NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

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HPDT	**1089/Med19/454P**
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** **Applicant**
AND	**DR N**, registered medical practitioner, of X **Practitioner**

HEARING held by video conference on 25 March 2020

TRIBUNAL:	Mr D M Carden (Chair) Dr B Howcroft, Dr A MacDiarmid, Dr I Stewart, and Ms D Fenton (Members) Ms K Davies (Executive Officer)
APPEARANCES:	Ms A Miller and Ms A Lane for the Professional Conduct Committee Mr H Waalkens QC and Ms S Beattie for the practitioner

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Introduction

[1] Mr N is a registered medical practitioner, practising as a consultant and orthopaedic surgeon. Investigations into his conduct were undertaken by a Professional Conduct Committee (PCC) of the Medical Council of New Zealand (the MCNZ).

[2] A charge of professional misconduct with various particulars was laid against Mr N and has since been amended. The amended Charge (with all Appendices omitted) is set out in the Schedule to this decision.

[3] The particulars of the Charge essentially referred to Mr N's

a) having prescribed medications including drugs of dependence, drugs of abuse and/or controlled drugs for his own use,

b) having written prescriptions for his [6 family members] all including drugs of dependence or controlled drugs or drugs of abuse;

c) having failed to document adequately treatment or medications prescribed to family members;

d) having failed to disclose or having mislead the MCNZ in two applications for Annual Practising Certificate (APC);

e) having mislead or attempted to mislead the MCNZ as to the extent of his addiction issues in representations made to it in 2017; and

f) having requested alterations to his medical records when these were requested by the PCC.

[4] The Charge has been heard by the Tribunal by audio/visual conference hearing facility (during the 2020 Covid-19 lockdown crisis). Both parties were represented by counsel.

The hearing

[5] Because of restrictions imposed during the Covid-19 lockdown the hearing was conducted by audio/visual link where members of the Tribunal and support personnel, counsel for the parties, and Mr N and a witness for him participated as required.

[6] There was presented to the Tribunal an Amended Agreed Summary of Facts and the PCC relied on this in support of the Charge as amended. There was also produced an agreed bundle of documents and a supplementary agreed bundle of

documents (the bundle) which was accepted on the basis that had been directed following a preliminary 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

[7] The bundle largely comprised MCNZ statements, New Zealand Datasheets, Ministry of Health prescribing Data, certain correspondence, copies of the applications for APC to which the Charge referred, various medical records for the respective family members, and certain reports. To the extent these were referred to by counsel or the evidence these have been taken into account also by the Tribunal.

[8] Mr N did not give evidence in opposition to the Charge. The amended Agreed Summary of Facts includes certain admissions by him along with admission of the disciplinary Charge as amended and that his conduct amounts to professional misconduct deserving disciplinary sanction. Mr N did give evidence himself in the context of any penalty order to be made and called evidence from Dr Andrew Connolly, a professional colleague, and produced certain statements. Those are referred to below in the context of penalty discussion. Certain factual matters in the evidence of Mr N are also taken into account in the context of consideration of the Charge.

Background

[9] Having obtained his appropriate qualifications, Mr N was registered with the MCNZ in [ ] and has become vocationally registered in the orthopaedic surgery scope of practice in which he has practised since [ ].

[10] Mr N had a tooth extraction and root canal in [ ] which caused him left-sided neuralgic pain and facial pain. He was seen by an otolaryngologist on [ ] November 2007 for pain which was recorded as having generally improved with Voltaren.

[11] From [ ] Mr N developed an alcohol and drug addiction which he addressed by voluntarily attending [Clinic] (also referred to in the documents as [Clinic]) for four weeks and attending Narcotics Anonymous. In [ ] he stopped attending Narcotics Anonymous and in about [ ] he started taking oxycodone again. He developed a tolerance to this and became physiologically dependent.

[12] Mr N had issues with substance dependence and from mid – [ ] was taking oxycodone daily. In [ ] Mr N was voluntarily admitted for addiction treatment at [Private Hospital]. He was discharged on [ ], the patient progress notes having recorded his drug use and addiction.

[13] Mr N's discharge plan when he left [Private Hospital] involved his being monitored by a general practitioner and Dr R agreed to undertake that role, after he was telephoned by Dr T from [Private Hospital] to explain Mr N's history and situation. Mr N enrolled with Dr R at X Medical Centre on [ ] when hair testing kits were ordered for Mr N to test his sobriety. Dr R never conducted a hair test on Mr N as he was told by Mr N that he was engaged in Narcotics Anonymous meetings and was well supported and that [EN] was the best tool for assessing whether he had relapsed.

[14] Mr N continued to have ongoing contact with Dr R although this was an informal arrangement. During this period, between June 2006 and June 2017 Mr N prescribed certain medications for his own use on 76 occasions as set out in Appendix A to the Charge (not transcribed in this decision).

[15] Also, between August 2005 and August 2007 and then between June 2013 and April 2014 Mr N prescribed oxycodone as set out in Appendix B to the Charge (not transcribed in this decision). Some of these prescriptions are acknowledged by Mr N to have been for his own use although it is not possible to identify precisely which ones.

