



New Zealand
Health Practitioners
Disciplinary Tribunal

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DECISION NO: 314/Med10/145P

IN THE MATTER of the Health Practitioners
Competence Assurance Act 2003

AND

IN THE MATTER of disciplinary proceedings
against **DR JOHANNES
IGNATIUS VILJOEN
WILSON**, medical practitioner of
Auckland

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

Hearing in Auckland on 5 and 6 July 2010

TRIBUNAL:

Mr Bruce A Corkill QC (Chairperson)

Dr Julie Kimber, Mr Harry O'Rourke, Dr William
Rainger and Dr Tessa Turnbull (Members)

Ms Gay Fraser (Executive Officer)

Ms Jacqui Kennedy (Stenographer)

APPEARANCES:

Mr Michael Heron and Mr Michael Thomas, for
Professional Conduct Committee

Introduction

1. Dr J I V Wilson is a medical practitioner of Auckland.
2. On 10 March 2010, a Professional Conduct Committee (PCC) laid disciplinary charges against Dr Wilson with the Tribunal, under the Health Practitioners Competence Assurance Act 2003 (HPCA Act).

The Charge

3. The final form of the charge is:

“TAKE NOTICE that a Professional Conduct Committee appointed by the Medical Council of New Zealand pursuant to section 71 of the Health Practitioners Competence Assurance Act 2003 (“Act”) has determined in accordance with section 80(3)(b) of the Act that a charge of professional misconduct should be brought against Johannes Ignatius Viljoen Wilson before the Health Practitioners Disciplinary Tribunal.

The Professional Conduct Committee has reason to believe that grounds exist entitling the Tribunal to exercise its powers under section 100 of the Act.

PARTICULARS OF THE CHARGES:

The Professional Conduct Committee charges that Dr Johannes Ignatius Viljoen Wilson, Medical Practitioner of Auckland:

1. *Between August and October 2007, imported the non-consented medicine Jintropin, without being in possession of details of the specifications for testing the quality of that medicine or a certificate of the results of testing in respect of every batch of that medicine distributed in New Zealand, in contravention of section 42 of the Medicines Act 1981;*

AND/OR

2. *Between June 2006 and October 2007, at Auckland, prescribed large quantities of Xanax, a Class C controlled drug, to two patients in circumstances which departed significantly from the usual prescribing practice of general practitioners;*

AND/OR

4.

3. *On or about 8 March 2001, at Auckland, prescribed the medicine Triject to Anthony Jon Gerred without beforehand completing a professional consultation with him;*

AND/OR

3. *On or about 8 March 2001, at Auckland, prescribed the medicine Xenical to Marie Scott without beforehand completing a professional consultation with her;*

AND/OR

4. *Between 14 May 2003 and 4 July 2007, at Auckland, obtained large quantities of the non-consented medicine "MPO" (comprising 60mg ephedrine and 30mg caffeine) from Pharmaceutical Compounding NZ Ltd, and supplied this non-consented medicine to patients in a manner which posed a danger to the health and safety of the public;*

AND/OR

6. *Between July 2006 and July 2007, at Auckland, prescribed non-consented Human Growth Hormone products and non-consented testosterone products to [Patient X] in a manner which posed a risk to her health and safety;*

AND/OR

7. *Between 26 October 2007 and 10 December 2007, obtained large quantities of Sudomyl (a medicine containing the Class C controlled drug pseudoephedrine); and thereafter:*
- (a) Supplied Sudomyl to individuals who were not patients; and*
 - (b) Falsified patient records to indicate Sudomyl had been supplied to patients who in fact never received Sudomyl;*

AND/OR

8. *Between 2003 and 2007, Dr Wilson exploited patients by charging an excessive margin for the non-consented medicine "MPO".*

The conduct alleged in 1 to 8 above either separately or cumulatively amounts to professional misconduct under s100 of the Act."

Legal Principles

Onus and standard of proof

4. The burden of proof was on the PCC.
5. As to standard of proof, the appropriate standard is the civil standard, that is proof to the satisfaction of the Tribunal on the balance of probabilities, rather than the criminal standard. The degree of satisfaction called for will vary according to the gravity of the allegations. The greater the gravity of the allegations the higher the standard of proof.
6. In the decision of *Z v Complaints Assessment Committee* [2009] 1 NZLR 1, a majority of the Supreme Court stated that in civil proceedings in New Zealand (including disciplinary proceedings) there is a civil standard, the balance of probabilities, which is applied flexibly according to the seriousness of matters to be proved and the consequences of proving them. The Court endorsed the classic passage of Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-362 to the effect that the affirmative of an allegation must be made out to the reasonable satisfaction of the fact finder. Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, and the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the Tribunal.

Professional Misconduct:

7. The approach to professional misconduct under s100(1)(a) and (b) is well settled – examples of the correct approach are found in *Nuttall* (8/Med04/03); *Aladdin* (12/Den05/04 and 13/Den04/02D) and *Dale* (20/Nur05/09D).

8. The subsections provide that malpractice and/or negligence and/or conduct likely to bring discredit to the profession can constitute professional misconduct.

9. “Malpractice” is defined in the Collins English Dictionary (2nd ed) as:

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

10. In the New Shorter Oxford English Dictionary (1993 edition) the word is defined as:

“Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer ... 2 gen criminal or illegal action: wrongdoing, misconduct.”

11. Malpractice, although often equated with negligence, is perhaps better considered a broader concept, capable of encompassing neglect, but also of extending to trespassory conduct in the process of caring for patients in relation to consent, breaches of patient confidence and fiduciary obligations, and other forms of conduct reaching the necessary level of gravity, such as assaulting a patient, swearing at or threatening a patient, a deliberate failure to obey an instruction or sexual misconduct (see para 23.65, “Medical Law in New Zealand”, 2006).

12. Negligence and malpractice were discussed by Gendall J in *Collie v Nursing Council of New Zealand* [2000] NZAR 74. His Honour said:

“Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent, ethical and responsible practitioners and there must be behaviour

which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, or oversight or for that matter carelessness.”

13. Similarly, it is for the Tribunal to decide whether the conduct, if established, would be likely to bring discredit on the medical profession. In the same case Gendall J stated:

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

14. There are two steps involved in assessing what constitutes professional misconduct:

- 14.1 The first step involves an objective analysis of whether or not the health practitioner’s acts or omissions can be reasonably regarded by the Tribunal as constituting:

- malpractice; or
- negligence; or
- otherwise meets the standard of having brought, or was likely to bring discredit to the practitioner’s profession;

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

15. This approach to the assessment of professional misconduct under the statute is well established under previous decisions of the Tribunal, and in authorities such as *McKenzie v MPDT & Anor* [2004] NZR 47.

Threshold:

16. The correct approach to threshold for the charge is that described by the Court of Appeal in *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774, which endorsed the earlier statement of Elias J in *B v Medical Council* (noted at [2005] 3 NZLR 810). She made the important point that the threshold is “*inevitably one of degree*”. The Court of Appeal expressed the issue in this way:

“In cases of both professional misconduct and conduct unbecoming it will be necessary to decide if there has been a departure from acceptable standards, and then to decide whether the departure is significant enough to warrant sanction.”

17. In determining whether discipline is warranted, there must be positive reasons to justify such a conclusion.
18. The Tribunal accepts and applies all the above principles in this case.

Service of Charge

19. On 25 March 2010 the District Court made an order for substituted service on Dr Wilson, directing that documents be posted to the address of Dr Wilson’s parents; and by sending a copy of all such documents to an identified email address.
20. The Tribunal received evidence that notice of the charge was served by way of a process server on Dr Wilson’s father, at the address shown in the order for substituted service, on 7 April 2010. Notice of the charge was also sent to the email address identified by the Court, on 25 May 2010.
21. Advice of the date, time and venue of the hearing was given by way of letter sent by courier post to Dr Wilson’s parents at the address shown in the order for substituted service; and by way of email at the identified email address, on 9 June 2010.

22. The Tribunal was satisfied that proper service of the charge, and the hearing date, was effected in terms of the order of substituted service.

Hearing

23. Dr Wilson did not attend the hearing.
24. The PCC filed affidavits from its ten intended witnesses, and relevant documents prior to the hearing. It was directed that five of the witnesses attend the hearing, so that the Tribunal would have an opportunity of asking questions; unfortunately one of those witnesses was unable to attend for reasons the Tribunal accepts, but the remaining four did, which assisted the Tribunal in its deliberations. One of the witnesses gave evidence by video link from overseas.
25. The PCC witnesses were:
- Ms M T Scott and Mr A J Gerred, Medsafe employees who obtained medications from Dr Wilson in 2001;
 - Patient X, who Dr Wilson attended between approximately July 2006 and July 2007;
 - Ms M Van Staden, a qualified pharmacist and employee of Pharmaceutical Compounding New Zealand Limited (PCNZ), who explained the work of PCNZ, and summarised the compounded products supplied by that organisation to Dr Wilson;
 - Mr J M McDonald, pharmacist, and owner and manager of Unichem Pharmacy in Newmarket, Auckland, who gave evidence of a substantial

number of PSOs placed by Dr Wilson between May 2004 and December 2007;

- Ms N I Squire, a senior investigator in the Investigation and Enforcement Team of Medsafe, based in Auckland, who gave evidence of concerns raised by an investigation carried out in respect of the activities of Dr Wilson, between June 2007 and January 2008, as reported to the Medical Council of New Zealand (MCNZ);
- Mr L, [], who gave evidence as to Dr Wilson's practice in that period;
- Dr S R Milsom, a physician with specialist expertise as an endocrinologist, who gave expert evidence and comment, following a review of the medical notes and treatment of Patient X;
- Dr A J Gray, an addiction specialist, who gave expert evidence as to the prescribing of Xanax for methamphetamine withdrawal, and the supply of non-consenting medicine "MPO" to patients;
- Detective Sergeant M R Beal, an expert in the investigation of serious drug offending, being the manufacture, importation and distribution of Class A, B and C controlled drugs. He gave background evidence as to the importance of pseudoephedrine in the manufacture of methamphetamine. He commented on the scale of ephedrine ordered by Dr Wilson (as contained in MPO) and on the circumstances of the Sudomyl tablets ordered by Dr Wilson.

