NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

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HPDT	**1079/Med19/457P**
UNDER	The Health Practitioners Competence Assurance Act 2003 ("the HPCA Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act.
BETWEEN	**A PROFESSIONAL CONDUCT COMMITTEE** appointed by the **MEDICAL COUNCIL OF NEW ZEALAND** **Applicant**
AND	**DR E**, registered medical practitioner, of X **Practitioner**

HEARING held at Tauranga on 28 and 29 January 2020

TRIBUNAL:	Mr D M Carden (Chair) Dr P Miller, Dr J Woods, Associate Professor D Read, and Ms D McKinnon QSM (Members) Ms G Fraser (Executive Officer)
APPEARANCES:	Mr H Wilson and Ms S Ward for the Professional Conduct Committee Mr M McClelland QC for the practitioner

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Introduction

[1] Dr E is, and at material times was, a medical practitioner in rural New Zealand. He prescribed medications to two patients on [ ] July 2017 and [ ] January 2018. The medications were misoprostol (trade name Cytotec) and mifepristone (trade name Mifegyne). These medications are abortifacients.

[2] A complaint was laid with the Medical Council of New Zealand (the MCNZ) which appointed a Professional Conduct Committee (PCC) to investigate the matter pursuant to the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) and that PCC has laid a Charge against Dr E.

[3] The Charge was amended and the amended Charge is transcribed in full in the Schedule to this decision.

[4] In essence the Charge alleged:

a) That the prescribing by Dr E to his two patients of these medicines was contrary to the requirements of the Contraception, Sterilization and Abortion Act 1977 (the CSA Act);

b) That Dr E failed to ensure that he had adequate knowledge of the medications or of the requirements of the CSA Act;

c) That he failed to undertake appropriate clinical assessments;

d) That he failed to keep clear or accurate records; and,

e) In respect of Patient B that he knew, or ought to have known, that the dosage of misoprostol exceeded the recommended dose and/or prescribed misoprostol in combination with Primolut, an inappropriate treatment for termination of pregnancy.

[5] The Charge was heard by the Tribunal with both parties represented by counsel. The Tribunal was provided with an Agreed Statement of Facts and an agreed bundle of documents, the latter produced on the basis that had been directed at an earlier conference, namely that each document in the bundle:

> (i) is what it purports to be on its face;
> (ii) was signed by any purported signatory shown on its face;
> (iii) was sent by any purported author to, and was received by, any purported addressee on its face;
> (iv) was produced from the custody of the party indicated in the index;
> (v) is admissible evidence; and
> (vi) is received into evidence as soon as referred to by a witness in evidence, or by counsel in submissions, but not otherwise

[6] The Agreed Statement of Facts recited certain background detail, information concerning abortions in New Zealand, medications used in early medical abortions (as contrasted with surgical abortions), and detail of the consultations and prescribing for Patient A and Patient B. That Agreed Statement of Facts included Dr E's confirmation and admission of the facts as true and accurate and that they established each particular of the Charge to the required standard. Dr E accepted that the conduct in respect of particulars 1 – 4 and in respect of particulars 5 – 9 was contrary to accepted standards of medical practice, and/or was in breach of the MCNZ statement *Good Prescribing Practice* and, in respect of particulars 1 – 4 the requirements of the CSA Act. He accepted that his conduct as particularised in particulars 1 – 9 amounted to professional misconduct cumulatively amounting to malpractice or negligence in the scope of his practice and as having brought, or been likely to bring, discredit to his profession. He admitted that the admitted facts in the Charge disclosed conduct which warranted disciplinary sanction.

[7] The bundle included:

a) Registration information for Dr E;

b) Patient notes and information and communications concerning Patient A and Patient B;

c) Other correspondence;

d) MedSafe Data Sheets; and

e) The professional and ethical guidelines on which the PCC relied.

[8] The PCC relied on the Agreed Statement of Facts in support of the Charge. While Dr E accepted that his conduct amounted to malpractice or negligence and brought, or was likely to bring, discredit to his profession warranting disciplinary sanction, he did give evidence himself in the context of penalty once the Charge had been found to have been made out. This is referred to below but does canvas the factual background to the Charge and its particulars.

[9] From the outset the PCC applied, with the support of counsel for Dr E, for an order that the whole of the hearing be heard in private. Heavy reliance was placed by counsel for the practitioner on *N v A Professional Conduct Committee of Medical Council*[1].

[1] [2013] NZHC 3405; [2014] NZAR 350

[10] That was a judgment of the High Court against the decision of this Tribunal declining the appellant, Dr N, permanent name suppression. The four patients concerned with the treatment to which the charge had related had not complained about their treatment and did not know about the complaint or the disciplinary proceeding. The private information of the patients had been described by the Tribunal as "*sensitive and intensely private*" such that those privacy interests significantly outweighed the principles of open justice. There were a large number of redactions from the Tribunal's decision debated. It was pressed for the practitioner in that case that, if her name were not suppressed, it would not be difficult to imagine that the patients may have disclosed aspects of the consultations to family and friends but not necessarily the specifics (that the patients were pregnant and were prescribed misoprostol to procure an abortion).

[11] The High Court found that it was an error to discount the risk; the patients were not told that the hearing would be public or members of the media would be present and were not told that suppression of the practitioner's name might not continue. Even if the risk that patients might be identified was small, that was a factor entitled to considerable weight because of the highly private and sensitive nature of the consultations.

[12] Counsel for Dr E argued that if there were not a private hearing and information was provided (even if it were later suppressed) those present could use that information to "*join the dots*" and work out who the respective patients were.

[13] That application in the present case was declined by the Tribunal for reasons given at the time which in essence were that section 95(1) of the HPCA Act primarily requires that every hearing be held in public; and that the identity of the two patients could be adequately protected by orders prohibiting publication of any part of the hearing or the names or identifying details without the necessity for complete hearing in private. The *Dr N* decision is distinguishable on the basis that that related to an order for name suppression rather than a private hearing.

[14] In fact, as it transpired, there was no one present in the hearing room other than those entitled to be present and questions of privacy did not arise.

Background

[15] The essential facts are all contained in the Agreed Statement of Facts and, where relevant, documents in the bundle. Dr E has been a registered medical practitioner since 1977 and has other qualifications. He worked at the relevant practice at all material times and was not a certifying consultant under the CSA Act. The practice at which he worked was not a licensed institution under that Act.

[16] An abortion in New Zealand was at all relevant times and still is, governed by the CSA Act and certain provisions of the Crimes Act 1961. There are two methods of procuring abortions in New Zealand, one being a medical abortion which uses medication to induce the abortion and the second being a surgical abortion; and the CSA Act and the Crimes Act do not distinguish between the two methods.

[17] There are guidelines for use of medical abortions in New Zealand being *Guidelines for the Use of Mifepristone for Medical Abortions* (August 2004) published by the Abortion Supervisory Committee.

[18] There are established grounds under the Crimes Act on which a woman may seek an abortion and legal requirements imposed by the CSA Act include that:

a) All abortions must be performed within a licensed institution (section 18).

b) An abortion may only be performed if it is authorised by two certifying consultants who are satisfied that one of the grounds justifying an abortion exists (section 29).

[19] When a patient of a medical practitioner seeks an abortion there is a procedure to be followed prescribed by section 32 of the CSA Act and this includes procedures to be followed by the woman's own doctor (who may not be a certifying consultant). All doctors are required to arrange for a woman's treatment to be dealt with in accordance with the provisions of the CSA Act.

[20] Section 37 of the CSA Act makes it an offence to perform an abortion:

a) otherwise than in a licensed institution; and

b) Otherwise than in pursuance of a certificate issued by two certifying consultants.

[21] Mifepristone (trade name Mifegyne) has been approved in New Zealand for the termination of pregnancy since 2001. It is indicated for:

a) Medical terminations of developing intra-uterine pregnancy,

b) Softening and dilation of the cervix uteri prior to surgical termination of pregnancy during the first trimester,

c) Preparation for the action of prostaglandin analogues in the termination of pregnancy for medical reasons (beyond the first trimester), and

d) Labour induction following foetal death in utero.

[22] Misoprostol (trade name Cytotec) is a synthetic prostaglandin which has ulcer healing, gastric acid and antisecretory and mucosal protective properties. It is indicated:

a) For the treatment of duodenal and gastric ulcers in adults,

b) For the treatment of erosive gastroduodenitis associated with peptic ulcer disease in adults, and

c) In the prevention of stress-induced upper gastrointestinal mucosal bleedings and lesions in post-surgical adult intensive care unit patients.

[23] The MedSafe Data Sheet for misoprostol states that it is contraindicated in women who are pregnant or in patients for whom pregnancy has not been excluded. This is because misoprostol induces uterine contractions. Miscarriages caused by misoprostol alone may be incomplete. Use of misoprostol has been associated with birth defects including Mobis sequence (palsies of cranial nerves VI and VII), terminal transverse limb defects, and arthrogryposis.

[24] Misoprostol is not approved for obstetric or gynaecological use in New Zealand. However, following the use of mifepristone, misoprostol is commonly used to induce contractions to expel uterine product as a secondary drug to induce medical abortions. This is permitted by section 25 of the Medicines Act 1981 which allows a practitioner to use any medicine (approved or unapproved) for treatment of a particular patient in his or her care, provided all legal requirements for abortion are met.

[25] Because misoprostol is not registered for use in abortions the *Guidelines for the use of Mifegyne in Medical Abortions* state that patients must sign an informed consent. The Guidelines state that the consent must state that the drug is not registered for this purpose and that its use is evidence-based. The MedSafe Data Sheet for mifepristone recommends the following procedure for first trimester abortions:

> 600 µg mifepristone (3 tablets) in a single oral dose followed 36 - 48 hours later, by the administration of a prostaglandin analogue, misoprostol 400 µg orally.