[16] Also during relevant periods Mr N prescribed various drugs for family members as set out in the Appendices to the Charge (not transcribed in this decision). These included:

a) Between 28 August 2013 and 30 June 2017 48 prescriptions for [Mrs EN], which included medicines with a risk of addiction and alprazolam (Xanax), a psychotropic medication.

b) Between 10 June 2012 and 21 May 2017 59 prescriptions for [RN].

c) Between 19 January 2011 and 23 May 2017 12 prescriptions for [IN].

d) Between 2 January 2015 and 21 May 2017 16 prescriptions for [ON].

e) Between 8 November 2011 and 8 June 2017 15 prescriptions for [Mrs LN].

f) Between 23 June 2010 and 31 August 2016 6 prescriptions for [TN].

Details of those family prescriptions and background are the subject of particulars 4 – 9 discussed below.

[17] Mr N did not document the treatment provided to his family or record the medicines prescribed for them and this is the subject of particular 10 below.

[18] In his respective applications for Annual Practising Certificate completed 23 May 2008 and 4 June 2014 there were questions raised concerning mental or physical conditions. Mr N ticked the "*no*" entry in the 23 May 2008 application but did not answer the relevant question in the 24 June 2014 application. These are the subject of particulars 11 and 12 below.

[19] In the course of its investigation into prescribing practices by Mr N, the MCNZ wrote to Mr N on 10 August 2017 and again on 1 September 2017. Mr N replied to those letters with certain submissions. Mr N has acknowledged that he misled the MCNZ in those submissions concerning the extent of his addictions issues. That forms the subject of particular 13 below.

[20] Further in the course of inquiry the PCC wrote to Mr N's own general practitioner, Dr R, requesting medical records for Mr N from him. Around 12 February 2018 Mr N telephoned Dr R requesting that he remove from Mr N's notes the record he had made of Dr T's name and contact details. That is the subject of particular 15 below.

The Charge: discussion

[21] The submissions for the PCC referred to general principles; certain guides from the MCNZ including *Good Medical Practice* of various editions, *Good Prescribing Practice* (various editions), *Statement on Providing Care to Yourself and Those Close to You* (various editions) and *Maintenance and Retention of Patient Records*. It referred to various other decisions of the Tribunal in the context of relevant issues namely self-prescribing, prescribing to family members, failure to document treatment, and failure to disclose health issues addictions. The individual particulars of the Charge were then addressed.

[22] The PCC relied on the amended Agreed Summary of Facts and the acknowledgements in those by Mr N of the facts contained in that document and that his conduct was contrary to his professional obligations and amounted to professional misconduct under both section 100(1)(a) and (b) of the HPCA Act deserving disciplinary sanction.

[23] For his part, as noted above, Mr N did adduce evidence in the context of penalty, but that evidence does refer to certain factors concerning liability for the Charge. The submissions on his behalf discussed whether certain of the particulars separately warranted disciplinary sanction but urged that the Charge and its particulars be considered as a whole with Mr N's acknowledgement that cumulatively his professional misconduct did warrant disciplinary sanction.

[24] 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.

[25] 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.

[26] 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.[1]

[27] 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

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1 *Collie v Nursing Council of New Zealand;* [2001] NZAR 74 at [28].

sanction for the purpose of maintaining standards, protecting the public, or punishing the practitioner.[2]

[28] 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.

[29] The Tribunal finds the Charge is made out. The individual particulars are considered below.

Particulars 1 and 2: self-prescribing including oxycodone hydrochloride

[30] The evidence is clear that Mr N did prescribe for himself and his own use the drugs of dependence, drugs of abuse and controlled drugs on the occasions set out in Appendix A of the Charge and that he wrote prescriptions for oxycodone hydrochloride, a drug of dependence and/or abuse, some of which were for his own use on some of the occasions set out at Appendix B to the Charge.

[31] There are 76 occasions listed of medications self-prescribed by Mr N in Appendix A between 18 June 2006 and 12 June 2017. The Agreed Summary of Facts included an acknowledgment by Mr N that this included prescriptions for:

a) on 6 occasions over an 11-year period, codeine phosphate (a drug of dependence and/or drug of abuse);

b) on 6 occasions over an 11-year period, tramadol hydrochloride (a drug of dependence and/or drug of abuse and a controlled drug);

c) on 1 occasion in 2006 citalopram hydrobromide (a psychotropic medication); and

d) propranolol (a psychotropic medication)(although the Tribunal doubts this is a correct description, propranolol being rather a beta blocker).

[32] There are 74 occasions listed in Appendix B when Mr N prescribed oxycodone in a period between 24 August 2005 and 17 April 2014. The parties were agreed that it was not possible to identify the recipients of those prescriptions but there is the admission by Mr N that some must have been for his own use.

[33] The submissions for the PCC referred to documents in the agreed bundle evidencing the self-prescribing by Mr N. The submission was made that

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[2] *PCC v Nuttall;* 8/Med04/03P.

throughout the period Mr N, as a medical practitioner, should have avoided writing prescriptions for himself as this was contrary to the principles enunciated by the MCNZ. The left-side facial neuralgia which developed as a result of dental misadventure in the 1990s was, it was submitted, of little relevance because Mr N's medical records showed that he was never prescribed pain medication for his tooth pain and headaches over the period of the amended Charge.