26. Evidence from the witnesses will be referred to with regard to each particular, when each is analysed below.

Non-publication orders

27. The Tribunal was required to consider a number of applications for non-publication orders.
28. An application was made for a permanent order of non-publication of a patient who was to be a witness, including her identifying details and the content of her medical records.
29. In its decision dated 3 June 2010,¹ the Tribunal stated that it was satisfied it should make an interim order of non-publication of the patient's name, identifying details and content of medical records; the order was interim in case Dr Wilson became involved in the proceeding, and in order to give him the opportunity of making submissions. As he did not take part in the substantive hearing, the Tribunal was satisfied having regard to the factors outlined in its earlier decision, that the order should become permanent. The witness is referred to in this decision as Patient X.
30. At the hearing, it was also required to consider an application that all other patients whose names and identifying details fell for consideration in the evidence, should be the subject of a non-publication order. The Tribunal was satisfied that the individual privacy interests of each of the patients who had consulted Dr Wilson over a period of years, mentioned in the evidence, outweighed the public interest factors arising under Section 95 of the HPCA Act. It was accordingly satisfied that a permanent order of non-publication of name, identifying details and content of medical records of all patients referred to in the evidence should be made. Patients are referred to by

¹ Decision No. 308/Med10/145P.

letters of the alphabet, according to a table which will be made available to the parties.

31. The Tribunal was then required to consider an application for non-publication of name in respect of a person who had been a patient of Dr Wilson's, [] Mr L. The grounds for the application related to possible consequences for Mr L were he to be identified as a person having given evidence in this proceeding. The grounds for the application were contained in oral evidence which Mr L gave, and as developed by counsel at the hearing; all relevant information is recorded in the transcript of the Tribunal's hearing. The Tribunal was satisfied that the grounds relied on by Mr L, since they related to his personal safety, outweighed the normal open justice principles which would apply, and consequently made a permanent order of non-publication of name and his identifying details.

Amendment to charge

32. Following receipt of the PCC's closing submissions, it became apparent that the evidence led by the PCC in respect of Particular 7 meant that consideration needed to be given to clarifying the Particular.
33. Counsel for the PCC agreed that it was appropriate to make the amendment, and consequently, the Particular was amended to the form which appears above.
34. In this decision, it is convenient to deal with the Particulars in date order, rather than the order in which they appear in the charge.

Brief chronology

35. The Tribunal finds, on the basis of the evidence before it, that the background to the charge is as follows.
36. Dr Wilson graduated from the University of Pretoria in 1984. He is understood subsequently to have practised medicine in South Africa before moving to New Zealand. On 7 December 1995, he was registered in New Zealand within a general scope of practice.
37. It is understood that he initially practised in Remuera, at a practice known as the Kainos Clinic.
38. From May 2004 to 31 October 2007, Dr Wilson practised from a clinic called “Lifestyle Studios”, which was located in Newmarket, Auckland. During this time, he was associated with a South African biochemist named Martin La Grange, who also worked from the premises.
39. From June 2006 to January 2008, Dr Wilson also practised from the Alpha Clinic, located at 5/15 Anzac Avenue, Takapuna, Auckland. The Alpha Clinic was a small gym offering personal training, nutritional and medical advice. He practised at the Alpha Clinic once or twice a week, and was the sole medical practitioner at the clinic. The Alpha Clinic was operated by Carol Cameron and her son Jamie Cameron.
40. From late 2007 to approximately July 2008, Dr Wilson operated his own medical practice at 5 Scanlan Street, Grey Lynn, Auckland. He worked there three days per week.

41. Between 1999 and 2008, Dr Wilson regularly came to the attention of the Ministry of Health, the Police drugs squad, and the MCNZ. There was a range of concerns relating to the prescribing of drugs of abuse, the importing and prescribing of steroids and other medicines connected with sports and image enhancement. Particular evidence of such issues, as presented to the Tribunal, is now summarised.
42. In February 2001, Medsafe received information that patients were obtaining prescription medicines from a men's health clinic in Remuera, without having had a prior consultation with a medical practitioner.
43. In March 2001, two Medsafe employees obtained medications from the clinic without any prior consultation with Dr Wilson; in one case Xenical, a prescription medicine indicated for use in weight control, and in the other case Triject, a non-consented medicine used for the treatment of erectile dysfunction.
44. In April 2001, Dr Wilson commenced obtaining compounded medicines from Pharmaceutical Compounding New Zealand Limited (PCNZ); in September 2001 PCNZ commenced compounding ephedrine-based products for Dr Wilson; and in May 2003 at his request it commenced compounding "MPO", which contained ephedrine.
45. On 28 August 2003, Mr G Syme from the Ministry of Health visited Dr Wilson at one of his clinics and informed him that he should be obtaining informed consent from patients when supplying them with imported medicines.
46. From May 2004, Dr Wilson commenced placing practitioner supply orders (PSOs) with the Unichem Pharmacy in Newmarket for prescription medicine.

47. In October 2005, PCNZ, having discussed the issue with Medsafe, required Dr Wilson to provide patient names when ordering MPO; to that point he had not done so. Dr Wilson subsequently provided patient names to PCNZ. A Doctor Products Report was produced to the Tribunal which indicated the history of products obtained from PCNZ from 2001 to 2008.
48. In May 2006, Dr Wilson commenced obtaining Xanax tablets from the Aviemore Pharmacy using PSOs.
49. On 5 September 2006, following a meeting with Medsafe representatives, Medsafe wrote to Dr Wilson (and to the proprietors of the Alpha Clinic), making it clear what the law and obligations were governing the use of unregistered medicines. In particular, the obligations under Section 42 of the Medicines Act 1981 were explained. Section 42 provides that details of specifications for the testing of the quality of imported unregistered medicines, and a certificate of analysis for each shipment imported are required to be obtained and kept on site. It was noted that as a matter of appropriate practice, informed consent needs to be obtained in respect of such unregistered medicines from patients; such needs to be recorded on patient notes and should involve a full discussion with the patient that covers the importation and testing information, and any relevant risks of taking an unregistered product.
50. In June 2007, a Medsafe Investigation and Enforcement Team commenced investigating Dr Wilson's activities.
51. On 9 July 2007, PCNZ ceased compounding MPO for Dr Wilson as it could no longer source ephedrine. Dr Wilson had obtained 1,110,400 MPO capsules from 14 May 2003 to 9 July 2007.

52. On 7 September 2007, Customs intercepted a parcel of medicines addressed to Dr Wilson from a UK supplier.
53. On 11 September 2007, Ms Squire from Medsafe inspected the parcel, and found that it contained a number of new medicines, including Jintropin.
54. On 17 September 2007, Dr Wilson was formally interviewed by Medsafe staff regarding various aspects of his practice, including MPO prescribing. Two days later, he provided copies of 48 patient files to Ms Squire. Six of these were produced at the hearing.
55. Between June 2006 and October 2007, Dr Wilson received 6,720 Xanax tablets from the Aviemore Pharmacy.
56. On 11 October 2007, Customs intercepted a further parcel of medicines addressed to Dr Wilson from the same UK supplier. Ms Squire inspected the parcel and found that it contained a number of new medicines, including Jintropin.
57. On 26 October 2007, Dr Wilson commenced ordering large quantities of Sudomyl from the Unichem Pharmacy in Newmarket, via PSO.
58. On 31 October 2007, Ms Squire delivered a letter to Dr Wilson requesting testing information for the unregistered overseas medicines he had recently imported. In a voluntary statement, he admitted he did not have testing data. Dr Wilson was then advised that Medsafe had seized the medicines.
59. On 22 November 2007, Dr Wilson was formally interviewed by Medsafe for the second time regarding various aspects of his practice, including the obtaining of Xanax and Sudomyl.

60. On 10 December 2007, the pharmacist who had by then supplied substantial quantities of Sudomyl to Dr Wilson, ceased supplying that product following a discussion he had with Medsafe. Dr Wilson had obtained 39,900 Sudomyl tablets from 26 October 2007 to 10 December 2007.
61. In January 2008, Dr Wilson relocated his practice to a Grey Lynn address. Mr L, [], discovered Dr Wilson was prescribing large amounts of Xanax and Sudomyl to individuals who were not registered with the practice. Medsafe raided the Grey Lynn practice, but did not discover a box of Sudomyl he had in his car, where labels on the bottles of the product had been removed.
62. On 17 January 2008, Medsafe concluded their investigation into Dr Wilson's conduct and lodged a formal complaint with the MCNZ.
63. Dr Wilson continued to practise at the Grey Lynn premises until June 2008, when xx also lodged a complaint with the MCNZ.
64. Subsequently the MCNZ suspended Dr Wilson's APC.

Particulars 3 and 4 : Prescription of medicines without prior professional consultations

65. The PCC submitted:

“24. *In February 2001, Medsafe received information that patients were obtaining prescription medicines from the Mens Health Clinic in Remuera ("Clinic") without having had a prior consultation with a medical practitioner². Dr Wilson was running the Clinic at the time.³*

25. *On 6 March 2001, Ms Marie Scott telephoned the Clinic and requested the medicine Xenical.⁴ Xenical was a prescription medicine indicated for use in*

² Scott Affidavit, paragraph 6

³ Scott Affidavit, paras 6 & 9; Gerred Affidavit para 7

⁴ Scott Affidavit, para 8

*weight control. Ms Scott spoke to a receptionist at the Clinic and does not recall speaking to Dr Wilson at all about her request for Xenical.*⁵

26. *On 7 March 2001, Mr Anthony Gerred, a Medicines Control Advisor for Medsafe, contacted the Mens Health Clinic in Remuera and requested a repeat supply of the medicine Triject.*⁶ *Triject is a non-consented medicine used for the treatment of erectile dysfunction.*⁷ *Mr Gerred provided his phone number to the Clinic and subsequently spoke with Dr Wilson. Dr Wilson asked Mr Gerred about what dose of Triject he was currently taking, and then confirmed that Triject would be ready for Mr Gerred to collect from the Clinic the following morning.*⁸
27. *On 8 March 2001, Ms Scott and Mr Gerred went to the Clinic. Mr Gerred entered the Clinic and collected and paid for the Triject he had requested.*⁹ *Ms Scott then entered the Clinic and collected and paid for the Xenical she had requested.*¹⁰
28. *Later that day, Mr Gerred spoke with Dr Wilson at another Auckland practice. Dr Wilson admitted to Mr Gerred that no prior medical consultation had taken place in relation to either the supply of Triject to Mr Gerred, or the supply of Xenical to Ms Scott.”*¹¹

66. The Tribunal is satisfied that this is an accurate summary of the evidence adduced on these Particulars, and that the factual basis of these particulars is established. The conduct therein amounts to malpractice and negligence.