[26] The *Guidelines for the use of Mifegyne in Medical Abortions* noted that published peer review literature indicates a range of other protocols with various doses and, for misoprostol, route of administration. Primolut is not used in medical abortions.

Patient B: [ ] July 2017

[27] It is appropriate to deal with this patient first, being the first of the two patients to be attended to by Dr E. On [ ] July 2017 she attended a consultation of Dr E with a suspected pregnancy and this was her first consultation about this. During the consultation Patient B requested an abortion.

[28] Dr E offered to refer Patient B to the [ ] Family Planning; but Patient B explained that she had already approached Family Planning but had been unable to confirm an appointment with it. Dr E and Patient B discussed the option of Patient B seeking treatment from the [ ], a private health care provider which specialises in termination of pregnancies and related services.

[29] Dr E then wrote a prescription for Patient B for misoprostol 200 µg x 30 tablets. He also wrote a prescription for Patient B for Primolut 5 µg x 28 tablets and Cilazapril 5 µg x 90 tablets. Because Patient B intended to have her abortion under the care of [ ], Dr E did not discuss how or when to take the medication or the potential side effects or complications of the medication with Patient B.

[30] Dr E's subjective notes for this consultation were (corrected for legibility):

> "*LNMP [Last Normal Menstrual Period] x/06 [[x] June] G1 [Gravida 1] K5/28 [Menstrual cycle - 5 days bleeding in 28 days]*
> *Medical [TOP – Termination of Pregnancy]*
> *Arnge [R] Asci*"

[31] Patient B left the consultation at 8:20 am that day. The Agreed Statement of Facts said that at 9:38 am that day Dr E called [ ] in a call lasting 2 minutes and 3 seconds and spoke to an associate doctor named Dr R. There was produced to the hearing telephone records confirming a call lasting that period of time at that time, 9:38 am. The phone call was therefore after Patient B had left the consultation with Dr E. (As noted below, in his evidence to the Tribunal on

penalty Dr E said that he believed he contacted [ ] during the consultation while Patient B was in the room and referred to his notes.) The PCC asked the Tribunal to rely on the Agreed Statement of Facts on this issue.

[32] At 8:20 pm Dr E updated his subjective notes for the consultation which then read (again with expansions for legibility):

> "***[ ] Jul 2017 Dr E ()***
> *LNMP [Last Normal Menstrual Period] x/06 [[x] June] PT+ [pregnancy test positive]*
> *G1 [Gravida 1]*
> *no contraception*
> *no planned pregnancy*
> *K5/28 [Menstrual cycle - 5 days bleeding in 28 days]*
> *PH [Past history] astma [sic]– minimal*
> *hypertension*
> *Non smoker*
> *Discussed c [ ]*
> *[forms]*
> *USS*
> *AN [Antenatal] bloods*
> *Medical [TOP - Termination of Pregnancy]*
> *Arnge [R] Asci*
> *Rx: Misoprostol 200mcg Tab -2/dat - 30*
> *Rx: Primolut N 5mg Tab (blister) – 4 /day – 28*
> *Rx: Cilazapril 5mg Tab – 1 tabs, Once Daily – 90*
> *Out Box: Lab referral, Antenatal Group (1st visit)*
> *Out Box: [ ] Radiology Ltd*
> *Out Box: Lab referral*"

[33] In his evidence on penalty referred to below Dr E said that an audit had indicated that the addition of misoprostol to the note had been created at 8.09 am.

[34] An appointment for Patient B to have an ultrasound was created at 9:16 am on [ ] July 2017. This ultrasound occurred on [ ] July 2017 at 8:30 am. The results of the ultrasound were sent to Dr E at 9:18 am on [ ] July 2017 and marked as received at 11:18 am that day.

[35] Patient B subsequently made an appointment with [ ] Family Planning. She did not take the misoprostol prescribed to her by Dr E and disposed of it.

Patient A : [ ] January 2018

[36] The Agreed Statement of Facts records that Patient A was a regular patient at the practice (although in his evidence Dr E said that he had only consulted with Patient A first on [ ] January 2018). On [ ] January 2018 Patient A attended for

a consultation with Dr E. She had missed her period so Dr E ordered blood tests for her, including a hormone test to establish whether or not she was pregnant.

[37] On [ ] January 2018 Patient A attended another consultation with Dr E, having previously taken an at-home pregnancy test which indicated she was pregnant. Patient A's appointment was scheduled to start at 8:45 am that day (although there was no evidence or agreed fact as to when the appointment did in fact commence).

[38] During the consultation with Dr E Patient A requested a medical abortion; Dr E offered to refer her to the [ ] Family Planning; but Patient A declined the referral and Dr E agreed to prescribe her the medication instead.

[39] During the consultation Dr E looked up the required medications for a medical abortion online using the MedSafe website. Dr E issued a prescription for mifepristone (Mifegyne) 200 mg (but referred to in the Agreed Statement of Facts as mcg) x 1 tablet at 8:52 am and misoprostol 200 µg x 4 tablets at 8:54 am. The purpose of those prescriptions was agreed in the Agreed Statement of Facts to be to procure a medical abortion. Dr E also prescribed Tramadol hydrochloride 500 mg x 29 tablets.

[40] Dr E discussed expectations around pain and bleeding from the abortion process with Patient A and advised her that, if pain and bleeding were intolerable or excessive, she needed to seek medical help by calling the practice or, if after hours, an afterhours service or an ambulance.

[41] Dr E knew the area in which Patient A lived and that she intended to have a responsible adult friend with her at her home when she took the mifepristone and misoprostol.

[42] Dr E did not take any steps to ensure that Patient A planned to take the misoprostol and/or mifepristone on the premises of a licensed institution.

[43] The notes from the consultation read:

> **"[ ]** ***Jan 2018 Dr E ()***
> *Insistson medical abortion*
> *Advised fully*
>
> *needsto have phine*
> *Needs USS*
> *Warnrd re bleeding\\Refusrs surgical TOP*
> *Rx: Mifegyne 200mg Tab – 1 stat – 1*

Rx: Misoprostol 200mcg Tab – 4 stat – 4

Outbox: [x] Radiology Ltd
Rx: Tramadol Hydrochloride 50mg Cap – 1 QID – 29"

[44] Contrary to the requirements of the CSA Act the intended abortion had not been authorised by two certifying consultants prior to Dr E's prescribing Patient A Mifegyne and misoprostol. It is also acknowledged in the Agreed Statement of Facts that, contrary to the guidelines for medical abortions in New Zealand, prior to prescribing the Mifegyne and misoprostol for Patient A Dr E did not:

a) Establish the gestation of Patient A's pregnancy; and/or

b) Exclude the possibility of Patient A having an ectopic pregnancy; and/or

c) Document what support Patient A had in place; and/or

d) Document Patient A's consent for the off-licence use of misoprostol.

[45] At 9:01 am that day an appointment for an ultrasound to determine the gestation and location of Patient A's pregnancy was created; and Patient A left the consultation with Dr E at 9:05 am. Patient A underwent an ultrasound at 2:30 pm that afternoon with the results being sent to Dr E at 5:23 pm, the report having been marked by the radiology company as received as at 5:31 pm on [ ] January 2018.

[46] On the afternoon of [ ] January 2018 Patient A went to the local pharmacy to have the prescription filled and was advised that it did not have the mifepristone (Mifegyne) in stock. The pharmacist called the medical practice where Dr E was and Patient A was advised that she should return to her GP to make an appointment with Family Planning. Patient A duly made that appointment with Family Planning and she did not obtain any of the medication prescribed to her by Dr E on [ ] January 2018.

The Charge

[47] It was the case for the PCC, based on the Agreed Statement of Facts and relevant legal principles and authorities, that Dr E's conduct in respect of both of, and each of, Patient A and Patient B was malpractice or negligence in the scope of his practice as a medical practitioner and brought, or was likely to bring, discredit to his profession. Submissions were made in respect of the respective

patients in the context of applicable standards and guidelines and by comparison to other cases said to be relevant.

[48] In submissions on Dr E's behalf the Charge was accepted as misconduct warranting disciplinary sanction as noted in the Agreed Statement of Facts; but issue was taken with some matters contained in submissions for the PCC including that there was no allegation in the Charge of "*recklessness*" or of any wrongful lack of resistance to patient pressure.

[49] The Charges are laid under section 100(1)(a) and/or (b) of the HPCA Act. These provide that orders can be made by the Tribunal if, after conducting a hearing, it finds that the practitioner has been guilty of professional misconduct because of any act or omission that amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time of the conduct or because of any act or omission that has brought, or was likely to bring, discredit to the profession in which the practitioner practised at the time of the conduct.

[50] If negligence or malpractice is alleged that must be established as behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error or oversight or even carelessness.

[51] Discredit to the profession involves a breach of an objective standard with the question to be asked being whether reasonable members of the public informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the profession in question was lowered by the behaviour of the practitioner.[2]

[52] In considering any charge of misconduct under the HPCA Act the Tribunal must, having found the acts or omissions in question which were misconduct or likely to bring discredit to the relevant professional, also consider whether the acts or omissions in question are of such severity as to warrant a disciplinary sanction for the purpose of maintaining standards, protecting the public, or punishing the practitioner.[3]

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2 *Collie v Nursing Council of New Zealand;* [2001] NZAR 74 at [28].
3 *PCC v Nuttall;* 8/Med04/03P.

[53] The onus of proving the Charges lies on the PCC. The standard is the balance of probabilities. The more serious the allegation, the higher the level of proof required.