[34] It was further submitted that Mr N had appropriate care available to him and did not avail himself of that care. The records show that Mr N saw Dr Y, otolaryngologist, for this very issue on [ ] November 2007. Dr Y referred Mr N for further opinion but there is no evidence that Mr N ever saw the referee for that opinion.

[35] Attention was also drawn by the PCC to an email from Dr Y which includes reference to Dr Y's having a Pain Medicine Fellowship and it was submitted he was well-placed to treat Mr N's facial pain and headaches.

[36] The PCC submitted, and the Tribunal accepts, that those records show that Mr N was almost certainly self-prescribing out of convenience which is in direct contravention of his obligations under the MCNZ guidelines. This shows a disregard by Mr N of his obligations under those guidelines. He had the opportunity to obtain appropriate care from other medical practitioners and did not do so. As to self-prescription of the controlled drug Tramadol the PCC made reference to *Dr Craig*[3] and the very serious breach of professional obligations where doctors abuse their rights to prescribe controlled drugs by doing so for themselves.

[37] The background for Mr N and his use of medications to which this Charge refers are mentioned above.

[38] Over the period of time to which those particulars relate there have been various editions of the MCNZ guideline *Good Medical Practice*. The June 2008 edition includes:

> *"Make sure you register with an independent general practitioner so that you have access to objective medical care. Do not treat yourself.*"

[3] 844/Med 16/348P.

[39] The April 2013 and December 2016 editions provided similarly but rather provide "*You should not treat yourself*". The MCNZ publication "*Good Prescribing Practice"* in both the 2010 and 2016 editions state:

> *"Avoid writing prescriptions for yourself or for those with whom you have a close personal relationship. It is never appropriate to prescribe or administer drugs of dependence or psychotropic medication to yourself or someone close to you*."

There is similar provision in the MCNZ "*Statement on Providing Care to Yourself and Those Close to You"*.

[40] The PCC referred the Tribunal to two previous decisions of the Tribunal namely *Dr A*[4], a case of a doctor who wrote prescriptions in her own name and in the names of family members for supply of prescription medicines for her own use. A finding of professional misconduct was made by the Tribunal, the Tribunal noting that, in respect of her prescribing for family members, the records of prescription for them would have been inaccurate and could have affected future treatment for them. In the context of her having consumed the drugs without adequate medical oversight, the Tribunal said:

> *"Dr A had her own general practitioner and had had prescriptions from that person for drugs that she needed including those in question in this Charge. The practitioner was overseeing her use of those drugs and health generally and for Dr A to have consumed the drugs without that practitioner's, or any other adequate independent, oversight, put her health at risk and in jeopardy. It also meant that the records that her own general practitioner was keeping as to her use of these drugs was inaccurate. Subsequent advice and prescription from her medical practitioner could have been inaccurate and jeopardised not only Dr A but also the professional reputation of her own doctor*."

Dr Craig[5]. This was a case of a doctor prescribing in the names of family and friends over a 15-month period and obtaining and consuming the medications without appropriate oversight. That case can be distinguished in the present instance where the consideration is as to Mr N having self-prescribed these medications.

[41] The statements of the MCNZ are guidelines and are not obligatory but they do form a framework for standards expected of medical practitioners. They are

[4] 1046/Med18/431P.
[5] 844Med16/348P.

promulgated by the MCNZ under section 118 of the HPCA Act which provides that the functions for that authority include setting standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners in the medical profession.

[42] The Tribunal notes how the wording of the appropriate guidelines has changed over the years, it only being the November 2016 edition of *Statement on Providing Care Yourself and Those Close to You* that uses the words "***must not***".

[43] The list of medications in Appendix A to the Charge is a long one with many entries including those occasions referred to in paragraph 31 above where there have been prescriptions of significant concern. As noted above, the Tribunal accepts the PCC submissions on the severity of this self-prescribing, including tramadol. In respect of the prescriptions to which Appendix B refers for oxycodone hydrochloride the parties have been unable to identify which of those prescriptions were for Mr N himself and his own use. Mr N admitted that he had issues with substance dependence and that from mid-2013 until April 2014 he was taking oxycodone daily that had not been prescribed for him by any other practitioner.

[44] The Tribunal finds particulars 1 and 2 established as malpractice on Mr N's part and conduct bringing discredit to his profession separately warranting disciplinary sanction.

Particulars 4 – 9: prescribing to family members

[45] The particulars of the Charge and the detail in the Appendices refer to various periods of time and various prescriptions for the respective members of Mr N's family [EN][ ].

[46] The PCC did not argue before the Tribunal that any of the prescribing for family members was in fact for Mr N's own use.