Particular 5 : Obtaining large quantities of the non-consented medicine “MPO” and supplying it to patients in a manner which posed a danger to the health and safety of the public

67. The PCC submitted:

- “29. *Pharmaceutical Compounding NZ Limited (“PCNZ”) holds a licence to operate a pharmacy under the Medicines Act and specialises in the extemporaneous compounding of medicines.*¹²
30. *In 2001, Dr Wilson introduced himself to PCNZ and explained that he wanted to compound a weight loss medicine for his patients.*¹³ *In 2003, Dr Wilson*

⁵ Scott Affidavit, para 10.

⁶ Gerred Affidavit, para 5 & annexure AJG-1.

⁷ Squire Affidavit para 25; Gerred Affidavit para 4.

⁸ Gerred Affidavit, paras 9-10.

⁹ Gerred Affidavit, paras 11-16.

¹⁰ Scott Affidavit, para 1.

¹¹ Gerred Affidavit, para 22.

¹² Van Staden Affidavit, para 7.

¹³ Van Staden Affidavit, para 11.

asked PCNZ to compound a special weight loss medicine called "MPO", which contained 30mg of caffeine and 60mg of ephedrine.¹⁴ Since 15 October 2004, ephedrine has been classified as a Class C controlled drug under the Misuse of Drugs Act.¹⁵

31. *PCNZ began compounding MPO for Dr Wilson on or about 14 May 2003.¹⁶ The MPO was compounded in a capsule form and supplied to Dr Wilson in bottles each containing 100 capsules.¹⁷ Between 14 May 2003 and 9 July 2007, PCNZ compounded approximately 11,104 bottles of MPO for Dr Wilson, or a total of approximately 1,110,400 capsules of MPO.¹⁸*
32. *MPO is a non-consented medicine in terms of the Medicines Act which means that its safety, quality and efficacy have not been tested by Medsafe.¹⁹ Dr Wilson was aware that MPO was a non-consented medicine.²⁰*
33. *Dr Wilson was able to order MPO from PCNZ by relying on the exemption contained in section 25 of the Medicines Act, which allows a registered medical practitioner to administer, or arrange for the administration of medicines, for the treatment of a particular patient under his or her care.²¹ Initially, Dr Wilson was able to obtain MPO from PCNZ without consistently providing the names of the patients that required the medicine.²² However, following a meeting with Medsafe in 2005, PCNZ thereafter ensured that Dr Wilson consistently provided patient names for his MPO orders, from 21 October 2005 onwards.²³*
34. *In an interview with Medsafe on 17 September 2007, Dr Wilson was questioned about the MPO he had obtained from PCNZ. Dr Wilson claimed that he had 600-700 patients receiving MPO in the previous 6 months.²⁴ Dr Wilson stated that he told patients to take a dosage of one MPO capsule, three times daily. Dr Wilson said that a bottle of MPO, which contained 100 capsules, would last a patient approximately one month.²⁵ Dr Wilson said he usually prescribed a patient between 1-3 containers of MPO at a time.²⁶*
35. *On 19 September 2007, at Ms Squire's request, Dr Wilson provided copies of 48 patient files from the Alpha Clinic.²⁷ According to the patient files provided by Dr Wilson, 9 of the 48 patients were recorded as having been provided with MPO.²⁸*

¹⁴ Van Staden Affidavit, para 15; Squire Affidavit annexure NIS-1 at p16.

¹⁵ Squire Affidavit, para 34.

¹⁶ Van Staden Affidavit, para 16.

¹⁷ Van Staden Affidavit, para 17.

¹⁸ Squire Affidavit, para 32.

¹⁹ Squire Affidavit, para 35; Van Staden Affidavit, para 22.

²⁰ Squire Affidavit, annexure NIS-1 at p18.

²¹ Squire Affidavit, para 36.

²² Squire Affidavit, para 37.

²³ Van Staden Affidavit, para 27 & annexure MVS-1 at p60.

²⁴ Squire Affidavit, para 40 & annexure NIS-1 at p17.

²⁵ Squire Affidavit, para 41 & annexure NIS-1 at p16.

²⁶ Squire Affidavit, para 41.

²⁷ Squire Affidavit, para 44 & annexure NIS-2.

²⁸ Squire Affidavit, para 44 & annexure NIS-2.

36. *Ms Squire compared Dr Wilson's explanation to the patient names listed as having received MPO in the PCNZ "Doctor Products Report".²⁹ Ms Squire found that for the 6 month period from 1 January 2007 to 30 June 2007, Dr Wilson ordered 2,013 bottles of MPO (or 201,300 capsules) for 195 different patients - a significantly lower number of patients than the 600-700 patients Dr Wilson claimed during the interview.³⁰ Ms Squire also found that 9% of the patients listed for this period (17 patients) received 24% of the total MPO ordered for the period (494 bottles).³¹*
37. *Dr Gray was asked to comment on whether Dr Wilson had created a danger to public health and safety by obtaining and supplying large quantities of MPO.³² In Dr Gray's opinion, the constituents of the MPO capsules (ephedrine and caffeine) are not in themselves particularly alarming.³³ In relation to the 5 patient files he reviewed, Dr Gray's view was that those patients were at a relatively low risk of danger from consuming MPO, but the risk could be significantly increased if the stated dosage was exceeded.³⁴*
38. *Dr Gray was also asked to comment on the quantities of MPO supplied to three patients, as taken from the PCNZ "Doctor Products Report", which equated to a daily dosage of between 11 and 16 capsules of MPO.³⁵ In Dr Gray's opinion, the quantity of MPO prescribed would represent a serious overdose, assuming the patients consumed those quantities of MPO.³⁶ Dr Gray went on to express his opinion that it is more likely that Dr Wilson forwarded the list of names to PCNZ as an expedience, and that the named patients did not correlate with the individuals who ultimately received the MPO.³⁷ In Dr Gray's opinion, there is also no evidence to support Dr Wilson's claim that MPO is an effective pharmacological approach to weight loss.*
39. *Ms Squire reviewed some of the literature regarding the use of ephedrine for weight loss. Ms Squire found that in 2004 the United States Food and Drug Administration ("FDA") prohibited the sale of dietary supplements containing ephedrine alkaloids (ephedra) because such supplements presented an unreasonable risk of illness or injury.³⁸*
40. *Detective Sergeant Michael Beal, a member of the Auckland Drug Squad of the New Zealand Police, was asked to comment on the large quantities of MPO obtained by Dr Wilson. Mr Beal was informed that Dr Wilson obtained approximately 1,110,400 capsules of MPO from PCNZ between 14 May 2003 and 9 July 2007, each capsule containing 60mg of ephedrine. Mr Beal*

²⁹ Squire Affidavit para 53.

³⁰ Squire Affidavit, para 55 & annexure NIS-5.

³¹ Squire Affidavit, para 57 & annexure NIS-6.

³² Gray Affidavit, para 24.

³³ Gray Affidavit, para 26.

³⁴ Gray Affidavit, para 38(b).

³⁵ Gray Affidavit, para 42.

³⁶ Gray Affidavit, para 44.

³⁷ Dr Gray, para 45.

³⁸ Squire Affidavit, para 50 & annexure NIS-3

calculated that the total quantity of ephedrine contained in these tablets was 66.624 kilograms.

41. *Detective Sergeant Beal states that there appears to be no accurate record of how the MPO tablets were actually disposed of by Dr Wilson.³⁹ Mr Beal states that the volume of MPO obtained would have required a very large patient base, which is not supported by the records maintained by the clinics in this case. Mr Beal further states that while there is no clear evidence that MPO was being used to facilitate the diversion of pseudoephedrine for illicit purposes, the circumstances were clearly consistent with the type of arrangement that could allow this to occur.⁴⁰ Mr Beal notes that if the ephedrine contained within the MPO capsules was diverted to methamphetamine manufacture, this would yield between 33.312 and 49.968 kilograms of methamphetamine, with a street value between \$8,328,000 and \$15,989,760.*
42. *To summarise in relation to this particular of the charge, the PCC submits that professional misconduct is established if the Tribunal finds that any one of the following scenarios is established on the facts:*
- (a) *Dr Wilson provided MPO to some of his patients, but in quantities that Dr Gray has stated would "represent a serious overdose" if those patients in fact consumed all of the MPO ordered under their names, thereby posing a danger to the health and safety of those patients; and/or*
 - (b) *Dr Wilson provided the MPO to the patients listed in the PCNZ Doctor Products Report and in the quantities stated in that report. The quantities supplied to the patients however exceeded the dosage stated as being appropriate on Dr Wilson's own account, creating a risk that the MPO would be diverted for illicit purposes, and thereby posing a danger to the health and safety of the public generally; and/or*
 - (c) *An analysis of the PCNZ Doctors Product Report shows that the number of patients listed as requiring MPO, is significantly less than the actual patient base claimed by Dr Wilson. It is more likely that Dr Wilson simply provided a list of patient names to PCNZ as an expedience which made possible the diversion of large quantities of ephedrine for illicit purposes, thereby posing a danger to the health and safety of the public generally."*

68. The Tribunal accepts that paragraphs 29 to 36 of the submission contain a correct summary of the evidence placed before the Tribunal, which it accepts.

³⁹ Beal Affidavit, para 43.

⁴⁰ Beal Affidavit, para 44.