[54] For an abortion in New Zealand to be legal the requirements of the Crimes Act and the CSA Act must be met. The grounds for an abortion include where the continuation of the pregnancy would result in serious danger to the life, or to the physical or mental health, of the woman or girl[4]. If the pregnancy meets one or more of the criteria in the Crimes Act, the woman may have an abortion but this is only legal if the requirements of the CSA Act are met, the key requirements for which are:

a) That the abortion must be performed at a licensed institution[5].

b) That the abortion must be authorised by two certifying consultants prior to being performed[6].

c) That the woman must be advised of her right to seek counselling[7]. and

d) That the certifying consultants must submit a record of the case to the Abortion Supervisory Committee[8].

[55] That Committee, established by the CSA Act, has published guidelines and standards which include the *Guidelines for the Use of Mifepristone in Medical Abortion in New Zealand* (September 2004) and *Standards of Care for Women Requesting Induced Abortion in New Zealand* (October 2009).

[56] The PCC relied on the publications promulgated by the MCNZ pursuant to its statutory function[9] including *Good Medical Practice* and *Good Prescribing Practice*. The former, *Good Medical Practice,* outlines the key standards which the public and profession expect competent doctors to meet and includes a summary of obligations when providing clinical care and in prescribing medication or treatment. Doctors may only prescribe medication or treatment when they have an adequate knowledge of the patient's health and are satisfied that the medication or treatment is in the patient's best interests.

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4 Section 178A(1)(A) Crimes Act 1961
5 Section 18
6 Section 29
7 Section 35
8 Section 36
9 Section 118 of the HPCA Act

[57] That standard also outlines obligations to keep clear and accurate patient records.

[58] The second guide, *Good Prescribing Practice*, makes clear that practitioners should only prescribe medication or treatment when they have adequately assessed the patient's condition and/or have adequate knowledge of that condition; and that medications must not be prescribed simply because a patient demands them.

[59] That obligation includes staying informed on relevant policy legislation, being familiar with all medication prescribed, and taking adequate history of the patient with accurate and timely patient records.

[60] There is further provision for practitioners who prescribe medication for an unapproved use that doctors must take responsibility for overseeing the patients care and monitoring any follow-up treatment.

[61] Of the cases referred to by the PCC in its submissions[10] the Tribunal found the closest relevant case to be *Dr N*[11] where a doctor had prescribed or dispensed misoprostol to three patients intending to procure an abortion. She was a certifying consultant under the CSA Act but was found to have failed to undertake appropriate clinical assessments in respect of one patient to establish if the pregnancy was non-viable and failed to ensure that the patient had adequate support. She prescribed and instructed a nurse to dispense misoprostol to another patient without having seen that patient in a consultation or undertaken an appropriate clinical assessment. She failed to document the prescribing or dispensing to each of the four patients referred to in the particulars. She was found to have professionally misconducted herself both severally and cumulatively in respect of all four patients with the illegality of her prescribing of misoprostol, inappropriate care, and demonstrated failure to provide each patient with the opportunity to consider expected risks, side effects, costs and benefits.

[62] The other cases concerned a doctor prescribing with reckless disregard (and the Tribunal accepts that there is no allegation of recklessness in this case); and failures to keep accurate and detailed records.

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[10] *Dr N*; 543/Med12/224P; *Dr S*; 499/Med11/197P; *Dr Gouse*; 30/Med05/11D; and *Dr Williams*; 909/Med16/371P

[11] Refer paragraph 9 above; HPDT decision 543/Med12/224P

[63] Dealing now with the respective patients in time sequence order:

Patient B: Particulars 5 – 9: [ ] July 2017

[64] The allegation is that on [ ] July 2017 Dr E prescribed 30 x 200 mcg tablets of misoprostol in circumstances where Patient B was pregnant and intended to seek a termination of pregnancy. There is no disagreement as to the facts of the consultation, the pregnancy, the intention to seek the termination or the prescription of the tablets of misoprostol. This is consistent with such notes as Dr E kept.

[65] What did prove to be controversial is the time at which Dr E consulted with [ ]. The Agreed Statement of Facts signed by Dr E were that he called [ ] at 9:38 am, Patient B having left the consultation at 8:20 am.

[66] In his evidence on penalty, however, Dr E said that he believed he contacted [ ] during the consultation while Patient B was in the room. He relied on the note that he had made subjectively at 8:09 am in its reference to "*Arnge [R] Asci*". He interpreted that note to say that he did ring [ ] while Patient B was in the room and spoke to an "*associate doctor*" whose name he recorded in the notes and whom he believed was Scottish or Irish and understood to be an associate doctor at [ ].

[67] Dr E said that he explained Patient B's circumstances to Dr R and asked whether [ ] could perform a termination. He said he was sure that he gave Dr R Patient B's name because they (Dr R/[ ]) and Patient B were to communicate with one another following scans and tests. Dr E said that because his notes at 8:09 am that day referred to the conversation that must have occurred before that time. He said that Dr R directed him to request a blood test and an ultrasound for Patient B so that [ ] could evaluate her pregnancy and proceed with the relevant information.

[68] Dr E then said that he was further advised or directed by Dr [R] to dispense the misoprostol tablets to Patient B and have her collect the prescription prior to seeing someone from [ ]. He said that over the telephone [ ] confirmed they were happy to see Patient B and, subject to blood and scan results, perform the termination. He said that the doctor he spoke to read out the drugs and quantities that she wanted him to prescribe and those were the drugs that he did prescribe.

[69] The idea, Dr E said, was that once Patient B had the prescription dispensed and the blood test and scan results were available, [ ] would arrange to see her and conduct the termination. There was no indication by, or agreement with, [ ] that Dr E would be involved in any way in Patient B's termination or post-termination care. He did not need to be involved as it was his understanding, he said, that [ ] alone would be dealing with every aspect of her termination.

[70] Dr E said that it was never the intention that Patient B would take the misoprostol at home or alone and he most certainly did not proceed on that basis. It was rather always his intention and understanding that [ ] would perform the termination using the misoprostol that he had provided to Patient B effectively at ['s] direction for that very purpose.

[71] Patient B had also expressed to him, Dr E said, that she was conscious that the timeframe for obtaining an early medical abortion was running short; and it was Dr E's understanding from Dr [R] that Patient B would attend [ ] shortly after the medications were obtained to carry out the termination.

[72] Dr E said that he arranged for Patient B to have a blood test and an ultrasound; and further that he later checked with Patient B as to whether his recollection of the consultation was correct, she then clarifying that she did not convey instructions from [ ] to him.

[73] Dr E's evidence went on to say that, with the benefit of hindsight, he appreciated that he ought to have "*interrogated the matter in more detail – especially the volume of misoprostol which was requested and the role of the Primolut*". At the time, he said, he had no reason to doubt that [ ]/Dr [R] knew what they were doing and that what he was asked to prescribe was entirely appropriate.

[74] Dr E said it was not his intention personally to procure a termination for Patient B, the termination to be procured and effected by [ ]. For that reason, he said, he did not research how the medical termination would be carried out by [ ].

[75] His prescription of both misoprostol and Primolut was at the direction of the [ ] doctor, he repeated; he assumed that the scripts that he was directed to provide were appropriate, given that [ ] is authorised to perform terminations of pregnancy; and at the time he believed that the Primolut would have been required to manage any post-termination bleeding if necessary following the termination of pregnancy at [ ].

[76] Dr E believed that this was the first time in his career that he had been consulted on an early medical termination; that his practice is very busy which in part explains why he would have followed the directions of [ ] without giving them too much thought; that he arranged for the tests and prescriptions as requested and did not engage further with the proposed medical termination. He said that he did not know why he was directed to prescribe 30 tablets of misoprostol but that that was the direction which he followed.

[77] As to the time of Dr E's telephone discussion with [ ], telephone records were produced to the Tribunal which showed that a call was made by him to [ ] at 9:38 am that day. This was after Dr E's consultation with Patient B and Dr E said that he could not explain the timing but continued to believe that he spoke to Dr [R] prior to making his record at 8:09 am when he specifically referred to "*Arnge [R] Asci*".

[78] The Tribunal has taken account of Dr E's evidence in those matters. Dr E's recollection of events must be considered in the light of what he also said, namely that he could not recall ever having prescribed misoprostol to anyone other than Patient A when he was notified by the PCC on [ ] August 2018 of concerns regarding the prescription of misoprostol for Patient B on [ ] July 2017 (over 13 months earlier). He also said that his recollection of the consultation was limited and gave his evidence based on consultation notes, prescription records and a telephone conversation he had had with Patient B.

[79] The Tribunal cannot ignore the incontrovertible evidence from that telephone record that shows that a telephone call was made between Dr E and [ ] at 9:38 am on the day in question and that has been an agreed fact in the Agreed Statement of Facts signed by Dr E.

[80] The Tribunal has concluded that it must accept that as a fact. The note that Dr E made in his own notes at 8:09 am are interpreted by him now as being that that records a telephone conversation he made at the time, but the note is entirely open to other explanations, such as that he was aware that [ ] carried out terminations of this kind, or that he made some reference to Dr [R's] name in his discussion with Patient B. Certainly the notes are inadequate as to the context in which Dr [R's] name may have been noted in the notes and the Tribunal is not prepared to take the interpretation offered by Dr E, given his

own stated difficulties of recollection and given the incontrovertible evidence as to the timing of the telephone call.

[81] There were the further factors that the [ ] did not open until 8:30 am; and that while the subjective note made by Dr E at 8:09 am referred to Dr [R], his expanded notes at 1:20 pm also referred to "*discussed [with] [ ]*" but this was at a different place from the reference to Dr [R], and Dr E could not explain why there was no reference to [ ] in his original subjective notes.

[82] The Tribunal has proceeded on the basis that at the time of his consultation with Patient B when she was in his rooms there was no discussion with [ ] or Dr [R] and any guidance from Dr [R] to him as to the medication to be prescribed for Patient B for her termination occurred after Patient B had left his rooms.