[47] The PCC relied again on the various editions of "*Good Medical Practice"* applicable in relevant periods and "*Statement on Providing Care to Yourself and Those Close to You"* applicable at relevant periods. The April 2013 and December 2016 editions of "*Good Medical Practice"* include:

> *"11 Other than in exceptional circumstances you should not provide medical care to yourself or anyone with whom you have a close personal relationship.*"

[48] The June 2008, April 2013 and December 2016 editions include:

> *"You may prescribe drugs of treatment, including repeat prescriptions, only when you:*
> *- have adequate knowledge of the patient's health.*
> *- are satisfied that the drugs or treatment are in the patient's best interests.*"

[49] The 2006 and 2007 edition of "*Statement on Providing Care to Yourself and Those Close to You"* include:

> "*05 The following are specific situations when treating yourself, family members, people you work with and friends* ***should be avoided****:*
> *- Prescribing or administering drugs of dependence.*
> *- Prescribing psychotropic medication.*
> *- Undertaking psychotherapy…*
> *06 It is also inappropriate to provide care to yourself and those close to you in the majority of other clinical situations*."

(emphasis added)

[50] The June 2013 edition refers to monitoring by an independent practitioner and that wherever possible, doctors should avoid treating people with whom they have a personal relationship.

[51] The November 2016 edition is more explicit including:

> "*You* ***must not*** *treat yourself, family members or those close to you [in certain situations relevant here]* (emphasis in original text)".

[52] There are exceptions provided for relating to emergencies and urgent situations but those do not apply here.

[53] In his evidence Mr N said:

> "*I now recognise, and have for some considerable time, that in doing so* [writing prescriptions for his family] *I failed to observe the boundaries between being a doctor and being a husband, father and son. I accept that I exercised poor judgement and lacked insight into what I was doing. I did so because I was struggling myself to cope through these challenging and distressing times.*"

Prescribing for EN – Particular 4

[54] The 48 prescriptions Mr N wrote for [ ][EN] set out in Appendix D to the Charge included prescriptions of the following drugs of dependence, drugs of abuse or controlled drugs:

a) On 2 occasions, oxycodone hydrochloride;

b) On 6 occasions paracetamol with codeine (although the total in the Schedule is in fact 7);

c) On 6 occasions tramadol hydrochloride; and

d) On 13 occasions alprazolam (Xanax).

[55] The PCC referred to four decisions of the tribunal[6]. Those have been considered.

[56] The submissions for the PCC included:

a) With reference to any suggestion that the prescribing was in relation to various medical conditions and injuries for family members the extract from the appeal decision for *Dr Emmerson*: "*whether the prescriptions were justified clinically is beside the point.*"

b) Emphasis on the scale of prescribing, a total of 156 prescriptions over a period of 7 years; and the nature of the medications prescribed, namely controlled drugs, drugs of dependency and psychotropic drugs. That was, it was submitted, sufficient to rebut any argument that Mr N's conduct could be excused on the basis that it was clinically justified and served to emphasise why it was important that independent objective practitioners were responsible for his family members' care.

[57] The PCC drew attention to the range of medication prescribed by Mr N for [EN] that her own general practitioner had never prescribed her, including:

a) Drugs of dependence and drugs of abuse (oxycodone, paracetamol with codeine, tramadol and alprazolam).

b) Psychotropic drugs (alprazolam).

c) Salbutamol (Ventolin).

d) Diclofenac.

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[6] *Dr N;* 900/Med16/369P (on appeal *A v PCC* [2018] NZHC 1623; *Dr E;* 136/Med07/76D; *Dr M* 941/Med17/382P and *Dr Emmerson;* 887/Med16/358P (on appeal *Emmerson v PCC* [2017] NZHC 2847).

[58] It submitted that it was especially dangerous for Mr N to have prescribed these medications in circumstances where [EN] had not received them before or been properly assessed by an independent medical practitioner to determine whether they were appropriate and safe for her use.

[59] The explanation in the Agreed Summary of Facts and Mr N's affidavit referred to the consultation on [ ] November 2014 that [EN] had had with an orthopaedic surgeon about her feet and the subsequent treatment she had had for this. The PCC submitted, however, that, because [EN] was under the care of another orthopaedic surgeon, there was no clinical need for Mr N to prescribe her pain relief. Attention was drawn to the medications for pain relief prescribed by Mr N for [EN] after the consultation on 22 July 2015 with a specialist concerning her foot. [EN] was regularly reviewed by the orthopaedic surgeon specialist but Mr N nonetheless prescribed pain relief for her both immediately before and after those appointments which the PCC submitted

> "*demonstrated a laissez faire attitude to providing care for [EN] based on convenience rather than proper clinical management."*

[60] There was also mention of the stress and medical condition for [EN] arising from the condition of, and care for [RN]. Mr N referred to discussion he had had with [EN] that she had taken some of RN's medication to help her sleep. Mr N said that he subsequently provided [EN] with Xanax on occasions and this made her life (and as a consequence their lives together) much more bearable. Mr N said that, "*in the context of the chaos, despair and dysfunction in [their] family, [he] did not think through the potential consequences of this*" and said he felt desperate to help [EN] and did what he could to try to help the family situation.

[61] The Tribunal accepts the submissions of the PCC concerning the context of Mr N's prescribing as is articulated in the particulars of the Charge for [EN]. He may have had some concerns about her foot issues, but these were being seemingly adequately dealt with by the orthopaedic surgeon she was consulting and there was no need for Mr N independently to prescribe the medications for [EN] that he did. Despite the stresses from the situation concerning [RN], and the stress and pressure this placed on [EN], it was inappropriate for Mr N to be prescribing for her the medications that he did to the extent that he did.