69. The evidence summarised in the PCC's submission at paragraph 36, as to the statistical analysis undertaken by Ms Squire, is also correct.
70. In respect of the expert opinion given by Dr Gray, who has had extensive experience in dealing with drug and alcohol addictions, in investigating and managing the abuse of prescription medication, and in monitoring prescribers under the statutory provisions of the Medicines Act 1981 and the Misuse of Drugs Act 1975, is correctly stated in the submission at paragraphs 37 and 38.
71. It is clear that the prescription of MPO was a regular feature of Dr Wilson's practice. His printed "client consultation form", which had a template for prescribed medication, had a specific printed reference to MPO, but not to any other pharmaceutical. Mr L informed the Tribunal that in 2008, after PCNZ was no longer providing the product, Dr Wilson was looking for ways of trying to replicate or duplicate the ingredients contained in the product.
72. Dr Wilson's prescribing practices are very concerning. It is worth repeating the analysis carried out by Ms Squire in her evidence:
- "52. During the 17 September 2007 interview, Dr Wilson stated that he told patients to take a dosage of one MPO capsule, three times per day. He also said that one bottle of MPO, containing 100 capsules, would last a patient one month. Dr Wilson also claimed to have 600-700 patients who were receiving MPO during the previous 6 months.*
- 53. I recently tested Dr Wilson's explanation against the PCNZ records for MPO. From 21 October 2005 onwards, the PCNZ Doctors Products Report for Dr Wilson lists the patient names that Dr Wilson submitted to PCNZ, along with the quantity of MPO ordered by Dr Wilson for each named patient.*
- 54. I took several patient names from the PCNZ Doctors Products Report and totalled the quantity of MPO purportedly supplied to each patient during a period of approximately 6-7 months. I found that:*
- (a) The quantity of MPO ordered by Dr Wilson between 8 December 2006 and 4 July 2007 under the patient name of [Patient B] totalled 23*

bottles of MPO, or 2,300 capsules. If this patient took that quantity of MPO over this period that would equate to an average daily dose of approximately 11 capsules of MPO, or a total of 660 mg of ephedrine per day.

(b) The quantity of MPO ordered by Dr Wilson between 8 December 2006 and 6 July 2007 under the patient name of [Patient C] totalled 27 bottles of MPO, or 2,700 capsules. If this patient were taking this quantity of MPO over this period that would equate to an average daily dose of approximately 12 capsules of MPO, or a total of 720 mg of ephedrine per day.

(c) The quantity of MPO ordered by Dr Wilson between 12 January 2007 and 15 June 2007 under the patient name of [Patient D] totalled 30 bottles of MPO, or 3,000 capsules. If this patient were taking this quantity of MPO over this period that would equate to an average daily dose of approximately 19 capsules of MPO, or a total of 1140 mg of ephedrine per day.

55. *Following this initial analysis, I completed a more detailed analysis of the PCNZ Doctors Report for MPO for the 6 month period from 1 January 2007 to 30 June 2007. I found that during this period, Dr Wilson had ordered 2,013 bottles of MPO for 195 different patients – a significantly lower number of patients than the 600-700 patients Dr Wilson claimed to have prescribed MPO to during the 6 months prior to the interview. This amounts to 201,300 MPO capsules during this period.*

56. *During the period 1 January 2007 to 30 June 2007, I found that it was most common for Dr Wilson to order three bottles at a time for a patient. On 654 occasions, Dr Wilson ordered 3 bottles of MPO for a patient, on 14 occasions 2 bottles were ordered for a patient, and on 23 occasions one bottle was ordered for a patient. The total number of MPO bottles ordered per patient during this period ranged from 1 bottle (12 patients) to 45 bottles (1 patient). Annexed and marked “NIS-5” is a schedule I prepared which shows the number of patients who received various quantities of MPO bottles.*

57. *For this period I also calculated that 9% of patients (17 patients) received 24% of the total MPO ordered for this period (494 bottles). Annexed and marked “NIS-6” is a schedule I prepared setting out the MPO ordered for each of these 17 patients. This schedule displays the patient name, the total numbers of bottles ordered, the average number of tablets per day, the total amount of ephedrine, the dates the orders were placed and the number of bottles ordered on each occasion.”*

73. Other examples were evident in the patient records placed before the Tribunal. In one instance (Patient E) was prescribed with what was apparently a three month supply on 11 July 2007, and eleven days later was prescribed a further one month

supply.⁴¹ In a further example (Patient F), what was said to be a three month supply was prescribed on 31 May 2007, and a further three month supply was prescribed on 11 July 2007, a period of only six weeks later.⁴²

74. The Tribunal has considered carefully the “scenarios” described by the PCC at paragraph 42 of its submission. The Tribunal is of the view that it is entitled to assume Dr Wilson did provide MPO to the patients who he named in the PCNZ Doctor Products Report. There is no evidence that he did not do so, and having regard to the patient files which the Tribunal has seen, it is more likely than not that this occurred.
75. A relevant contextual matter relates to the explanation given by Dr Wilson to patients, as recorded in two sets of patient notes that were before the Tribunal. It appears Dr Wilson was advising his patients that MPO medication contains “ephedra”, with the implication that it had a different risk profile to ephedrine. Dr Gray advised the Tribunal that this statement was inaccurate, and possibly designed to be misleading. He also said that the risk of developing dependence on MPO was real for susceptible individuals, who used this medication daily for a period of one month.
76. In the period 1 January 2007 to 30 June 2007 (the six month period analysed by Ms Squire), patients should not have been given more than six bottles of MPO. The evidence shows, however, that 94 patients were given quantities far in excess of this over that period, ranging from 8 bottles up to 45 bottles.

⁴¹ Pp. 96 and 100 of Ms Squire’s documents.

⁴² Squires documentation, pp. 130 and 133.

77. Accordingly, the Tribunal is well satisfied that Dr Wilson provided MPO to some of his patients in quantities that, as Dr Gray stated, would “represent a serious overdose” if those patients in fact consumed all of the MPO ordered under their names; and that obviously posed a danger to the health and safety of those patients. There was a risk of adverse consequences from overdose; and as Dr Gray advised, there was a risk of dependence.
78. Further, if patients did not consume all of the MPO they received, there was a risk it could be diverted for illicit purposes, given the significant ephedrine content. That risk also posed a danger to the health and safety of the general public.
79. For the purposes of this Particular, the Tribunal does not need to consider Detective Sergeant Beal’s evidence that Dr Wilson’s motive for obtaining huge quantities of MPO was in fact to take part, himself, in the diversion of large quantities of ephedrine for illicit purposes. The components of the Particular are well established without having to consider this possibility.
80. The Tribunal is satisfied that this Particular is established, and amounts to malpractice and the bringing of discredit to the medical profession.

Particular 8: Exploited patients by charging in excess of margin for the non-consented medicine MPO

81. The PCC submitted:

“69 *During an interview with Medsafe on 17 September 2007, Dr Wilson stated that he purchased one container of MPO (100 tablets) from PCNZ for approximately \$35-36 (excluding GST).*⁴³ *Ms Van Staden states that PCNZ charged Dr Wilson \$34.71 plus GST per bottle of MPO compounded by PCNZ.*⁴⁴

⁴³ Squire Affidavit para 120 & annexure NIS-1 at p 22.

⁴⁴ Van Staden Affidavit, para 16.

- 70 *During the Medsafe interview, Dr Wilson said he would sell one bottle of MPO to a patient for \$150, although three months prior to the interview the price was \$100.⁴⁵ A sale price of \$150 consistent with the price recorded as having been charged to [Patient X] on 14 July 2007, 5 April 2007 and 22 November 2006.⁴⁶*
- 71 *Ms Squire notes that this represents a margin of between 177%-316%.⁴⁷ Ms Squire states that from her previous experience as an investigator at both the Commerce Commission and Serious Fraud Office, it is exceedingly rare for a legitimate business to operate on margins of 177%-316%. These margins are more typical of the range found in the black market, or in other fraudulent activities.⁴⁸*
- 72 *Dr Gray felt unable to comment on whether the margin charged by Dr Wilson was exploitative of patients, as this fell outside his expertise.”⁴⁹*
82. The Tribunal is satisfied that the evidence referred to in the PCC submission is a correct summary of the evidence placed before the Tribunal, which it accepts.
83. There is a reliable basis for the margins mentioned, in the form of the evidence given by PCNZ as to its charges (\$34.71 plus GST per bottle of MPO compounded by PCNZ). There is also reliable evidence as to the amount which patients were charged.
84. The Tribunal is satisfied that the factual basis for this particular is established, was exploitative of patients (even if prepared to pay such sums); and that such conduct amounts to the bringing of discredit to the medical profession.

Particular 2: Prescription of large quantities of Xanax

85. The PCC submitted:

“19 Between May 2006 and November 2007, Dr Wilson obtained Xanax from the Aviemore Pharmacy in Auckland using Practitioner Supply Orders

⁴⁵ Squire Affidavit para 120 & annexure NIS-1 at p 22.

⁴⁶ Squire Affidavit, para 121 & annexure NIS-2 at pp 24, 25, 29 & 37.

⁴⁷ Squire Affidavit, para 120.

⁴⁸ Squire Affidavit, para 122.

⁴⁹ Gray Affidavit, para 47.

(“PSOs”).⁵⁰ *Between June 2006 and October 2007, Dr Wilson obtained a total of 6,720 0.5mg Xanax tablets from the Aviemore Pharmacy in this manner.*⁵¹ *Xanax is classified as a Class C controlled drug under the Misuse of Drugs Act 1975.*⁵²

20 *Between May 2007 and December 2007, Dr Wilson obtained a total of 760 0.5mg Xanax tablets from the Broadway Pharmacy in Auckland using PSOs.*⁵³

21 *In an interview with Medsafe on 22 November 2007, Dr Wilson stated that he supplied all of the Xanax to two patients, including one who was a high profile New Zealander with a methamphetamine problem.*⁵⁴ *Dr Wilson explained that he prescribed Xanax to the two patients to counter the effects of using methamphetamine. Dr Wilson stated that he prescribed between 30 and 50 tablets of Xanax to those patients per day. Dr Wilson acknowledged that this was well above the recommended daily dosage.*⁵⁵

22 *Dr Adrian Gray, an addiction specialist, was asked to comment on Dr Wilson’s prescription of the controlled drug Xanax for methamphetamine withdrawal.*⁵⁶ *In summary, Dr Gray’s opinion is that the prescription of 30-50 Xanax tablets per day by a general practitioner to a patient for amphetamine withdrawal is completely inappropriate, and it would be an understatement to describe this as a significant departure from the usual prescribing practice of general practitioners.*⁵⁷

23 *Dr Gray notes that the Medsafe Data Sheet for Xanax describes a usual dosage range of 0.5mg to 4mg, whereas Dr Wilson’s stated dose would be equivalent to a dosage range of 15mg to 25mg per day.*⁵⁸ *In Dr Gray’s experience, a dose of 10mg of Xanax would be extremely rare even if prescribed by a specialist psychiatrist.*⁵⁹ *In Dr Gray’s opinion, the daily dosage described by Dr Wilson is vastly above the maximum dosage recommendation and could conceivably cause death by respiratory depression - especially if taken concurrently with alcohol or opioid-based painkillers.”*⁶⁰

86. The Tribunal accepts that the submission accurately describes the evidence placed before it, which it accepts.

⁵⁰ Squire Affidavit, para 76.