Particular 5 – Prescription of Misoprostol

[83] The allegation in particular 5 is factually correct, namely that Dr E did prescribe 30 x 200 mcg tablets of misoprostol to Patient B on [ ] July 2017 in circumstances where Patient B was pregnant and intended to seek the termination of the pregnancy. Those facts are undisputed.

Particular 6 – Failures prior to prescribing

[84] The Tribunal finds the allegation in particular 6 to be made out that prior to prescribing misoprostol to Patient B on [ ] July 2017, first that Dr E failed to ensure that he had adequate knowledge of the medications prescribed and the treatment they were intended for (termination of pregnancy); and secondly, that Dr E failed to undertake appropriate clinical assessment in regard to the pregnancy, including the gestation of Patient B's pregnancy.

[85] This was on Dr E's own evidence the first time he had been asked to participate in a medical termination of a pregnancy. The Agreed Statement of Facts included that the consultation was scheduled to start at 8:00 am and, although there was no evidence before the Tribunal that the consultation did in fact start then, the Tribunal is prepared to accept that it did start about then. The prescription for misoprostol occurred some 9 minutes later at 8:09 am. The Tribunal finds that at that time Dr E had not spoken to [ ] or Dr [R] and indeed was unlikely to have been able to have done so.

[86] There is no evidence of Dr E's having made his own inquiries in that short period as to the appropriateness of prescribing misoprostol for the medical termination of pregnancy for his patient and the Tribunal is prepared to find that the PCC has, in light of the acknowledgements made by Dr E, established on the balance of probabilities that he failed to ensure he had adequate knowledge of the medication prescribed, misoprostol.

[87] The Tribunal finds that his intention was that Patient B would have her termination carried out at [ ] (or some other appropriate health care provider as a licensed institution) and that he was prepared in the meantime to prescribe misoprostol for her so that she could take it as later directed by [ ] or Dr [R] (or wherever she was to have the termination).

[88] Dr E has acknowledged in the Agreed Statement of Facts that he did not discuss with Patient B how or when to take the misoprostol medication or the potential side effects or complications of that medication. He had a professional and ethical duty to understand the medication he was prescribing and the treatment it was intended for.

[89] As the doctor issuing the prescription he was responsible for the treatment and needed to understand his patient's condition and the treatment prescribed. The inappropriate dosages and combinations of medications referred to below under particular 8 demonstrate to the Tribunal Dr E's lack of knowledge of the medications prescribed or the treatment they were intended for.

[90] The Tribunal is also prepared to find that the PCC has, in light of the acknowledgements made, also established on the balance of probabilities that Dr E failed to undertake appropriate clinical assessment in regard to the pregnancy, including the gestation of Patient B's pregnancy.

[91] The guideline, "*Good Prescribing Practice"*, requires that doctors only prescribe medicines or treatment when they have adequately assessed the patient's condition and are therefore satisfied that the medicines or treatment are in the patient's best interests. The MedSafe Data Sheet for misoprostol states that it should never be prescribed where the pregnancy has not been confirmed by ultrasound scan or biological test or where there is a suspected extra-uterine (ectopic) pregnancy.

[92] Accurate dating of the gestation is important because, if the pregnancy is more established than estimated, there is an increased risk of pain, increased bleeding,

and the increased likelihood of a failed abortion. Further complications may arise if the pregnancy is extra-uterine. A second dose of misoprostol may be appropriate if the gestation has reached a later stage. The guidelines also require that antenatal blood tests are taken to measure haemoglobin to establish whether Anti-D should be offered prior to commencement of the termination procedure.

[93] The chronology set out in the Agreed Statement of Facts makes it clear to the Tribunal that Dr E failed before he prescribed misoprostol to undertake an appropriate clinical assessment in any way to assess the gestation of Patient B's pregnancy. The consultation commenced at about 8:00 am; the misoprostol was prescribed for Patient B by Dr E at 8:09 am; at that time Patient B had not had any ultrasound examination or antenatal blood tests; the antenatal blood tests were taken for Patient B on [ ] July 2017; an ultrasound appointment occurred at 8:30 am on [ ] July 2017; and the results were sent to Dr E at 9:18 am on [ ] July 2017, two days after he had prescribed for Patient B.

[94] The submissions for the PCC referred to Dr E's prescribing as "*reckless*" (and there was the objection noted above that this was not part of the Charge), contrary to the requirements of "*Good Prescribing Practice"*, and contrary to accepted medical procedure for termination of pregnancy; and exposed Patient B to unnecessary risk.

[95] The Tribunal finds that the facts alleged in particular 6 are made out and that there was malpractice on Dr E's part in his scope of practice and conduct by him which brought discredit to his profession; and that severally this warrants disciplinary sanction for protection of the public and maintenance of standards in the profession.

Particular 7 – patient records

[96] This particular alleges a failure to keep clear and/or complete patient records in relation to Dr E's prescribing of misoprostol to Patient B. The content of those notes is transcribed above. It is the case for the PCC that these did not meet basic standards of medical record-keeping in that they did not document:

a) Any examination findings.

b) Any options discussed.

c) Any diagnosis.

d) Any information given to the patient.

e) Patient management plans.

[97] While the notes record Patient B's last menstrual period as having been on [ ] January 2017, that an at-home pregnancy test was positive, that the pregnancy was unplanned, and that Patient B was not on any contraception, it is the case for the PCC that, in not containing those further details, Dr E failed to meet basic standards of medical record keeping.

[98] It is further claimed by the PCC that the notes of the consultation do not clearly identify what happened concerning Dr E's consultation and discussion with [ ] or that this occurred after the consultation. The timing of that discussion with [ ] is referred to above and the Tribunal has found that, during his consultation with Patient B, Dr E did not make contact with [ ] and could not have done so because it was not open.

[99] As noted, his notes are singularly ambiguous as to when that discussion took place and the Tribunal finds that in that respect also the notes do not meet necessary standards. The Agreed Statement of Facts includes an acceptance by Dr E that this particular does set out conduct that was contrary to accepted standards of medical practice and/or was in breach of the MCNZ statement "*Good Prescribing Practice*".

[100] In his evidence Dr E accepted that the records could have been clearer or contained more information; that he did not provide information to Patient B and record that in his notes about the use of misoprostol to procure an abortion (because, he says, he was not the doctor who was going to be performing the termination and that that was [ ]), and that he assumed that [ ] would provide Patient B with all relevant information.

[101] The Tribunal finds the facts in this particular to be made out, that this was negligence in failing to keep adequate records in his notes on Dr E's part, that this was conduct which brought discredit to his profession, and that it warrants disciplinary sanction cumulatively with other particulars as noted below to protect the public and maintain standards in the profession.

Particular 8 – Inappropriate prescribing

[102] This separate particular alleges inappropriate prescribing of misoprostol to Patient B on [ ] July 2017 with two sub-particulars namely that Dr E knew, or ought to have known, that the dosage of misoprostol exceeded the recommended

dose of 400 µg; and/or that Dr E prescribed misoprostol in combination with Primolut, which is inappropriate for the treatment of terminating a pregnancy which Patient B intended to seek.

[103] This particular needs to be considered on its own, but should also be read in combination with particular 6 above. In the Agreed Statement of Facts Dr E has admitted that the conduct set out in this particular was contrary to accepted standards of medical practice and/or was in breach of the MCNZ statements on "*Good Prescribing Practice*". He also accepts that cumulatively this amounts to malpractice in the scope of his practice and has brought discredit to his profession, as noted below, warranting disciplinary sanction.

[104] In his evidence Dr E accepted that he had prescribed the quantity of misoprostol as alleged (30 x 200 µg tablets). He does say, however, that in doing so, it was not his intention personally to procure the termination for Patient B which was to be procured or effected by [ ]. He said that that was the reason he did not research how the termination would be carried out by [ ].

[105] The Tribunal has found that Dr E's contact with [ ]/Dr [R] did not occur while Patient B was with him in the consultation but later. Dr E's explanation of his prescribing was that this was at the direction of Dr [R] and Dr E said that he was advised or directed by Dr [R] to dispense the misoprostol tablets to Patient B which the Tribunal takes as saying that the quantity of misoprostol prescribed was also as directed by Dr [R].

[106] The Tribunal does not accept that there was any contact with Dr [R] and finds that Dr E himself elected the quantity to prescribe and he did so, on his own acknowledgement, without adequate research.

[107] The Tribunal accepts Dr E's acknowledgement in the Agreed Statement of Facts and finds that this particular is also made out on its facts and as alleged as a breach of standards.

[108] As to the dosage, 30 x 200 µg tablets, this is consistent with the use of misoprostol for the prevention of gastric ulcers and erosions in patients continuing NSAID therapy[12]. The MedSafe Data Sheet for Mifegyne (mifepristone) as a medical alternative to surgical termination of intra-uterine

[12] MedSafe Data Sheet Cytotec page 5

pregnancy in early pregnancy is 400 µg misoprostol orally (up to 36 - 48 hours) following 600 mg mifepristone (3 tablets) in a single dose.

[109] The submissions for the PCC also referred to other aspects of inappropriate prescribing which the Tribunal has considered carefully which in summary referred to:

a) The universal suggestion for a single dose of misoprostol with a secondary dose if the abortion is not imminent after 4 - 5 hours.

b) The recommendation for misoprostol to be administered 36 - 48 hours after administration of mifepristone.

c) The administration of 800 µl of misoprostol vaginally following oral administration of mifepristone.

d) That the dose of misoprostol prescribed by Dr E was not proven safely to terminate a pregnancy with a risk of causation of birth defects.

e) The additional prescription by Dr E of Primolut which is a strong progesterone used to treat dysfunctional uterine bleeding and endometriosis and is contraindicated in patients with known or suspected pregnancy. and

f) The prescribing of APO-Cilazapril also contraindicated during pregnancy.