[62] As is noted in the other cases there needs to be an objective assessment of a person's needs for medication and it is significantly unlikely that Mr N would have had the necessary objectivity in considering [EN]'s position and need for the medications that he prescribed. That would likely have been aggravated by his own stress and pressure concerning, [RN], such that his objectivity in relation to prescribing for [EN] was impaired.

[63] The Tribunal finds this particular of the Charge made out as malpractice on Mr N's part in the scope of his practice and as conduct which brought discredit to his profession and separately warrants disciplinary sanction.

Prescribing for RN – Particular 5

[64] Appendix E to the Charge lists 59 occasions between 10 June 2012 and 21 May 2017 when Mr N prescribed medications for [RN], Mr N gave significant evidence to the Tribunal concerning [RN]'s condition and history and the medications and treatment she had been receiving for this. The Tribunal has considered this evidence carefully and compassionately and has significant sympathy for Mr N, [EN], and other members of the family in relation to the situation they were in with RN and her needs.

[65] One stage of this long journey was described by Mr N as "*living in a black tunnel where there was no glimmer of light*". Mr N said that in 2016 he and [EN] "*gave up on New Zealand's mental health services*" and had RN admitted to a hospital in the [ ]. Mr N spoke very highly of the care she received there and the skill, compassion, and empathy that the specialists had for her. Following treatment, RN returned with [ ] to New Zealand but required follow-up treatments for a period of 18 months as prescribed.

[66] Mr N described that his prescribing for RN was undertaken out of what he believed at the time to be a necessity. Although there were repeat scripts available, the administration of the drug, Xanax, as well as other medication was, he said, left up to him to use on an "*as she needed*" basis . Mr N's evidence referred to RN's having destroyed drugs, not only those for her but also others for members of the family. He said that he wrote repeat scripts for these medications "*knowing that they were the key to allowing [RN] to live.*"

[67] Submissions for the PCC analysed medical records in support of a submission that RN's general practitioner declined to provide a prescription for a

medication that had not previously prescribed to her without first conducting an assessment and said that this was a clear example of Mr N prescribing for convenience rather than allowing time for that consultation with a general practitioner and assessment. That put RN at risk, it was submitted, because her medication needs were not subject to ongoing reassessment.

[68] Attention was drawn to the fact that many of the medications prescribed by Mr N for RN were psychotropic drugs and it was submitted that these could not be seen as falling within the scope of practice of an orthopaedic surgeon.

[69] Taking into account the guidance from the MCNZ guidelines and other decisions of this Tribunal, the Tribunal concludes that there has been malpractice on Mr N's part in prescribing for [RN], over the period and to the extent that he did. Having regard, however, to the circumstances of that prescribing, the Tribunal concludes that this does not separately warrant disciplinary sanction but does warrant such sanction cumulatively with other charges and particulars.

Prescribing for IN – Particular 6

[70] Appendix F to the Charge lists 12 occasions between 19 January 2011 and 23 May 2017 when Mr N prescribed various medications to , [IN]. The PCC submitted that the evidence showed that Mr N had prescribed for IN out of convenience. He prescribed Tramadol for her on 10 November 2015 while she was an inpatient in hospital and the submission from the PCC was that it could not be sensibly said that it was not possible for IN's treating doctors to attend to her pain while she was an inpatient in the hospital. Morphine sulphate tablets were prescribed for her when, it was said, she would still have had the tablets she received on discharge from hospital, with detail been given by the PCC in its submissions.

[71] The written submissions for the PCC included that it was open to the Tribunal to infer that Mr N's prescription of morphine sulphate for IN on 22 November 2015 was not for the purpose of helping her manage her pain until she could be reviewed. In his evidence Mr N said that that was not correct and that the prescribing was to manage IN's pain. Mr N elaborated on that issue in his evidence, referring to an operation that IN had had when aged 14 in 2015 and significant pain at the surgical site that developed outside working hours. He

gave her some scripts to help her get through that pain. That may deal with the prescriptions around that time but does not explain other prescriptions (in August 2016 in February 2017) for paracetamol with codeine.

[72] The Tribunal finds that Mr N's prescribing for , [IN], was, on the basis of the relevant applicable guides and by comparison to other cases, malpractice on his part and conduct bringing discredit to his profession. Taking account of the explanation that Mr N offered concerning the November 2015 prescriptions, the Tribunal nevertheless finds that this warrants disciplinary sanction separately and cumulatively with other particulars. There are too many other occasions of prescribing not explained by Mr N for this to be treated cumulatively only.

Prescribing to ON – Particular 7

[73] Appendix G to the Charge has 16 entries between 2 January 2015 and 21 May 2017 of prescriptions by Mr N for, [ON]. These include on one occasion codeine phosphate, on three occasions paracetamol with codeine and on three occasions Tramadol hydrochloride.

[74] The parties agreed that ON had sustained several injuries playing football over the 2015 and 2016 seasons and on [ ] 2017 he underwent ankle reconstruction surgery and was prescribed Tramadol by his then orthopaedic surgeon following this surgery.