⁵¹ Squire Affidavit, para 79 & annexures NIS-9 & NIS-10.

⁵² Squire Affidavit, para 77; Gray Affidavit, para 12.

⁵³ Squire Affidavit, para 84 & annexure NIS-12; MacDonald Affidavit, annexure JMM-1.

⁵⁴ Squire Affidavit para 81 & annexure NIS-11 at p336.

⁵⁵ Squire Affidavit, annexure NIS-11 at pp 336-337.

⁵⁶ Gray Affidavit, para 8(a).

⁵⁷ Gray Affidavit, para 21.

⁵⁸ Gray Affidavit, paras 19-20 & annexure AJG-1.

⁵⁹ Gray Affidavit, para 20.

⁶⁰ Gray Affidavit, para 18.

87. It also accepts the expert evidence from Dr Gray, to the effect that the daily dose of Xanax prescribed (30 to 50 tablets of 0.5 mg) is “vastly above the maximum dosage recommendations and could conceivably cause death by respiratory depression.”
88. According to the evidence, this product was supplied to two patients, including one with a methamphetamine problem; it was prescribed to counter the effects of using methamphetamine.
89. The Tribunal is satisfied that the charge is well established, and that such prescribing departs significantly from the usual prescribing practice of general practitioners. This conduct constitutes malpractice, and the bringing of discredit to the medical profession.

Particular 6: Prescription of non-consented Human Growth Hormone products and testosterone products to a patient in a manner which posed a risk to her health and safety

90. The PCC submitted:

“43 *[Patient X] was a patient of Dr Wilson between July 2006 and July 2007.⁶¹ [Patient X] initially consulted Dr Wilson in relation to hormone replacement therapy, as well as her general health and fitness.⁶² She subsequently consulted Dr Wilson on 18 occasions between 11 July 2006 and 14 July 2007.⁶³*

44 *[Patient X's] patient file shows that she was prescribed several non-consented medicines by Dr Wilson, including human growth hormone (Genesis & Jintropin), testosterone gel, Clenbuterol and DHEA.⁶⁴ Dr Stella Milsom, a specialist endocrinologist, was asked to provide an expert opinion in relation to Dr Wilson's treatment of [Patient X].⁶⁵ Ms Squire was asked to comment on the nature of the medicines prescribed to [Patient X].*

⁶¹ [Patient X] Affidavit, para 1.

⁶² [Patient X] Affidavit, para 2. Milsom Affidavit, para 14; Squire Affidavit, annexure 2 at pp 23-74.

⁶³ Milsom Affidavit, para 14; Squire Affidavit, annexure 2 at pp 23-74.

⁶⁴ Squire Affidavit, paras 58-72 and annexure NIS-2 at pp 23-74.

⁶⁵ Milsom Affidavit, para 1 to 12.

Testosterone gel

- 45 *Dr Wilson prescribed testosterone gel to [Patient X] at her first consultation on 11 July 2006.⁶⁶ There are consented medicines in New Zealand that contain testosterone, but none of those are in the gel form prescribed to [Patient X].⁶⁷*
- 46 *The dosage of testosterone gel prescribed is unclear from the consultation form and the advice given is largely illegible.⁶⁸ Dr Milsom notes that [Patient X's] testosterone level at this consultation is very high.⁶⁹ Dr Milsom states that there is no clinical indication for testosterone therapy treatment for [Patient X], and in fact [Patient X's] already high blood levels of testosterone are a contraindication to testosterone therapy treatment.⁷⁰*
- 47 *Dr Milsom notes that there are no approved preparations of testosterone therapy available for women in New Zealand and therefore practitioners who prescribe testosterone to women must use modified doses of male preparations, for which there is very limited safety data.⁷¹ In Dr Milsom's opinion, the prescription of testosterone gel by Dr Wilson in these circumstances fell below the standard of care one would expect from a general practitioner such that it posed a risk to [Patient X's] health and safety.*
- 48 *Ms Squire notes the approved clinical indications for products with ministerial consent that contain testosterone include the treatment of hypogonadism in men (failure of the testes to produce testosterone), to cause masculinisation when gender change from female to male is required, and for osteoporosis caused by androgen deficiency.⁷² Dr Milsom notes that testosterone is a controversial treatment in women for symptoms of androgen deficiency, which [Patient X] did not suffer from.⁷³ The possible adverse effects associated with using testosterone are extensive and include worsening of heart failure, renal failure and hypertension, liver tumours, liver toxicity, psychiatric disturbances, virilisation in women, and predisposition to diabetes.⁷⁴*
- 49 *Dr Wilson continued testosterone treatment for [Patient X] at subsequent consultations when there was no clinical indication for it:*
- (a) *Dr Wilson continued to prescribe testosterone gel to [Patient X] at their third appointment [undated].⁷⁵*

⁶⁶ Milsom Affidavit, para 28; Squire Affidavit, annexure NIS-2 at p 66.

⁶⁷ Squire Affidavit, para 64.

⁶⁸ Milsom Affidavit, para 28.

⁶⁹ Milsom Affidavit, para 21.

⁷⁰ Milsom Affidavit, para 33.

⁷¹ Milsom Affidavit, para 30.

⁷² Squire Affidavit, para 65.

⁷³ Milsom Affidavit, para 29.

⁷⁴ Squire Affidavit, para 66.

⁷⁵ Milsom Affidavit, para 37; Squire Affidavit, annexure NIS-2 at p 64.

- (b) *Dr Wilson continued to prescribe testosterone gel to [Patient X] at their fourth appointment on 17 August 2006,⁷⁶ when blood tests showed that [Patient X's] testosterone level had in fact risen.⁷⁷ Dr Milsom believes that [Patient X's] high levels of total testosterone and free testosterone were partly due to the testosterone gel treatment prescribed by Dr Wilson.⁷⁸ Dr Milsom stated that these levels were within the normal male range and would have been high enough to virilise [Patient X].⁷⁹ In Dr Milsom's view it was clearly inappropriate for Dr Wilson to continue with testosterone therapy for [Patient X] given that he had not excluded other pathologies (eg cancer) for her elevated testosterone levels, and because her current testosterone levels were so abnormal.⁸⁰*
- (c) *It is likely that testosterone treatment was continued at the fifth appointment on 9 September 2006.⁸¹*
- (d) *Dr Wilson continued prescribing testosterone gel to [Patient X] at their sixth appointment on 20 September 2006.⁸²*
- (e) *Dr Wilson prescribed testosterone gel to [Patient X] at their seventh appointment on 20 November 2006,⁸³ despite a further blood test showing that [Patient X's] testosterone level had increased even further and was now at an extremely abnormal level.⁸⁴*
- (f) *Dr Wilson prescribed testosterone gel to [Patient X] at their eighth appointment on 22 November 2006. Dr Milsom considered this to be inappropriate given [Patient X's] extremely high levels of testosterone.⁸⁵*
- (g) *Dr Wilson prescribed testosterone gel to [Patient X] at their sixteenth appointment on 26 April 2007.⁸⁶ [Patient X] had further blood tests between 13 February 2007 and 16 April 2007, which showed that [Patient X's] testosterone level varied between 2.7 to 7.4 during this period, lower than it had been in 2006. This may have been caused by [Patient X] using the testosterone gel variably.⁸⁷*

50. *There is no documentation on [Patient X's] patient file to suggest that Dr Wilson discussed with [Patient X] why he was prescribing testosterone gel to her, the risks associated with using testosterone, how the treatment was to be*

⁷⁶ Squire Affidavit, annexure NIS-2 at p 64.

⁷⁷ Squire Affidavit, annexure NIS-2 at p 62.

⁷⁸ Milsom Affidavit, para 44.

⁷⁹ Milsom Affidavit, para 43.

⁸⁰ Milsom Affidavit, para 44.

⁸¹ Milsom Affidavit, para 52; Squire Affidavit, annexure NIS-2 at p 36.

⁸² Squire Affidavit, annexure NIS-2 at p 35.

⁸³ Squire Affidavit, annexure NIS-2 at p 38

⁸⁴ Milsom Affidavit, paras 55 & 58; Squire Affidavit, annexure NIS-2 at p 50.

⁸⁵ Milsom Affidavit, para 59; Squire Affidavit, annexure NIS-2 at p 37.

⁸⁶ Squire Affidavit, annexure NIS-2 at p 27.

⁸⁷ Milsom Affidavit, para 75.

monitored, or that he was prescribing an unregistered hormone therapy (testosterone gel).⁸⁸ [Patient X] cannot recall why Dr Wilson prescribed testosterone products to her.⁸⁹ In Dr Milsom's opinion, Dr Wilson should have made further investigations before any treatment was prescribed for [Patient X]. In particular, Dr Wilson should have asked about [Patient X's] medication history, conducted a physical examination, and further investigated [Patient X's] abnormal biochemistry - particularly her high testosterone level.⁹⁰

Human growth hormone

- 51 Dr Wilson commenced growth hormone treatment for [Patient X] at their tenth appointment on 8 December 2006.⁹¹ and gave further prescriptions for growth hormone at the twelfth (15 February 2007), thirteenth (20 February 2007), sixteenth (26 April 2007) and eighteenth (14 July 2007) appointments.⁹²
- 52 One of the growth hormones prescribed by Dr Wilson was Jintropin.⁹³ Jintropin is a non-consented medicine in New Zealand,⁹⁴ although Dr Wilson never mentioned this to [Patient X].⁹⁵ Dr Milsom could not find any data about the safety or quality of Jintropin, and therefore there is no safety assurance as to the dose, the consistency between doses, and potential contamination with other compounds.⁹⁶ Dr Wilson himself did not have any testing data for Jintropin. Dr Wilson prescribed another non-consented growth hormone to [Patient X] at their sixteenth appointment on 26 April 2007, called "Genesis".⁹⁷
- 53 Dr Milsom states that there was no indication that [Patient X] had adult hormone deficiency, the only condition for which growth hormone treatment is indicated for adults in New Zealand.⁹⁸ In Dr Milsom's opinion, Dr Wilson's consultation notes suggest that there was no clinical advice given to [Patient X], no physical examination, no testing of [Patient X's] growth hormone levels or IGF-1 levels, and no explanation of the possible side effects of growth hormone treatment.⁹⁹
- 54 There are a number of possible adverse effects which can flow from the inappropriate use of growth hormones including the stunting of bone growth, fluid retention, heart enlargement, elevated intracranial pressure, eye damage, increased insulin, infection site reactions, localised lipotrophy,

⁸⁸ Milsom Affidavit, para 32.

