction occurs between a clinician and a consumer.

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146. While professional bodies clearly have an essential role in setting professional standards, that does not replace the responsibility of an organisation, such as a DHB, to ensure that its staff provide services in accordance with the Code.

147. I consider that the DHB could have provided better guidance to staff to maintain professional boundaries and conflicts of interest. I am critical they did not do so. However, the DHB has taken action to improve the guidance provided to staff, and anticipates that a local guideline will improve recognition, active reflection, and the seeking of senior guidance. It is positive that the DHB has gained further learning from this investigation.

148. I note that clear and helpful policies from employing authorities are the starting point, but it is essential that policies are accompanied by training and information to staff about what the policy means in practice to ensure organisations have a culture of compliance with policies.

Recommendations

149. I recommend that Dr B:

a) Provide a written apology to Mr A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Complete the "Rural Training" resource on the RANZCP website, and provide HDC with her reflections and learning from this training and this complaint, within three months of the date of this report.

150. I recommend that RN C:

a) Provide a written apology to Mr A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Attend the NZNO Professional Forum Presentation on Code of Conduct and Professional Boundaries, or contact the NZNO for relevant resources if the Professional Forum Presentation is not available, and provide HDC with her reflections and learning from this training and this complaint, within three months of the date of this report.

151. I recommend that the DHB:

a) Provide a written apology to Mr A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Consider how its codes of conduct and relevant guidelines may be improved in light of the findings in this case and the changes introduced by the Medical Council of New Zealand, and provide HDC with a copy of its updated and additional guideline for

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professional boundaries and potential conflicts of interest, within three months of the date of this report.

c) Provide refresher training to mental health and addiction service staff on professional boundaries and conflicts of interest, and provide HDC with evidence of this within six months of the date of this report.

d) Inform other DHBs of any changes it makes and the reasons for doing so, in a way that maintains the anonymity of the parties involved, within six months of the date of this report.

Follow-up actions

152. A copy of this report with details identifying the parties removed will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name. I will ask that the Medical Council of New Zealand consider whether a review of Dr B's competence is appropriate. I will also write to the Medical Council of New Zealand and the New Zealand Medical Association, asking that they consider reviewing the current wording of standards and guidelines in relation to maintaining professional boundaries, in light of this case, to give clearer guidance on the ethics of financial transactions between consumers and providers.

153. A copy of this report with details identifying the parties removed will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name. I will ask that the Nursing Council of New Zealand consider whether a review of RN C's competence is appropriate. I will also write to the Nursing Council of New Zealand asking that it consider reviewing its current wording in standards and guidelines in relation to maintaining professional boundaries, in light of this case, to give clearer guidance on the ethics of financial transactions between consumers and providers.

154. A copy of this report with details identifying the parties removed will be sent to the Director of Mental Health, the Director General of Health, the Royal Australian and New Zealand College of Psychiatrists, and Te Ao Māramatanga — New Zealand College of Mental Health Nurses, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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