[75] It is the case for the PCC that Mr N should not have prescribed medication to ON regardless of his role as [ ] at the football club where ON played. This prescribing did not come within any exception for emergency situations. In his evidence Mr N referred to those matters as mentioned in the amended Agreed Summary of Facts.

[76] The Tribunal finds that, based on the principles enunciated in the guidelines and by comparison to other cases, there was malpractice on Mr N's part in prescribing for [ON], as alleged in the Charge and that this was conduct bringing discredit to his profession. The circumstances of his prescribing as [ ] to the football club for [ON], is not an excuse for that having happened and this conduct separately and cumulatively warrants disciplinary sanction.

Prescribing for LN – Particular 8

[77] Appendix H lists 15 occasions between 8 November 2011 and 8 June 2017 when Mr N prescribed medications for [LN]. These included Tramadol hydrochloride, a drug of dependence and/or abuse.

[78] [LN] had [ ] and a history of back pain, having had spinal surgery in [ ] and revision spinal surgery in [ ]. In May [ ] she developed [ ].

[79] The submissions for the PCC referred to three occasions when Mr N prescribed medication for her on the same day as, or within a short period after, she had been prescribed the medications from a general practitioner. It was submitted that prescribing the same medications on the same day highlighted the importance of coordinated care and good clinical records with the double up showing a genuine risk of harm to [LN] associated with Mr N's prescribing.

[80] The submissions also made an analysis of the records to demonstrate, it was submitted, that [LN] was proactive and regularly telephoned her general practitioner for repeat prescriptions; and that it was clear that there was no need for Mr N to provide prescriptions for her.

[81] In his evidence Mr N referred to [LN's] medical condition and said that

> "*factors such as immobility and difficulty in getting to hospital meant that, as an interim measure, [he] would provide [his mother and father] with scripts for medicine that had previously been prescribed or that would alleviate immediate pain and suffering.*"

[82] Having regard to the proximity in time between Mr N's prescribing and [ ] having had prescriptions from her general practitioner, the Tribunal does not accept those reasons for his prescribing for [LN]. There was no need for him to do so. His doing so created confusion and the potential of risk for [LN] in that her general practitioner did not know, and had no record, of what was prescribed for her and could not make future decisions based on an accurate factual position.

[83] Mr N referred to some of the scripts for [ ] and other family members as being for over-the-counter medicines obtainable without needing a prescription. That does not excuse that process and especially does not refer to those medications which do need prescription.

[84] Having regard to the principles enunciated in the guidelines and the other cases mentioned, the Tribunal finds that there is malpractice on Mr N's part in this prescribing for [ ] and, having regard to the length of the period and quantity,

and the drugs in question having included Tramadol hydrochloride, this separately warrants disciplinary sanction and cumulatively with the other particulars.

Prescribing for TN – Particular 9

[85] Appendix I to the amended Charge lists 6 occasions between 23 June 2010 and 31 August 2016 when Mr N wrote prescriptions for [TN] including on one occasion each for codeine phosphate and Tramadol hydrochloride, drugs of dependence and/or abuse and/or controlled drugs.

[86] Mr N's evidence, as noted above, referred to the immobility and difficulty of getting to hospital for [ ].

[87] The submissions for the PCC acknowledged that this prescribing did not have the same concerning features as for other family members but was nevertheless a clear departure from obligation not to prescribe for family members.

[88] The Tribunal accepts that there has been malpractice by Mr N in the scope of his practice and conduct bringing discredit to his profession but that this does not separately warrant disciplinary sanction; but cumulatively with other particulars does warrant such sanction.

Particular 10: failure to document treatment

[89] This particular refers to Mr N's failure to document, or adequately to document, the treatment and/or medications prescribed to family members as listed in paragraphs 4 – 9. There was a total lack of clinical records for all of this prescribing for all of his family members.

[90] In the amended Agreed Summary of Facts Mr N acknowledged that he had a professional responsibility to keep contemporaneous, accurate and legible records of treatment provided to his family members and any medicines prescribed to them. He admitted that he did not document the treatment provided and says that he was aware that the records on prescriptions dispensed by pharmacies were available to authorised healthcare providers and so would have been visible to the respective general practitioners of the family members.

[91] It was said that Mr N says that he did not attempt to conceal the prescriptions he had written for his family; and there is no evidence adduced by the PCC to the contrary. Mr N admits that this conduct was contrary to his professional

obligations and did not comply with *Good Medical Practice*, the MCNZ *Statement on Maintenance and Retention of Patient Records* and *Good Prescribing Practice*.

[92] The PCC submitted that by those admitted actions, Mr N had failed to keep contemporaneous, accurate and legible records; and that it was crucial to proper care to have adequate notes that allow both the practitioner and any other medical practitioner dealing with the same patient to have a contemporaneous record.