⁸⁹ [Patient X] Affidavit para 21.

⁹⁰ Milsom Affidavit, para 34.

⁹¹ Milsom Affidavit, para 61; Squire Affidavit, annexure NIS-2 at p 32.

⁹² Squire Affidavit, annexure NIS-2.

⁹³ Milsom Affidavit, para 67.

⁹⁴ Squire Affidavit, para 60.

⁹⁵ [Patient X] Affidavit, para 19.

⁹⁶ Milsom Affidavit, para 68.

⁹⁷ Squire Affidavit para 58 & annexure NIS-2 at p 27.

⁹⁸ Milsom Affidavit, para 61; Squire Affidavit para 61.

⁹⁹ Milsom Affidavit, paras 62-63.

*peripheral oedema, stiffness, arthralgia, myalgia, and paraesthesia.*¹⁰⁰ Additionally, there is no long-term data which supports the safety of treating healthy women with growth hormone.¹⁰¹ Dr Wilson further used preparations or medications from unknown suppliers, which increased the risk of dose variability and contamination, when safer recognised medications were available.¹⁰²

55 *Dr Wilson was reminded by Medsafe on two occasions that (28 August 2003 and 5 September 2006) he needed to obtain informed consent from patients when prescribing new medicines, and when he was prescribing medicines for a non-approved or "off-label" use.*¹⁰³ Ms Squire is unable to find anything in [Patient X's] patient file which indicates that she was informed that the medicines she was being prescribed were non-consented, or being used for an off-label purpose.¹⁰⁴

56 *In summary, Dr Milsom's opinion is that Dr Wilson's treatment of [Patient X], particularly the prescription of non-consented growth hormone and testosterone products, fell below the standard of care you would expect from a general practitioner such that it posed a risk to [Patient X's] health and safety."*¹⁰⁵

91. During the course of the hearing, it was established that there was apparently a page missing from the patient questionnaire completed by Patient X (page 3 of the questionnaire).¹⁰⁶ It is possible, therefore, that a page relating to "medical history and present medical condition" may have been completed by Patient X. If so, the criticism made in Dr Milsom's evidence to the effect that at the initial consultation Dr Wilson had failed to take a history on certain matters¹⁰⁷ would not be correct.

92. For this reason, criticism should not be made as to the adequacy of the initial consultation with Patient X on 11 July 2006.

93. However, the issue of acute concern, in relation to the prescribing of testosterone gel, is the prescribing of the testosterone gel from August 2006 to 22 November 2006,

¹⁰⁰ Squire Affidavit, para 63; Milsom Affidavit, para 63.

¹⁰¹ Milsom Affidavit, para 63.

¹⁰² Milsom Affidavit, para 81.

¹⁰³ Squire Affidavit, para 74.

¹⁰⁴ Squire Affidavit, para 75.

¹⁰⁵ Milsom Affidavit, para 84.

¹⁰⁶ Compare pages 41 and 42 of Ms Squire's material with, say, page 122.

¹⁰⁷ Paragraph 27 of her brief.

when the testosterone and free testosterone levels were abnormally high, and at one point (20 November 2006) “extremely abnormal”.

94. The Tribunal accepts Dr Milsom’s evidence that it was highly inappropriate for Dr Wilson to continue with testosterone treatment, given the high levels attained; nor was there any clinical reason for prescribing the product.
95. Turning to the prescribing of Human Growth Hormone products, the Tribunal accepts Dr Milsom’s opinion that the medication was prescribed to Patient X in the absence of any accepted medical indication for such treatment. Further, the use of such medications from unknown suppliers increased the risk of dose variability and contamination, notwithstanding the existence of safer alternatives in New Zealand for recognised medical indications.
96. Accordingly, the Tribunal accepts that in the period involved, prescribed non-consented Human Growth Hormone products and non-consented testosterone products were prescribed to Patient X in a manner which posed a risk to her health and safety.
97. This Particular is established, and amounts to negligence and malpractice.

Particular 1: Importation of a non-consented medicine without possessing testing details

98. The PCC submitted:

“9 *Section 42 of the Medicines Act 1981 prohibits an importer of a medicine from selling, distributing, or advertising any medicine without being in possession of the details of the specifications for testing the quality of that medicine and a certificate of the results of testing in respect of every batch of that medicine distributed, or to be distributed, in New Zealand.*

- 10 *On 5 September 2006, Dr Wilson was advised by Medsafe that if he was importing non-consented medicines, he was required by law to obtain and keep possession of the data required by section 42 of the Medicines Act.*¹⁰⁸
- 11 *On 7 September 2007 and 11 October 2007, the New Zealand Customs Service ("Customs") intercepted two parcels of medicines imported by Dr Wilson from a supplier in the United Kingdom, "3S Nut & Pharma".*¹⁰⁹ *Both parcels were inspected by Ms Nicola Squire, a senior investigator employed by the Ministry of Health, and found to contain a number of non-consented medicines in terms of the Medicines Act 1981.*
- 12 *The parcels contained a total of 50 ampoules of "Jintropin", a growth hormone with the active ingredient "somatropin"*¹¹⁰ *Jintropin is a non-consented or "new" medicine in terms of the Medicines Act ,*¹¹¹ *While there are consented medicines in New Zealand that contain somatropin, Jintropin is not one of these.*¹¹² *There are a number of adverse effects which can flow from the inappropriate use of growth hormones such as Jintropin.*¹¹³
- 13 *Ms Squire subsequently made enquiries about the supplier of the medicines through the UK Medicines and Healthcare Products Regulatory Agency ("MHRA"). The MHRA informed Ms Squire that 3S Nut & Pharma was neither a registered company, nor a registered pharmacy.*¹¹⁴
- 14 *On 31 October 2007, Ms Squire personally delivered a letter to Dr Wilson which requested information about the testing specifications for the medicines imported by Dr Wilson in September and October 2007.*¹¹⁵ *Dr Wilson initially told Ms Squire that the information should be at the Alpha Clinic, but when asked if he had ever requested that information from the supplier, Dr Wilson acknowledged that he had not.*¹¹⁶
- 15 *At Ms Squire's request, Dr Wilson then agreed to make a voluntary statement.*¹¹⁷ *In that statement, Dr Wilson admitted that he did not have any of the section 42 information requested by Ms Squire and that the imported medicines were for patients at the Alpha Clinic.*¹¹⁸ *One of the patients who received Jintropin from Dr Wilson was [Patient X].*¹¹⁹ *[Patient X] was never informed by Dr Wilson that Jintropin had not been approved for use in New Zealand.*¹²⁰

¹⁰⁸ Squire Affidavit para 89 & annexure NIS-8.

¹⁰⁹ Squire Affidavit, para 90.

¹¹⁰ Squire Affidavit, paras 94 & 106.

¹¹¹ Squire Affidavit, para 91.

¹¹² Squire Affidavit, para 60.

¹¹³ Squire Affidavit, para 63.

¹¹⁴ Squire Affidavit, para 92.

¹¹⁵ Squire Affidavit, para 115 & annexure NIS-17.

¹¹⁶ Squire Affidavit, para 116 & annexure NIS-18.

¹¹⁷ Squire Affidavit, para 117.

¹¹⁸ Squire Affidavit, para 118 & annexure NIS-19.

¹¹⁹ Squire Affidavit, para 58; [Patient X] Affidavit, para 19.

¹²⁰ [Patient X] Affidavit, para 19.

- 16 *In his statement, Dr Wilson also admitted that his only prior contact with the supplier of the medicines was a telephone call and an email.*¹²¹ *Dr Wilson acknowledged having had no previous dealings with the supplier. Dr Wilson also later acknowledged, during a formal interview with Medsafe, that he made no independent inquiries about the supplier.*¹²²
- 17 *On 7 November 2007, Ms Squire personally delivered a further letter to Dr Wilson which confirmed that Dr Wilson did not have the requested section 42 information. The letter advised Dr Wilson that the medicines were being seized, until further application by Dr Wilson.*¹²³
- 18 *During an interview with Ms Squire on 22 November 2007, Dr Wilson confirmed that he did not have, and never did have, any of the data and test certificates for Jintropin.*¹²⁴ *In this interview, Dr Wilson admitted that he had not made any independent inquiries about the supplier.”*¹²⁵
99. The Tribunal accepts that the PCC’s submission constitutes an accurate summary of the evidence placed before the Tribunal, which it accepts.
100. In short, in the relevant period Dr Wilson imported the non-consented medicine Jintropin, without being in possession of details of the specifications for testing the quality of that medicine, or holding a certificate of the results of testing in respect of each batch. This was a contravention of Section 42 of the Medicines Act 1981.
101. What is of particular concern in this instance is that, about twelve months prior to the importation, Dr Wilson had been warned by letter sent by Medsafe that he was required to comply with Section 42. The Tribunal is bound to conclude that the importation was a deliberate flouting of the legislative requirements.
102. It is satisfied that the elements of the Particular are made out, and as such constitute negligence, malpractice, and brings the medical profession into disrepute.

¹²¹ Squire Affidavit, annexure NIS-19.

¹²² Squire Affidavit, annexure NIS-1 pp2-3

¹²³ Squire Affidavit, para 119 and annexure NIS-20.

¹²⁴ Squire Affidavit, annexure NIS-11 at pp 333-334.

¹²⁵ Squire Affidavit, annexure NIS-1 at pp 2-3 & p 19.