[110] The Tribunal accepts the PCC submission that the dosage of misoprostol prescribed and medications with which it was prescribed in combination were inappropriate and placed Patient B at risk and were in breach of Dr E's obligations set out in "*Good Prescribing Practice*" and accepted standards of medical practice.

[111] It also accepts and finds that this conduct amounted to malpractice on Dr E's part in the scope of his practice and as conduct bringing discredit to his profession; severally warranting disciplinary sanction to maintain standards in the profession and protect the public.

[112] Particular 9 is a statement of standards which is accepted by Dr E and needs no finding by the Tribunal.

Particulars 5 – 9: Patient B – Summary

[113] The Tribunal finds that the facts alleged in the sub-particulars of particulars 5 – 9 are made out; that in respect of particulars 6 and 8 these severally amount to

malpractice in the scope of Dr E's practice and conduct bringing discredit to his profession and severally and cumulatively warrant disciplinary sanction. This is for the maintenance of standards in the profession and for protection of the public. Medical practitioners should not be prescribing medications of which they do not have adequate knowledge or for intended treatments of which they do not have adequate knowledge and that they should not be undertaking inappropriate clinical assessments.

[114] Dr E said that he relied on what he was advised by Dr [R] but the Tribunal has found that his prescribing had occurred before his discussion with Dr [R] and Dr E must take full responsibility for what he chose to prescribe for Patient B at the time. This is a significant breach of standards and also put Patient B, as a member of the public, at risk.

Patient A: Particulars 1 – 4: [ ] January 2018

[115] The essential and agreed facts concerning Patient A are set out above. In his evidence Dr E elaborated on these. Dr E had seen Patient A on [ ] January 2018 when she told him she had not had her period for three months and Dr E ordered blood tests that day. Those then confirmed that Patient A was pregnant but did not provide the gestation period.

[116] When Patient A consulted with Dr E on [ ] January 2018 to receive a diagnosis of her pregnancy Dr E requested an ultrasound which revealed that Patient A was almost 7 weeks pregnant. Dr E said that Patient A was upset, distressed and worried about the news and insisted immediately on the termination of her pregnancy. Dr E said that he explained to Patient A that he would refer her to Family Planning who would arrange an early medical termination for her. Dr E said that Patient A told him "*in no uncertain terms that she did not want to attend Family Planning*" giving her reasons. Dr E's brief notes include "*insists on medical abortion*".

[117] Dr E said that he tried to assuage Patient A's concerns and persuade her to go to Family Planning a number of times but Patient A emphatically refused this. Dr E said that this placed a lot of pressure on him and he struggled to come to terms with the extraordinary situation and how he should deal with it.

[118] Dr E said that during this discussion Patient A alluded to the availability of illegal terminations which he said would put her at a significant and real risk.

He said that he believed it was the safest way forward to deal with Patient A's termination, referring to funding difficulties for other resources. Coupled with her "*significant distress*" and the suggestion for illegal termination Dr E said he made the "*tough decision*" that the safest course of action for Patient A being to prescribe her Mifegyne and misoprostol, a decision he said he did not make lightly.

[119] Dr E said that he did not know the gestation period for Patient A's pregnancy but organised a scan to determine this. Dr E prescribed for Patient A misoprostol 200 mg Tab – 4 stat and Mifegyne 200 mg Tab - 1 stat and said that he "*believe[d] it was agreed between Patient A and [him] that she would take the medication the next day*". By that time, he said, he would have had an opportunity to review the scan results, determine the pregnancy gestation and location, and whether he thought it was safe enough for her to take the medication. Dr E said that both Patient A and he agreed that no action would take place until this process had occurred.

[120] No other evidence was provided to the Tribunal concerning this. Dr E said that he could not recall ever having prescribed any of those medications before so he conducted research into them on his computer, the main purpose being to determine the appropriate and safest dose for Patient A; but also to research possible side effects that Patient A should be alerted to to determine if her health was at risk or she was having a bad reaction.

[121] Dr E said that he prescribed the medications and made very clear to Patient A the risks involved and what she should do if things started to go wrong, explaining expectations of pain and bleeding as well as other possible side effects. He gave evidence about further discussion and instruction and said that in his opinion Patient A was fully informed when she made her decision to go ahead with the termination of her pregnancy.

[122] Patient A assured him she would not take the medication on her own and would be accompanied and looked after by a responsible adult friend; and Dr E said he considered that Patient A completely understood the risks involved in using the medications.

[123] Dr E said that at the end of the consultation he discussed follow-up consultation and advised Patient A of the need for counselling after such a procedure.

[124] As noted above it was agreed that when on [ ] January 2018 Patient A went to a pharmacy to have the prescription filled she was advised that there was no mifepristone (Mifegyne) in stock. Patient A was advised to return to her general practitioner to make an appointment with Family Planning which she duly did. Patient A did not then obtain any of the medication prescribed for her by Dr E on [ ] January 2018.

Particular 1 – prescribing misoprostol and or mifepristone: [ ] January 2018

[125] It is agreed by Dr E that on [ ] January 2018 he prescribed both misoprostol (trade name Cytotec) and mifepristone (trade name Mifegyne) to Patient A. The question is whether the sub-particulars are made out.

[126] Sub-particular a. refers to an intention to procure an abortion. This is admitted by Dr E in the Agreed Statement of Facts and confirmed in his sworn evidence. The background behind the reasons are not part of the Charge but may be taken into account in determining penalty. Accordingly this sub-particular is found to be made out as a matter of fact.

[127] Sub-particular b. alleges that the intended abortion had not been appropriately certified. Again there is no question that factually this is correct. It is admitted by Dr E in the Agreed Statement of Facts and his outline in his evidence that makes no reference at all to authorisation by certifying consultants as required by the CSA Act. It is plain from that evidence that Dr E did not anticipate there would be any such authorisation for the intended abortion; but rather that he prescribed medications for Patient A for her to use for that purpose. That sub-particular is found to be made out on the facts.

[128] Sub-particular c. refers to knowledge of intentions. The Tribunal finds that as a matter of fact Dr E knew that Patient A was not intending to take either the misoprostol or the mifepristone on premises licensed under the CSA Act. He certainly ought to have known this in the context of the discussion he had had with Patient A and the Agreed Statement of Facts includes an acknowledgment by him of this particular.

[129] The submissions for the PCC referred to the requirements of the CSA Act which include section 32 which requires practitioners who are not certifying consultants and who consider that the grounds in section 187A of the Crimes

Act 1961 are met refer the case to two certifying consultants with a request to determine whether the abortion can be authorised. Dr E did not follow this process and as such, it was submitted, his actions were in breach of the CSA Act and accepted standards of practice.

[130] Reference was made to the MCNZ guidelines referred to above. As noted above, Dr E did not really dispute this factual allegation.

[131] Accordingly, the factual circumstances on which particular 1 is based as set out in the three sub-particulars are found to be made out on the facts. The question for the Tribunal is whether in those circumstances the prescription of misoprostol or mifepristone by Dr E for Patient A on [ ] January 2018 was negligence or malpractice under section 100(1)(a) of the HPCA Act or was conduct bringing, or likely to bring, discredit to his profession under section 100(1)(b) of that Act. This is alleged separately in the Charge.

[132] The Charge at particular 4 describes the circumstances and prescribing as being contrary to the MCNZ statement on "*Good Prescribing Practice*", the requirements of the CSA Act, and contrary to the "*Guidelines for the use of Mifepristone for Medical Abortions in New Zealand*" issued by the Abortion Supervisory Committee.

[133] The Tribunal has taken account of the provisions of those documents and notes the cases referred to, particularly *Dr N*[13]. It finds that the charge of professional misconduct under those sub paragraphs of that subsection is made out.

[134] Patient A made it clear to Dr E that she wanted to have a medical termination of her pregnancy and she wanted to have it with some urgency, to the extent of apparently threatening him with taking matters into her own hands in a way which could have compromised her health and safety. Dr E may have had some compassion for her in the circumstances and wanted to avoid that outcome, but the provision of the Guidelines and of the CSA Act are clear. It was not appropriate for Dr E to have prescribed either the misoprostol or the mifepristone for Patient A in the way that he did. He should have taken care to ensure that the requirements of the CSA Act were met.

[13] See notes 1 and 11 above

[135] He should not have taken Patient A's assurance that she would not take the medication before he had had an opportunity to review her scan results and determine the pregnancy gestation and location, particularly if he was uncertain about whether it was safe enough for her to take the medication. He should not have limited the question of counselling to advising Patient A of the need for this and should have made whatever arrangements were needed for counselling at the time. There was professional misconduct on his part as mentioned above.

Particular 2: failures prior to prescribing

[136] There is a measure of overlap in the allegations in this particular which contain four sub-particulars of alleged failure by Dr E prior to his prescribing misoprostol and mifepristone to Patient A on [ ] January 2018. These relate to adequate knowledge of medications, adequate knowledge of the requirements of the CSA Act, undertaking of appropriate clinical assessments, and ensuring a plan to take the medications on the premises of a licensed institution.

Sub-particular a. – adequate knowledge of medications

[137] Dr E's position is that he could not recall ever having prescribed either of these medications before. That is somewhat surprising a statement to make given that he had prescribed misoprostol to Patient B only some six months previously. Dr E's position on that was, as noted above, that he was merely prescribing medication for his then patient, Patient B, so that she could have the medication for the purpose of a medical termination of pregnancy by [ ]/Dr [R]. The Tribunal is prepared to accept that his having written the prescription for Patient B on that earlier occasion may have escaped his memory at the time he was consulted by Patient A.