[93] Reliance was placed on the Tribunal decisions *Dr E*,[7] *Williams*[8] and *Dr N*.[9] In particular reference was made to the following paragraphs from *Williams*:

> *"68. Notes must be kept comprehensively. This enables the medical practitioner himself or herself to accurately recall earlier detailed consultation rather than rely on memory. It enables any other medical practitioner dealing with the same patient, as appears to have often been the case in this practice, to have a comprehensive record of what had transpired at any relevant consultation*".
>
> *216. The adequacy of note-taking matters are alleged in the context of the primary allegation of inappropriate prescribing. The notes simply do not paint nearly a clear enough picture of consideration of previous patient history, features supporting the diagnosis, any comprehensive treatment plan, any changes to that plan and the reasons for those changes, or other reason for the continued prescription of this potent topical corticosteroid. Of themselves the inadequacies in the note-taking warrant disciplinary sanction*".

[94] Emphasis was especially placed on:

a) The prescriptions provided by Mr N for RN which were extensive but unknown to her primary medical practitioner.

b) The overlap and double up between the care Mr N provided to his mother, Mrs LN, where her general practitioners were unaware of his prescribing.

[95] Mr N did not comment on this in his evidence nor was it expressly addressed in submissions.

[96] The Tribunal finds there has been a breach of standards by Mr N in relation to his obligation to keep contemporaneous, accurate and legible records of

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[7] 136/Med07/76D.
[8] 909/Med16/371P.
[9] 543/Med12/224P.

treatment provided and medications prescribed. These are the standards required by the guidelines from the MCNZ. There are extensive medications prescribed by Mr N for his family members. Many of them are medicines with a risk of addiction, psychotropic medications and/or drugs of dependence and/or abuse.

[97] It is important for any person for whom medicines are prescribed that there be an accurate record of the amount prescribed and the reasons behind this. This not only helps the person prescribing to keep an accurate record of what is done and why; but, where there is another general practitioner normally advising the patient/member of the family, it is important that that practitioner knows the situation for future diagnosis and prescription. This is emphasised in the extract from the Tribunal decision in *Williams* referred to above.

[98] The Tribunal finds that this is malpractice on Mr N's part in the scope of his practice and is conduct bringing discredit to his profession. It separately warrants disciplinary sanction and cumulatively with other charges.

Particulars 11 and 12: failure to disclose health issues addictions

[99] In each of the respective Applications for Practising Certificates dated 23 May 2008 and 4 June 2014 there were questions concerning Mr N's having been affected by a mental or physical condition. The text of each is set out in full in the Charge. The forms in each case required a "*yes/no*" response with further detail if "*yes*" were checked.

[100] In the first, that dated 23 May 2008 Mr N checked the "*no*" response to that question and that is the subject of particular 11. In respect of the second, that dated 4 June 2014, Mr N did not check either response; and indeed there are many other questions in the copy application form provided to the Tribunal where there does not seem to have been a response from Mr N either way. The failure to disclose forms the subject of particular 12.

[101] The submissions for the PCC referred to the case of *Dr U*[10] where the doctor had completed five applications for an APC incorrectly but defended the charge against her in that regard on the basis that her conduct did not bring discredit to her profession or was not sufficiently serious to warrant disciplinary sanction.

[10] 699/Med14/298P.

The Tribunal found that there was malpractice on her part warranting disciplinary sanction.

[102] The case of *Harrison*[11] involved a charge which included having made a false declaration in a nurse's application for an APC in the years following two criminal convictions (one for assault and one for drink-driving). As to the drink-driving conviction the nurse admitted that she knew that she had been convicted and that she should declare it and that particular of the charge was found made out separately warranting disciplinary sanction.

[103] The Agreed Summary of Facts referred to the background to these failures to disclose and to Mr N's drug and alcohol dependence issues at the time, the medications he had been receiving and the treatments he had received at [Clinic] and at the [Private Hospital].

[104] As to the 23 May 2008 application for the period 1 June 2008 to 31 May 2009 Mr N acknowledged that he ticked the "*no*" and completed section 9 declaring that the information given in the form was true and correct.

[105] Prior to that, the Agreed Summary of Facts said, [EN] had anonymously telephoned the MCNZ seeking advice regarding substance abuse on the part of a medical practitioner. Her call was returned by Dr Pat Alley, at the time a member of the Doctors' Health Advisory Service. [EN] told Dr Alley anonymously that [ ] had an alcohol reliance issue and was due to go into treatment for this. She asked if he should advise the MCNZ and, the Summary of Facts says, Dr Alley told her words to the effect that "*provided the doctor was being proactive and recognised that they had an issue to address then there was no need for this*". Dr Alley does not recall the details of the telephone conversation but it is agreed between the parties that he was able to confirm that this was entirely consistent with the approach he would have taken on hearing the information that [EN] had relayed.

[106] In his statement of evidence in support of penalty issues Mr N said that he did seek advice on both occasions of disclosure of substance dependence and in each instance was advised that it was not necessary to notify the MCNZ. He referred to the discussion that his wife had had with Dr Alley and said this was "*prior to [his] entry to [Clinic] in 2007*." Because of the response from Dr

[11] 867/Nur16/364P.

Alley to Mrs N's inquiry Mr N did not, he said, advise the MCNZ on his 2008 application for APC. He said that, while in retrospect he should have made this declaration, at the time he thought he was doing the right thing in following this advice.