Particular 7: Obtained large quantities of Sudomyl, and supplied it to individuals who were not patients, and falsified patient records to indicate the Sudomyl had been supplied to patients who in fact never received it

103. The PCC submitted:

- “57 *In May 2004, Dr Wilson started sending Practitioner Supply Orders ("PSOs") for various prescription medicines to the Unichem Pharmacy ("Pharmacy") in Newmarket, Auckland. The pharmacist, Mr John MacDonald, understood that the PSOs were supply orders for Dr Wilson's various clinics as there were never any patient names on the PSOs.*¹²⁶
- 58 *Between 26 October 2007 and 10 December 2007, Dr Wilson ordered and purchased approximately 39,900 Sudomyl tablets from the Pharmacy using PSOs.*¹²⁷ *A biochemist working with Dr Wilson, Mr Martin La Grange, told Mr MacDonald that they were using the Sudomyl as one of the components in a special weight loss medicine.*¹²⁸
- 59 *The active ingredient in Sudomyl is pseudoephedrine, a Class C controlled drug, and the primary precursor substance used in the manufacture of methamphetamine.*¹²⁹
- 60 *When the volume of Sudomyl being ordered by Dr Wilson increased noticeably in late November and early December 2007, Mr MacDonald contacted Medsafe and ultimately ceased supplying medicines to Dr Wilson.*¹³⁰
- 61 *Mr L was Dr Wilson's [] and was aware that Dr Wilson was obtaining large quantities of Sudomyl.*¹³¹ *Mr L states that Dr Wilson initially obtained Sudomyl from PCNZ.*¹³² *However, once PCNZ stopped supplying Dr Wilson with Sudomyl, Dr Wilson obtained two shipments of Sudomyl from a supplier in East Tamaki.*¹³³ *It is likely the supplier that Mr L is referring to is the Aviemore Pharmacy in East Tamaki, as electronic records from Aviemore Pharmacy show that Dr Wilson obtained 1,100 60mg Sudomyl tablets from that pharmacy in October 2007.*¹³⁴ *Mr L was also aware that Dr Wilson was obtaining Sudomyl from two other chemists, one based in Newmarket and one based in South Auckland.*¹³⁵

¹²⁶ MacDonald Affidavit, paras 7-8.

¹²⁷ MacDonald Affidavit, para 10 & annexure JMM-2; Squire Affidavit para 84 & annexure NIS-12.

¹²⁸ MacDonald Affidavit, para 11.

¹²⁹ Beal Affidavit, paras 19-21; Squire Affidavit para 83.

¹³⁰ MacDonald Affidavit, paras 18-22; Squire Affidavit, para 86.

¹³¹ L Affidavit, paras 6 & 20.

¹³² L Affidavit, para 20.

¹³³ L Affidavit, para 20.

¹³⁴ Squire Affidavit, annexures 9 & 10.

¹³⁵ L Affidavit, para 21.

- 62 *Mr L states that strange characters began arriving at Dr Wilson's Grey Lynn practice shortly after it started.¹³⁶ One of those people was referred to by Dr Wilson as "H". Dr Wilson told Mr L that "H" was the head of the Head Hunters gang.¹³⁷ Mr L states that Dr Wilson supplied "H" with hundreds of Sudomyl tablets under different names, none of which were genuine patients of the practice.¹³⁸ Mr Beal has personal knowledge of a senior member (but not the head of) of the Head Hunters gang, who is known and addressed as "H".¹³⁹*
- 63 *On one occasion, Dr Wilson told Mr L that he was selling a box of Sudomyl to "H", as well as to other unnamed people, and expected to receive \$20,000 for the Sudomyl. Mr L states that this box of Sudomyl disappeared from the practice but no money came in.¹⁴⁰*
- 64 *Mr L also states that "H's" girlfriend, known as "Ivana", would regularly collect Sudomyl from the practice on "H's" behalf.¹⁴¹ Dr Wilson regularly prescribed Sudomyl to "Ivana" and she would collect the Sudomyl without a prior appointment.¹⁴²*
- 65 *Mr L observed Dr Wilson writing up fictitious prescriptions at the practice, in the names of patients with whom he never held consultations with.¹⁴³ Dr Wilson would then pass on the prescriptions to someone else who would have the prescription filled.¹⁴⁴ For example, Mr L knew that Dr Wilson wrote Sudomyl prescriptions for a person named Salah Ibrahim, and Mr Ibrahim's extended family. Mr Ibrahim was not a patient of the practice, but was a regular visitor through the back entrance of the practice.¹⁴⁵*
- 66 *Mr L noticed that Dr Wilson also completed fictitious prescriptions for Sudomyl, Xanax and Paradex on Sundays, when Dr Wilson never saw any patients.¹⁴⁶ Mr L also discovered prescriptions on the practice's computer system that were completed by Dr Wilson in Mr L's name, even though Mr L had never been prescribed Sudomyl by Dr Wilson, or used Sudomyl before.¹⁴⁷*
- 67 *Mr Beal states that the 39,900 Sudomyl tablets Dr Wilson obtained from the Unichem Pharmacy in Newmarket would have yielded 2.394 kilograms of ephedrine.¹⁴⁸ This could have produced between 1.197 kilograms and 1.7955*

¹³⁶ L Affidavit, para 16.

¹³⁷ L Affidavit, para 17.

¹³⁸ L Affidavit, paras 17-18.

¹³⁹ Beal Affidavit, para 54.

¹⁴⁰ L Affidavit, para 23.

¹⁴¹ L Affidavit, para 19.

¹⁴² L Affidavit, para 19.

¹⁴³ L Affidavit, para 24.

¹⁴⁴ L Affidavit, para 24.

¹⁴⁵ L Affidavit, para 25.

¹⁴⁶ L Affidavit, paras 27-28.

¹⁴⁷ L Affidavit, para 30.

¹⁴⁸ Beal Affidavit, para 50.

*kilograms of methamphetamine, with a potential street value of between \$299,250 and \$574,560.*¹⁴⁹

68 *In Mr Beal's opinion, the circumstances surrounding the manufacture and supply of the pseudoephedrine bearing product MPO, and the subsequent order and supply of Sudomyl, are consistent with the creation of an appearance of legitimacy for a product that was intended to be diverted into illicit methamphetamine manufacture.*¹⁵⁰

104. The evidence of the obtaining of very significant quantities of Sudomyl in the six week period to which the Particular relates is well established. Very significant quantities were obtained from the Unichem Pharmacy – 39,900 tablets; and in October 2007 from the Aviemore Pharmacy – 1,100 tablets. The first limb of the Particular is thus made out.
105. The second limb of the Particular relates to what occurred thereafter, when Dr Wilson operated “Wilson Health” at Grey Lynn, where Mr L was xx.
106. Dr Wilson appears to have established Wilson Health at Grey Lynn because he had had to vacate his premises in Newmarket because of being in arrears in rental payments to the landlord. It is also evident that in the period he operated Wilson Health at Grey Lynn (December 2007 to June 2008), Dr Wilson appears to have been under significant financial pressure, [].
107. Mr L’s evidence clearly establishes:
- 107.1 The prescribing of large volumes of Xanax and Sudomyl;
- 107.2 The picking up of Sudomyl prescriptions by gang-related individuals who attended the practice on a regular basis, entering it at the back (locked) door

¹⁴⁹ Beal Affidavit, para 57.

¹⁵⁰ Beal Affidavit, para 58.

of the practice, those individuals then being given priority to other patients who had been waiting for extended periods of time to see Dr Wilson;

107.3 That the scripts were always for large quantities of Sudomyl (but also Xanax and sometimes Paradex);

107.4 That Dr Wilson obtained Sudomyl himself from at least two pharmacies;

107.5 That the fictitious prescriptions for Sudomyl were being completed on Sundays, when other staff were not present (although Mr L sometimes had to attend because Dr Wilson would inadvertently activate the alarm system, and was unable to deactivate it);

107.6 That Mr L found prescriptions completed by Dr Wilson for Sudomyl under his name in the practice computer system, when he had not received such scripts;

107.7 That Dr Wilson's behaviour in this period was "quite strange", and he often displayed a visible tremor or "shake"; he would bump into walls when he was walking down the corridor at the practice, and would sometimes fall asleep when talking to people, including patients.

108. The Tribunal questioned Mr L carefully on these assertions, and was satisfied having regard to the way in which he gave his evidence that it could be relied on. The irregular and excessive prescribing was also established in other instances, as already discussed. Dr Wilson clearly had a propensity for irregular and excessive prescribing practices, as the evidence regarding other pharmaceuticals such as Xanax and MPO shows.

109. Accordingly, the Tribunal was well satisfied that the second limb of the Particular was made out, namely that in the first six months of 2008, Dr Wilson was:

109.1 supplying Sudomyl to individuals who were not patients; and

109.2 falsified patient records to indicate Sudomyl had been supplied to patients who in fact never received it.

110. The Tribunal is satisfied that this Particular is established, and that it amounts to malpractice and brings discredit to the medical profession.

Conclusions

111. The Tribunal is satisfied that each of the Particulars is made out.

112. Considered separately, it is satisfied that Particulars 1, 2, 5, 6 and 7 would warrant discipline, having regard to the inherent seriousness of the allegations contained in each of those established Particulars.

113. The Tribunal is also required to consider the established particulars cumulatively.

114. Considered in that way, the eight Particulars amount to negligence, malpractice and the bringing of the medical profession into disrepute.

115. Considered cumulatively, the established Particulars amount to a very serious situation involving multiple significant breaches.

116. The Tribunal accepts the PCC's submission that overall the case is an example of grossly reckless handling of pharmaceuticals. This involved importation, supply and prescribing of a range of pharmaceuticals. The behaviour was sustained – involving a period of at least seven years – and involved multiple and serious examples of

mishandling and mis-prescription. Further, there is persuasive evidence that in doing so Dr Wilson created risk both to patients to whom he prescribed and to the public more generally.

117. For the foregoing reasons, then, there is absolutely no doubt that discipline is warranted.

118. This conclusion was announced at the commencement of the second day of the hearing, and submissions as to penalty were then received.

Penalty Principles:

119. In determining the appropriate penalties, the Tribunal recognised the following functions of disciplinary proceedings:

119.1 Protecting the public – this object is reinforced by section 3 of the HPCA Act;

119.2 to maintain professional standards – this object is emphasised in *Taylor v General Medical Council* [1990] 2 All ER 263; *Ziderman v General Dental Council* [1976] 2 All ER 344 and *Dentice v The Valuers Registration Board* [1992] 1 NZLR 720;

119.3 to punish the practitioner in question, as referred to in *Dentice v The Valuers Registration Board* and *Patel v Complaints Assessment Committee* (CIV-2007-404-1818, 13 August 2007, Lang J);

119.4 where appropriate, to rehabilitate the practitioner, as referred to in *J v Director of Proceedings* (CIV-2006-404-2188, 17 October 2006, Baragwanath J), and *Patel* (supra).