[138] Dr E did not give detail of the outcome of his research into the medication required for the medical termination of pregnancy for Patient A. It was the case for the PCC first that the record shows that there was only between 7 and 9 minutes between when Patient A's appointment was scheduled to start at 8.45 am and the issue of the prescription for mifepristone by Dr E at 8:52 am and misoprostol at 8:54 am. It further said that, although the dose of misoprostol prescribed by Dr E for Patient A (200 mg) is an accepted dose according to

professional guidelines, the dose specified in the MedSafe Data Sheet is 600 mg. It was argued for the PCC that that demonstrated an inadequate understanding by Dr E of the medications he was prescribing for Patient A or of the effects or likely side effects[14].

[139] The PCC says that Dr E should have known that Patient A would not have been able to obtain mifepristone at a pharmacy due to legal restrictions on its use. Although misoprostol use in medical abortion is common, its use is off-license and, as such, the MedSafe Data Sheet for misoprostol does not specify its dosage for use in abortion procedures. The dose prescribed by Dr E for Patient A is consistent with the dose suggested in the MedSafe Data Sheet for mifepristone, but the evidence-based protocol recommended in the *Guidelines for the use of mifepristone for Medical Abortion in New Zealand* is that 800 µl of misoprostol be administered vaginally.

[140] The PCC submitted, and the Tribunal accepts, that Dr E did not demonstrate an adequate understanding of the medications he prescribed to Patient A, or the likely effects and side effects. In prescribing mifepristone to Patient A, Dr E appears to have been unaware that she would have been unable to obtain this from a pharmacy and of the significant cost of this medication compared to the free service at Family Planning.

[141] The PCC further submits, and the Tribunal also accepts, that the prescription of 29 x 50 mg Tramadol hydrochloride capsules to Patient A in addition to one tablet of 200 mg mifepristone and 800 µg misoprostol demonstrates Dr E's limited understanding of the operation of mifepristone and misoprostol in procuring an abortion.

[142] Further submissions were made by the PCC concerning the drugs prescribed and quantities which the Tribunal accepts. This included that Dr E issued a prescription for mifepristone and misoprostol prior to receiving the results of the ultrasound ordered at the [ ] January 2018 consultation; and this would have confirmed the pregnancy and accurately dated the gestation prior to the medical abortion as required by professional guidelines. A requirement for confirmation by ultrasound scan or biological tests before prescribing mifepristone is

[14] Submissions paragraph 73 and Transcript page 46

provided in the MedSafe Data Sheet for mifepristone where again accurate dating of the gestation is important.

[143] The Tribunal accepts that Dr E's conduct of prescribing misoprostol and mifepristone to Patient A on [ ] January 2018 without first ensuring he had adequate knowledge of those medications was negligence and malpractice on his part and was conduct bringing discredit to his profession. Dr E has acknowledged this in the Agreed Statement of Facts.

Sub-particular b. – knowledge of CSA Act provisions

[144] This refers to Dr E's having failed to ensure that he had adequate knowledge of the CSA Act prior to prescribing misoprostol and mifepristone for Patient A. The submissions for the PCC did not expressly address this allegation but the Tribunal is prepared to find that this sub-particular is made out as malpractice or negligence on Dr E's part and as conduct bringing discredit to his profession.

[145] The Tribunal has already found as a matter of fact that Dr E has demonstrated an inadequate knowledge of the requirements of that Act. Dr E has acknowledged this in the Agreed Statement of Facts in general terms. Dr E knew that Patient A intended to have a responsible adult friend with her at home when she took the mifepristone and misoprostol and did not take steps to ensure that she planned to take these on the premises of a licensed institution.

[146] Dr E has acknowledged that the intended abortion had not been authorised by two certifying consultants prior to his prescribing for Patient A the misoprostol or mifepristone and that demonstrates to the Tribunal absence of adequate knowledge of the requirements of the CSA Act.

Sub-paragraph c. – appropriate clinical assessment

[147] This alleges a failure to undertake appropriate clinical assessment, including establishment of the gestation of Patient A's pregnancy. This is again acknowledged by Dr E in the Agreed Statement of Facts. The Tribunal finds that it is made out on the facts and as malpractice or negligence on his part and conduct bringing discredit to his profession.

[148] Reference has been made above to the timing of the consultation and the prescribing of the medications and the obligations there are in the MedSafe Data

Sheets for mifepristone for adequate establishment of the gestation of a pregnancy prior to prescribing these medications.

Sub-particular d. – licensed premises

[149] This refers to the failure to ensure that Patient A planned to take the misoprostol and mifepristone on the premises of a licensed institution. Again this is acknowledged by Dr E in the Agreed Statement of Facts. The facts are clearly established that he did not ensure this but rather that he knew that Patient A was to take these medications at her own home in the company of a responsible adult friend.

Particular 2: summary

[150] The allegations are found to be made out as noted above and that each of these separately and cumulatively are negligence or malpractice on Dr E's part and conduct bringing discredit to his profession; separately and cumulatively warranting disciplinary sanction.

Particular 3: inadequate notes

[151] The allegation is a failure to keep clear or accurate patient records in relation to the prescribing to Patient A and a failure sufficiently to record in her notes what information was given to her about the medications to procure an abortion. In the Agreed Statement of Facts there is no reference to this issue expressly but there is an admission by Dr E of this particular and of the breach of standards sufficient to amount to malpractice or negligence in the scope of his practice and conduct likely to bring discredit to his profession, warranting disciplinary sanction.

[152] The submissions for the PCC referred to the notes that Patient A was "*advised fully*" but categorise remaining entries as brief and simple. There is not, it is submitted by the PCC, enough detail to understand exactly what Patient A was advised or whether Dr E met his obligations to obtain informed consent for the proposed treatment. The records failed to meet basic standards of medical record keeping in that they did not document:

a) Details of the patients presenting complaint (namely that she had a suspected pregnancy and was seeking a termination);

b) Any examination findings;

c) Any diagnosis; and

d) Patient management plans.

[153] The notes do not state whether Dr E provided guidance to Patient A on how to take the medication simply recording "*stat*". All protocols require that misoprostol should be taken some hours after mifepristone and often days after; but there is no evidence that Dr E advised Patient A of this and certainly no record in his notes of that.

[154] The Tribunal finds this particular to be made out as negligence on Dr E's part and conduct bringing discredit to his profession cumulatively warranting disciplinary sanction in addition to particular 7 in relation to Patient B referred to above.

Particular 4 - Standards

[155] This is an allegation which refers to standards including the provisions and requirements of the CSA Act. It is not an allegation of misconduct as such (as was the case with particular 9 above) and the Tribunal need make no separate finding on the allegation there.

Particulars 1 - 3 and 5 - 8: summary

[156] The findings of the Tribunal in respect of the separate allegations in these particulars is contained above but in summary the Tribunal finds that Dr E prescribed misoprostol (trade name Cytotec) and mifepristone (trade name Mifegyne) to Patient A on [ ] January 2018 in the circumstances alleged and with the prescription failures referred to and with the failure to keep clear or adequate patient records; and that this was contrary to the MCNZ statement on "*Good Prescribing Practice"*, the requirements of the CSA Act, and the "*Guidelines for use of mifepristone for Medical Abortions in New Zealand"* issued by the Abortion Supervisory Committee. This is malpractice and negligence on Dr E's part separately in respect of the sub-particulars mentioned and separately from particulars 5 – 8 below, warranting disciplinary sanction to maintain standards in the profession and to protect the public.

[157] It further finds that Dr E prescribed to Patient B the quantities of misoprostol referred to in the Charge in circumstances where Patient B was pregnant and

intended to seek a termination of her pregnancy with prescribing failures mentioned and inappropriate prescribing as alleged and a failure to keep clear and complete patient records. This is malpractice and negligence on Dr E's part separately in respect of the sub-particulars mentioned and separately from particulars 1 - 3 above, warranting disciplinary sanction to maintain standards in the profession and to protect the public.

[158] Finally it finds that all of particulars 1 - 4 and 5 - 8 cumulatively warrant such sanction for those reasons. That decision having been announced to the hearing, submissions were made on penalty.

Penalty

[159] The PCC submitted that the appropriate penalty orders for the Tribunal to make were for censure, certain conditions, a fine of approximately $5,000.00 and costs. Attention was drawn to comparative cases, *Dr N*[15], *Dr Gouse*[16], and *Dr S*[17]. Aggravating factors were said to be that there were clear breaches of the law, clear breaches of professional standards, potential harm to patients, failure to undertake clinical examination, and a failure to stand up to patient pressure to prescribe (in respect of Patient A). While these are not necessarily aggravating features they are noted. In mitigation it was conceded that there had been an admission of wrongdoing and that there was no harm to the two patients. Suspension was said not to be necessary in this case, with the Tribunal's disapproval being expressed by an order for censure.

[160] The case of *Dr N* (where there had been a suspension for 6 months) was distinguished on the grounds that there was a more serious breach. It was accepted that suspension was not necessary in this case. The suggested fine of $5,000.00 was submitted to be appropriate in the circumstances and in line with previous cases; and necessary to reflect the seriousness of Dr E's misconduct.

[161] Conditions should be imposed in the interest of public safety, it was submitted, and these are discussed below.

[162] Dr E gave evidence in mitigation. He referred to background matters and his experience as a doctor and said that when he consulted in January 2018 with

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15 543/Med12/224P (On appeal [2013] NZHC 3405; [2014] NZAR 350). Noted above
16 30/Med05/11D
17 499/Med11/197P

Patient A he had had difficult times, referring to medical setback and being tired and depleted. He also referred to a tragic accident involving a personal friend that had been traumatic for him at the time. He said that he "*wholeheartedly [believed his] judgment would have been impaired as a result of [the] pressure and distress*". He gave extensive detailed evidence about the respective consultations with Patient A and Patient B which the Tribunal has noted and some of which is mentioned above. That must be read, however, in the context of the Agreed Statement of Facts.

[163] Dr E said that he tried several times to dissuade Patient A from not attending Family Planning because of negative feedback she had had from a friend. It was then that Patient A made reference to the illegal alternative open to her and he was extremely concerned that she might pursue that. He made what he described as the "*tough decision*" to prescribe Mifegyne and misoprostol and said that he did not know Patient A's gestation period but organised a scan for this. He referred, as noted above, to its having been agreed between Patient A and him that she would take the medication the next day after he had had an opportunity to review the scan results and determine the pregnancy gestation and location and whether it was safe for her to take the medication. Dr E said that he made it very clear to Patient A the risks involved and what she should do if things started to go wrong, explaining expected effects from the medication as well as possible side effects. Dr E said that he thought that Patient A was fully informed when she made her decision to proceed and that she completely understood the risks involved. He said that he advised Patient A of the need for counselling.

[164] The evidence he gave concerning Patient B was as noted above including that he believed that he had contacted [ ]/Dr [R] during the consultation while Patient B was in the room (rejected by the Tribunal) and that he prescribed the misoprostol tablets for Patient B to obtain the medications prior to her consultation with [ ]. He said it was never his intention that Patient B would take the misoprostol at home or alone and he did not proceed on that basis. He gave extensive evidence again concerning the events surrounding Patient B which are canvassed above.

[165] Dr E referred to a Performance Assessment that had been ordered by the MCNZ and its outcome including that he accepted that his notes could be better. He

referred to changes that he has made to his practice. He said that both patients are still patients of his and, he said, are very appreciative of all that he does for them and how he has helped them over the years. Dr E referred to his "*enviable reputation*" and the respect that he has in the area. He said that he does not intend to retire when he reaches the age for that and gave evidence concerning non-publication of his name as mentioned below.

[166] There was also produced to the Tribunal various references and extracts from these were emphasised; and which the Tribunal has taken careful note of.

Discussion

[167] The available penalties for the Tribunal are:[18]

a) That registration be cancelled.

b) That registration be suspended for a period not exceeding 3 years.

c) That the health practitioner be required, after commencing practice following the date of the order, for a period not exceeding 3 years, to practise his or her profession only in accordance with any conditions as to employment, supervision, or otherwise specified.

d) Censure.

e) A fine of up to $30,000.00 (but not if he or she has been convicted of a relevant offence or damages have been awarded against him or her – not the case here).

f) Costs.

[168] The principles behind penalty orders of the Tribunal as clearly set out on the basis of authorities[19] are:

a) What penalty most appropriately protects the public.

b) The important role of setting professional standards.

c) A punitive function (although this is not the principal purpose behind in the order but may be a secondary consequence).

d) Rehabilitation of the health professional.

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[18] Section 101 of the HPCA Act.

[19] *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 3354; *Katamat v PCC* [2012] NZHC 1633 at [49] ;*Joseph v PCC;* [2013] NZHC 1131 at [65] – [66]; *Singh v Director of Proceedings* [2014] NZHC 2848 (esp. paragraphs [56] – [60] and [66]).

e) That any penalty imposed is comparable to other penalties imposed upon health professionals in similar circumstances.

f) Assessing the health practitioner's behaviour against the spectrum of sentencing options that are available and trying to ensure that the maximum penalties are reserved for the worst offenders.

g) An endeavour to impose a penalty that is the least restrictive that can reasonably be imposed in the circumstances.

h) Whether the penalty proposed is fair, reasonable and proportionate in the circumstances presented.

[169] The Tribunal accepts that this is not a case calling for an order for cancellation of Dr E's registration or for suspension. It accepts the distinction that the PCC has made between this case and that of *Dr N* where there was a suspension ordered.

[170] It is not part of the Charge, but the Tribunal is concerned that Dr E appears not to have spent sufficient time with these respective patients, particularly Patient A, given the outline in his evidence that Dr E gave as to her then position concerning issues raised[20] which required some extensive and careful questioning and consultation and advice. The Tribunal is also concerned that Dr E apparently allowed himself to succumb to pressure from Patient A from the threat she was making concerning the unsatisfactory illegal alternative, although this too is not part of the Charge. As submitted by the PCC, a medical practitioner should act solely in the patient's best medical interests and should not be pressured by that patient into prescribing something inappropriately or illegally.

[171] The facts indicate to the Tribunal a significant lack of understanding by Dr E of the requirements of the CSA Act. Dr E is of an age where he should have been aware of the controversy preceding the enactment of that legislation and the ongoing social questions there are concerning procuring abortions. That should have led him to tread very carefully in advising both these patients and in prescribing for them. The time he apparently spent researching the medications was clearly not sufficient to be fully informed about the legal position arising

[20] Transcript page 101/9

from the CSA Act or indeed the complexities of the medications he was prescribing.

[172] It was only the second consultation he had for Patient A and the time spent with her dealing with her presenting issue of an unwanted pregnancy and in dealing with the other presenting concerns for her was woefully inadequate. It is disturbing for the Tribunal to realise that Dr E prescribed for Patient A when he had relatively recently prescribed for Patient B. That indicates to the Tribunal that Dr E's research into medications he was prescribing is significantly superficial and inadequate.

[173] The case calls for an order for censure of Dr E and that is ordered below. It also calls for a fine to be imposed as a deterrence to Dr E for the future and as a deterrence to his fellow professionals. The lesson must be learned that no medication should be prescribed without adequate consultation and without adequate research into, and understanding, of the legal, medical and ethical requirements for that patient. That fine is fixed at $7,500.00 and is ordered below.

[174] There should be conditions imposed on Dr E's practice on resumption of practice following this decision. There was a measure of acceptance by Dr E of the conditions proposed by the PCC. It was, however, emphasised on his behalf that Dr E had no intention to be involved in terminations of pregnancy, whether surgical or medical, at all and that therefore conditions for education as proposed by the PCC item (c) in that regard were unnecessary. While that may be Dr E's current stated intention, the Tribunal must work on the basis that there may be occasions in the future when Dr E is consulted by women seeking a termination of a pregnancy and may seek that he be involved in this, and it is important that he is aware of the ethics and law involved. Furthermore, the provisions of the CSA Act deal with more than just terminations of pregnancy and it is important that Dr E be more aware of its provisions by having appropriate educational conditions.

[175] The conditions proposed by the PCC are, subject to detail mentioned, accepted by the Tribunal as appropriate. The first is for Dr E to provide to the MCNZ at his expense access to his prescribing records and other documents reasonably required by it or an appropriate committee to monitor compliance with the CSA Act; and that should be for the period of three years.

[176] The second is that he make available to the MCNZ or a committee of it anonymised versions of all patient consultation records regarding any proposed abortion for review by the Medical Adviser to the MCNZ, again for a period of three years and at his expense.

[177] The third is that he participate in an educational course designed by, or approved by the Medical Adviser to the MCNZ which centres on the CSA Act, the MCNZ Statement on Good Prescribing Practice and on keeping good medical records, such course to be completed within 12 months and to be, including the cost of design and approval, at Dr E's cost. A condition on these terms was resisted on behalf of Dr E, reference having been made to the two years of education that has followed the MCNZ's Performance Assessment Committee assessment. The Tribunal however, considers that despite that, and having regard to the evidence that Dr E has given of his current understanding of the situation, that education is required. The parameters of the course as designed or approved will take into account what may have transpired during the Performance Assessment.

[178] The fourth is that he discuss this case within six months of the Tribunal's decision with his peer review group and other doctors who work in his practice and provide confirmation to the MCNZ that this has occurred.

[179] The fifth is that he disclose the findings and detail of this decision to his current and any future employer for a period of three years. It is only fair for the employer to know expressly of the situation referred to in this decision and take appropriate steps to protect the public accordingly.

Costs

[180] The PCC sought an order for costs and gave a detailed estimate of its total costs for investigation and prosecution of the charge at $50,957.56. Based on the usual principles the PCC argued that an order for contribution of 30 – 40% of those costs was appropriate. In addition the Tribunal must consider the resourcing costs for the Tribunal which were estimated to total $39,569.00. That gives a total of some $90,000.00.

[181] In reply, submissions for Dr E emphasised his full cooperation throughout and referred to the case of *Dr N* where a contribution of some 30% of costs was

ordered. It was submitted that the contribution should be of the range of 20-25%.

[182] Section 101 of the HPCA Act provides in this context:

> *"... the Tribunal may—*
>
> *....*
>
> *(f) order that the health practitioner pay part or all of the costs and expenses of and incidental to any or all of the following:*
>
> *(i) ...*
>
> *(ii) any inquiry made by a professional conduct committee in relation to the subject matter of the charge:*
>
> *(iii) the prosecution of the charge by ... a professional conduct committee, ...:*
>
> *(iv) the hearing by the Tribunal*".

[183] There are two statements of principle relevant from decisions in the High Court. The first of these is *Cooray v Preliminary Proceedings Committee*[21]:

> "*It would appear from the cases before the Court that the Council [the MCNZ that then had jurisdiction in the matter] in other decisions made by it has in a general way taken 50% of total reasonable costs as a guide to a reasonable order for costs and has in individual cases where it has considered it is justified gone beyond that figure. In other cases where it has considered that such an order is not justified because of the circumstances of the case, and counsel has referred me to at least two cases where the practitioner pleaded guilty and lesser orders were made, the Council has made a downwards adjustment*".