120. In *A v PCC* (5 September 2008, Keane J, CIV-2008-404-2927), the Court discussed carefully the range of sanctions available to the Tribunal, particularly cancellation and suspension.¹⁵¹ The Court stated that four points could expressly be derived from the authorities, and implicitly a fifth:

“[81] First, the primary purpose of cancelling or suspending registration is to protect the public, but that “inevitably imports some punitive element”. Secondly, to cancel is more punitive than to suspend and the choice between the two turns on what is proportionate. Thirdly, to suspend implies the conclusion that cancellation would have been disproportionate. Fourthly, suspension is most apt where there is “some condition affecting the practitioner’s fitness to practise which may or may not be amenable to cure”. Fifthly, and perhaps only implicitly, suspension ought not to be imposed simply to punish.

[82] Finally, the Tribunal cannot ignore the rehabilitation of the practitioner: B v B (HC Auckland, HC4/92, 6 April 1993) Blanchard J. Moreover, as was said in Giele the General Medical Council [2005] EWHC 2143, though “... the maintenance of public confidence ... must outweigh the interest of the individual doctor”, that is not absolute – “the existence of the public interest in not ending the career of a competent doctor will play a part”.”

121. In numerous cases, the need to consider and explain why lesser options have not been adopted is emphasised. But the Tribunal has to proceed on the basis of what is appropriate having regard to the public interest, and the need to maintain public confidence in the profession.¹⁵² Randerson J put the matter in this way:

*“[30] The consequences of removal from a professional register are ordinarily severe and the task of the Tribunal is to balance the nature and gravity of the offences and their bearing on the dentist’s fitness to practise against the need for removal and its consequences to the individual: **Dad v General Dental Council** [2002] 1 WLR 1538. As the Privy Council further observed at 1543:*

Such consequences can properly be regarded as inevitable where the nature or gravity of the offence indicates that a dentist is unfit to practise, that rehabilitation is unlikely and that he must be suspended or have his name erased from the register. In cases of that kind greater weight must be given to the public interest and to the need to maintain public confidence in the

¹⁵¹ Paras 77-82.

¹⁵² *Patel*, supra, para 30 per Lang J; *L v The Director of Proceedings*, Woodhouse J, 25 March 2009, CIV-2008-404-2268 [47-48].

profession than to the consequences of the imposition of the penalty to the individual.

[31] *I respectfully adopt the observations of the Privy Counsel and would add that it is incumbent on the Tribunal to consider carefully the alternatives available to it short of removal and to explain why the lesser options have not been adopted in the circumstances of the case. As well, while absolute consistency is something of a pipe dream, and cases are necessarily fact dependent, some regard must be had to maintaining reasonable consistency with other cases. That is necessary to maintain the credibility of the Tribunal as well as the confidence of the profession and the public at large.”¹⁵³*

Penalty

122. The PCC submitted that having regard to the broad range of the misconduct, that the only appropriate penalty was cancellation.
123. It was submitted this was necessary in order to protect the public, maintain proper professional standards, punish Dr Wilson, and serve as a general deterrent to other practitioners.
124. Counsel for the PCC also referred to two previous cases, which it submitted would assist the Tribunal:
- *PCC v Cullen*,¹⁵⁴ considered on appeal in *Cullen v PCC*.¹⁵⁵ Dr Cullen was charged with writing a substantial number of prescriptions (46,300 tablets over a two year period) for Sudomyl when there was no medical or clinical justification for much of that prescribing; and writing prescriptions for Sudomyl in the names of persons who were unaware of such. The Tribunal in that case cancelled Dr Cullen’s registration, imposed a fine of \$15,000, and

¹⁵³ Patel v The Dentists Disciplinary Tribunal HC AK AP77/02, 8 October 2002.

¹⁵⁴ *PCC v. Cullen*, 139/MED06/44P

¹⁵⁵ *Cullen v. PCC*, 2008, Heath J.

ordered him to pay a total contribution of \$25,000 towards the costs of both the PCC and the Tribunal, in respect of a period when he was not in receipt of legal aid. The High Court upheld the penalty of cancellation.

- *Vasan v The Medical Council of New Zealand*:¹⁵⁶ Dr Vasan admitted four charges of disgraceful conduct and professional misconduct which cumulatively established a pattern of indiscriminate prescribing of controlled drugs. This included inadequate assessment of patients for the prescribing of the drugs used, inadequate assessment of their true clinical status, and prolonged and repetitive prescribing of drugs of potential abuse. The High Court upheld the penalties imposed by the MCNZ, including deregistration (restoration not to be considered within two years), a fine of \$1,000 (the maximum available) and a costs order of \$180,000 (being close to fifty percent of actual costs of the MCNZ hearing and investigations of the PPC).

Penalty – discussion

125. The authorities require the Tribunal to consider whether any penalty short of cancellation can responsibly be considered.
126. The Tribunal considered all penalties short of outright cancellation, and concluded that for the following reasons the offending was so serious, and over such a period of time, that the protection of the health and safety of the public meant no outcome other than outright cancellation could be considered:

¹⁵⁶ *Vasan v The Medical Council of New Zealand*, HC Wellington, AP 43/91, 22 March 1991, Jeffries J.

- 126.1 The enormous volume of prescriptions for drugs that were capable of being diverted for illicit purposes (Xanax, MPO and Sudomyl), whether by Dr Wilson himself or by patients to whom the products were supplied.
- 126.2 The extended nature of the period over which the offending occurred
- 126.3 The wide range of misconduct, which in its scale and breadth gives rise to grave concerns.
- 126.4 The obviously deliberate nature of some of the misconduct (e.g. importing of unconsented pharmaceuticals in non-compliance with Section 42 of the Medicines Act, even when warned that compliance with the legislation was required)
- 126.5 The haphazard and disorganised way in which Dr Wilson appeared to operate, which took deliberate and cynical advantage of patients.
127. Such a result is consistent with the outcomes in *Cullen* and *Vasan*.
128. Consequently, the Tribunal was satisfied that the only possible penalty which it could properly impose, having regard to the objects of the Act as set out in Section 3 of the HPCA Act, was to cancel his registration.
129. There was also evidence, given by Detective Constable Beal, to the effect that:

“The circumstances surrounding the manufacture and supply of the pseudo-ephedrine bearing product, MPO, and the ordering and supply of Sudomyl, are consistent with the appearance of legitimacy for a product that was intended to be diverted into illicit methamphetamine manufacture.”

130. This possibility was supported by evidence given of persons affiliated with a gang being given prescriptions for Sudomyll, in significant volumes, via the back door of the Grey Lynn practice.
131. Whether or not there was a motive of illegal purpose, the significant volume of prescribed drugs and the risk of diversion supports the penalty of cancellation.¹⁵⁷
132. There is evidence that Dr Wilson was himself unwell at some stages of the chronology, particularly towards the end of the period under review. The Tribunal has no direct evidence as to whether this was caused by genuine ill-health, or whether the displayed symptoms were caused by drug abuse. Such a possibility could not be ruled out, but the Tribunal does not rely on this factor in reaching its conclusion as to cancellation.
133. During submissions, the Tribunal was informed by Counsel for the PCC that Dr Wilson was suspended on an interim basis from holding an APC by MCNZ on 29 April 2008. Other evidence received by the Tribunal suggested that Dr Wilson continued to practise until June 2008. If so, he was practising without an APC; however, as Dr Wilson was not charged on this basis, the Tribunal has not taken this possibility into account, albeit that, if correct, it would be a matter of significant concern.
134. The Tribunal also considered the possibility of imposing a fine. It considered that it needs to make it crystal clear that the wide range of significant misconduct which it was required to consider should be denounced in the strongest possible terms. It notes fines were imposed in *Vasan* and *Cullen*. It imposes a fine of \$20,000.

¹⁵⁷ The Tribunal has had regard to this evidence for penalty purposes only, being an approach mandated by the High Court in *Cullen*.

135. Turning to the question of costs, the conventional starting point when considering issues as to costs in the Tribunal is to take account of the principles in *Cooray*.¹⁵⁸ In a general way it is appropriate to take fifty percent of the reasonable costs incurred as a guide, and then decide whether the individual case justifies a departure from that starting point one way or the other, having regard to any relevant circumstances, so that there is a reasonable contribution to the costs incurred.
136. The Tribunal was advised that the PCC costs were approximately \$110,000; and the Tribunal's own costs were approximately \$22,500.
137. The Tribunal concluded that an appropriate imposition of costs would be at the level of fifty percent. A great deal of analysis and preparation was required in order to present the charge properly to the Tribunal, and it is not appropriate that the profession bear an undue proportion of those costs.
138. Accordingly, the Tribunal orders that Dr Wilson pay:
- 138.1 \$55,000 in respect of the costs and expenses of the PCC
- 138.2 \$11,000 in respect of the costs and expenses of the Tribunal.
139. No issues of non-publication of name for Dr Wilson arise, as he has not participated in the proceedings. The Tribunal records, however, that it is definitely in the public interest that Dr Wilson's identity be known in connection with the charge.
140. The current whereabouts of Dr Wilson is unknown and so, immediately following the hearing, the Tribunal issued a Minute recording the conclusions it had reached, and

¹⁵⁸ *Cooray v PCC*, Doogue J., 14 September 1995, Wellington Registry, AP 23/94

arranged for the Minute to be served via the means identified in the District Court order of substituted service.

Conclusion

- 141. The charge of professional misconduct is established.
- 142. Dr Wilson's registration is cancelled with effect from 14 July 2010 (being more than four days after the date of service of the Tribunal's minute, in accordance with Section 103(3) of the HPCA Act 2003).
- 143. A fine of \$20,000 is to be paid by Dr Wilson.
- 144. Dr Wilson is ordered to pay:
 - 144.1 \$55,000 in respect of the costs and expenses of the PCC
 - 144.2 \$11,000 in respect of the costs and expenses of the Tribunal.
- 145. The Tribunal directs that a copy of this decision and a summary of it be published on the Tribunal's website. The Tribunal further directs that a notice stating the effect of the Tribunal's decision be published in the *New Zealand Medical Journal*. It also recommends to the MCNZ that a copy of this decision be provided to relevant regulatory authorities overseas (Section 157 HPCA Act 2003).

DATED at Wellington this 12th day of July 2010

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B A Corkill QC
Chairperson
Health Practitioners Disciplinary Tribunal