[184] The second case mentioned is *Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council*[22]. There it was said[23]:

> "S*o far as costs orders were concerned, the Tribunal correctly addressed a number of authorities and principles. These included that professional groups should not be expected to bear all the costs of a disciplinary regime and that members of the profession who appeared on disciplinary charges should make a proper contribution towards the costs of the inquiry and a hearing; that costs are not punitive; that the practitioner's means, if known, are to be considered; that a practitioner has a right to defend himself and should not be deterred by the risk of a costs order; and that in a general way 50% of reasonable costs is a guide to an appropriate costs order subject to a discretion to adjust upwards or downwards…"*

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21 HPCA Act HC: AP 23/94; 14/9/95; Doogue J;
22 [2012] NZHC 1138
23 Paragraph 34

[185] The Tribunal has carefully assessed the position from the point of view of those authorities and the submissions of the parties. There was no evidence from Dr E that he could not afford a reasonable order for contribution and there was no significant challenge to the quantification of the costs involved.

[186] The Tribunal is of the view that the appropriate order towards costs totalling some $90,000.00 is a sum representing 25%, that is the sum of $22,500.00; and that is ordered below.

Non-publication of names

[187] The Tribunal has made and now confirms orders for complete non-publication of the names or any identifying details or particulars of the affairs of either patient, Patient A or Patient B.

[188] Dr E made an application for non-publication of his name and identifying details and the position of the PCC was that it did not object to that application and would abide the decision of the Tribunal, the submissions referring to matters of principle and concluding that there should be a condition on any non-publication order permitting the MCNZ to publish on Dr E's formal record a reference to the decision.

[189] In support of the application the submissions for Dr E referred to extracts from various judgments. It was said that Dr E's rehabilitation had for all intents and purposes been achieved but part and parcel of that must be his ability to continue to practise. In all probability, it was submitted, he would not be able to continue to practise if his name were published. That submission relied on evidence that Dr E had himself given referring, as noted above, to his enviable reputation and significant respect in his practice area and his large and very loyal patient base.

[190] Although he does not currently intend retirement, if there were publication of his name it was highly likely, he said, that he would immediately retire. He said he also thought that his wife and he would move away from their area of living and practice. Dr E referred to his local community.

[191] He also referred to his, and the patients', concern that publication of his name might have the effect of identifying either Patient A or Patient B who continue to be his patients. That theme repeated what had been said from the outset of the hearing concerning the request for private hearing and the ability of people to "*join the dots*" to identify the two patients in question.

[192] Dr E's evidence also referred to his wife's position professionally and socially and his belief that it would be inevitable that she would be subjected to unfair criticism and abuse, ridicule and even bullying if he were named. This evidence was supported by a letter written from a superior in the place of employment for Mrs E who said that his belief was that adverse public reaction would compromise her ability to continue in her role in that workplace and that she would be vulnerable to physical and emotional incidences in relation to the case.

[193] The submissions for Dr E relied heavily on the *Dr N* case. First similarities and distinctions from issues raised in that case were referred to. These included a reference to the recognition by the Tribunal when it heard the charge against Dr N that an abortion is a contentious issue in New Zealand and one that could engender strong reactions in some people. The recognition that the people who worked at the entities in question in the *Dr N* case could be subject to harassment in light of the very sensitive issues involved and the strong feelings that they engender in some members of the public. The outcome in the *Dr N* case was that, whereas the Tribunal had declined an order for non-publication of the doctor's name, the court reversed that on appeal and ordered non-publication of the doctor's name.

[194] The Tribunal has considered the application and is of the view that an order should be made as sought. The personal interests for Dr E are not considered to weigh heavily in support of the application. He chose to accept these two patients for the consultations they sought for medical termination of their pregnancies. He chose to proceed with prescription for them in apparent ignorance of, or disregard for, the provisions of the CSA Act and in the ways which have been found by the Tribunal to be malpractice or negligence on his part. In the normal course, he would need to take responsibility for that and that would include publication of his name.

[195] Against that, however, are the interests of his wife and children as outlined in his evidence and referred to in the material and submissions presented on his behalf. That has weighed with the Tribunal.

[196] The Tribunal has also taken account of the privacy needs for the two patients. Non-publication of their names and identifying details should be sufficient to protect their privacy. The case is very similar to the *Dr N* case mentioned. That case emphasises that naming the practitioner can have the unwanted

consequence of identifying the patients by those who are able to "*join the dots*" and so identify the patients. That outcome should be avoided and is a factor taken into account by the Tribunal.

[197] Accordingly the application for non-publication of the name and identifying details for Dr E is accepted by the Tribunal and an order accordingly is made below. The Tribunal exempts from that order the publication by the MCNZ in the practitioner's formal record reference to this decision.

Result and conclusion

[198] The Charge against Dr E is found to be made out in its particulars as set out above as malpractice and negligence in the scope of his practice by Dr E and as conduct bringing discredit to his profession.

[199] Dr E is ordered censured.

[200] Dr E is ordered to pay a fine of $7,500.00.

[201] An order is made that Dr E may, after commencing practice following the date of this decision, for a period of 3 years, practise his profession only in accordance with the following conditions:

a) That for that period of 3 years Dr E provide at his expense to the MCNZ access to his prescribing records for it to monitor compliance with the CSA Act.

b) That for that period of 3 years Dr E make available on request of the MCNZ or an appropriate committee of it, anonymised versions of all patient consultation records regarding a proposed abortion for review by the Medical Adviser to the MCNZ.

c) That Dr E participate within 12 months of the date of this decision (to be extended at its discretion by the MCNZ depending on the availability of resources) in an educational course designed, or approved, at Dr E's cost including the cost of design and approval, by the Medical Adviser to the MCNZ which centres on the CSA Act, the MCNZ statement on Good Prescribing Practice and on keeping good medical records

d) That Dr E discuss this case within a period of 6 months of the date of this decision with his peer review group and other doctors who work in his practice and provide reasonable confirmation to the MCNZ that this has occurred.

e) That for that period of 3 years Dr E disclose the findings in this decision to his current and any future employer.

[202] Dr E is ordered to pay the sum of $22,500.00 towards the costs of the investigation and prosecution of the Charge by the PCC and the resourcing costs for the Tribunal to be divided equally between them.

[203] An order for permanent non-publication of names and identifying details of the two patients referred to in the Charge, Patient A and Patient B, is confirmed.

[204] An order for permanent non-publication of the name and identifying details and particulars of the affairs of Dr E, his wife, the practice at which he worked and the pharmacy or pharmacies which met the prescriptions is made; but the Tribunal exempts from that order the publication by the MCNZ in the practitioner's formal record reference to this decision.

[205] Pursuant to section 157 of the HPCA Act the Tribunal directs the Executive Officer:

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

b) To request the MCNZ to publish either a summary of, or a reference to, the Tribunal's decision in its next available publication to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Auckland this 28th day of April 2020

.....
David M Carden
Chairperson
Health Practitioners Disciplinary Tribunal

SCHEDULE

CHARGE AS AMENDED

Pursuant to section 81(2) and 91 of the Act, the Committee charges Dr E, registered medical practitioner, acted inappropriately and/or contrary to acceptable medical practice in that he:

Prescribing to Patient A

1. Prescribed Misoprostol (trade name Cyotec) and/or Mifepristone (trade name Mifegyne) to Patient A on [ ] January 2018, in circumstances where:

    a. the Misoprostol and/or Mifepristone was intended to procure an abortion; and/or

    b. the intended abortion had not been authorised by two certifying consultants as required by the Contraception, Sterilisation and Abortion Act 1977; and/or

    c. Dr E knew, or ought to have known, that Patient A was not intending to take the Misoprostol and/or Mifepristone on the premises of an institution licenced under the Contraception, Sterilisation and Abortion Act 1977;

2. Prior to prescribing Misoprostol and/or Mifepristone to Patient A on [ ] January 2018, Dr E failed to:

    a. ensure he had adequate knowledge of the medications prescribed; and/or

    b. ensure he had adequate knowledge of the requirements of the Contraception, Sterilisation and Abortion Act 1977; and/or

    c. undertake appropriate clinical assessment in regard to the pregnancy, including establishing the gestation of Patient A's pregnancy; and/or

    d. ensure Patient A planned to take the Misoprostol and/or Mifepristone on the premises of a licenced institution;

3. Failed to keep clear and/or accurate patient records in relation to his prescribing of Misoprostol and/or Mifepristone to Patient A and/or failed to sufficiently record in Patient A's patient notes what information was given to Patient A about the use of Misoprostol and/or Mifepristone to procure an abortion;

4. Dr E's prescribing in the circumstances described above was:

    a. contrary to the Council's Statement on Good Prescribing Practice;

b. contrary to the requirements of the Contraception, Sterilisation and Abortion Act 1977; and

c. contrary to the Guidelines for the Use of Mifepristone for Medical Abortions in New Zealand issued by the Abortion Supervisory Committee.

Prescribing to Patient B

5. Dr E prescribed 30 200mcg tablets of Misoprostol to Patient B on [ ] July 2017, in circumstances where Patient B was pregnant and intended to seek a termination of the pregnancy.

6. Prior to prescribing Misoprostol to Patient B on [ ] July 2017, Dr E failed to:

    a. ensure he had adequate knowledge of the medications prescribed and/or the treatment they were intended for; and/or

    b. undertake appropriate clinical assessment in regard to the pregnancy, including the gestation of Patient B's pregnancy;

7. Failed to keep clear and/or complete patient records in relation to his prescribing of Misoprostol to Patient B;

8. Dr E's prescribing of Misoprostol to Patient B on [ ] July 2017 was inappropriate, as:

    a. Dr E knew, or ought to have known, that the dosage of Misoprostol exceeded the recommended dose of 400mcg; and/or

    b. Dr E prescribed Misoprostol in combination with Primolut, which is inappropriate for the treatment of terminating a pregnancy which Patient B intended to seek;

9. Dr E's prescribing in the circumstances described above was:

    a. contrary to the Council's Statement on Good Prescribing Practice; and/or

    b. contrary to accepted medical practice

The conduct alleged in particulars 1-9 separately and/or cumulatively amounts to professional misconduct under section 100(1)(a) and/or (b) of the Act.