[107] In relation to the June 2014 Application for the period 1 June 2014 to 31 May 2015 the Agreed Summary of Facts confirms that Mr N failed to disclose any addiction issues by not answering the question in section 7(d). Mr N does not refer to this expressly in his statement of evidence other than impliedly in reliance on the discussion that his wife had had with Dr Alley.

[108] Mr N admitted that at the time of the two applications he knew he had been affected by an addiction (drug and/or alcohol) disorder and that he did not disclose this to the MCNZ in either application.

[109] He admitted that the conduct was contrary to his professional obligation to make a true declaration on his APC application forms and to be honest in his dealing with the MCNZ.

[110] The Tribunal finds these two particulars of the Charge each made out. It accepts that there was the discussion between [EN] and Dr Alley. That was, however, in the context of ongoing practice during the then practising year and in the context of treatments that Mr N had received, particularly at the [Clinic].

[111] The Tribunal views that as different from the circumstance of completing an application for APC where there is an ongoing obligating for complete disclosure. The MCNZ, as registration authority, it is entitled, and obliged, to know the detail of any factor that may be relevant to the discharge by a medical practitioner of his or her professional responsibilities. It is for the MCNZ to assess whether what is disclosed impacts upon relevant considerations; and the obligation is on each practitioner for full disclosure.

[112] Had there been full disclosure by Mr N in the respective forms, then it was open to the MCNZ to inquire further into the matter. The forms provided that if the "*yes*" box had been checked, information in strict confidence detailing the condition, the duration of any treatment, name and contact details of a treating practitioner, or involvement of university/medical school/employer was sought along with consent to the MCNZ Health Manager contacting the treating practitioner for further information.

[113] If that consent were not given, the form said that there may be a delay issuing the APC while advice was obtained from the MCNZ Health Committee.

[114] Those processes left it quite open to Mr N as the applicant for APC to provide appropriate information and be completely open to the MCNZ to make its inquiries about impact of health issues, which included drug or alcohol addiction disorders, before deciding whether or not to issue an APC to him.

[115] As to the 2014 form, the same consideration applied but the copy form provided to the Tribunal indicated, and this is confirmed by the Agreed Summary of Facts, that there was no completion of question Disclosure 7(d). Indeed there was apparently no completion of any of the disclosures in section 7 or other sections of the form; and some responsibility must lie with the MCNZ for having processed the application in the absence of any response to those disclosure and other questions.

[116] The basic obligation remains, however, that it was up to Mr N as the applicant for an APC to disclose in an open and frank way all issues relevant to his request for continued permission to practise as a medical practitioner and he failed to do so.

[117] Taking into account the principles enunciated in the relevant guides from the MCNZ and other cases on this issue, the Tribunal finds that each of these particulars is made out as malpractice on Mr N's part and as conduct bringing discredit to his profession, each separately from each other and from other particulars, warranting disciplinary sanction.

Particulars 13 and 15: misleading the MCNZ and/or obstructing the PCC

[118] Particular 13 refers to submissions made by Mr N to the MCNZ dated respectively 22 August 2017 and 13 September 2017 referring to his having suffered from an addiction to pain relief and/or opioids and to having recovered from that addiction within one calendar year between May 2013 and May 2014. Reference was made in the sub particulars to Mr N's knowledge or awareness that he had undergone treatment for addiction at the [Clinic] in [ ]; that he had undergone treatment for addiction at [Private Hospital] between [ ] and that, prior to treatment at the [Private Hospital], he had suffered a relapse of his addiction issue in the preceding one year period.

[119] In the Agreed Summary of Facts Mr N admitted that he had made representations in those written submissions to the effect that he had suffered an addiction to pain relief as alleged in the Charge. That included:

> "*I cannot now precisely recall the relevant period of my addiction, but whilst it was more than six months I do not believe it was more than a year.*"

[120] Mr N acknowledged that he was aware he had had previous issues with alcoholism and had received treatment at the [Clinic] in [ ] that he did not disclose in those written submissions. Mr N also admitted he did not disclose the extent of his addiction issues in his written submissions, he having undergone treatment for opioid addiction at the [Private Hospital] between [ ] which included medically assisted withdrawal from opioids, individual counselling, family counselling sessions, and the "*twelve step*" programme.

[121] Mr N acknowledged that prior to his treatment at the [Private Hospital] he had suffered a relapse of his addiction in the preceding year.

[122] He acknowledged his professional obligation to be open and honest with the MCNZ and that he had mislead the MCNZ as to the extent of his addiction issues in his written submissions.

[123] The PCC referred to the case of *Dr Emmerson*[12] where, on appeal, the High Court observed that the doctor having lied about methamphetamine use and maintained the lie as long as possible was an attempt to minimise her drug use, no doubt motivated by fear of consequence.

[124] It submitted that, in light of the relevant obligations and similar cases, Mr N's attempt to mislead the Council about the nature and extent of his addictions fell well short of the professional standards expected of medical practitioners which could not be characterised as a one-off lapse in judgment and deserved disciplinary sanction.

[125] There were no separate submissions on Mr N's behalf in respect of this particular other than the general submission that the particulars could be dealt with cumulatively and did not need individual separate finding as to disciplinary sanction.

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[12] 887/Med16/358P; on appeal [2017] NZHC 2847.

[126] Despite that, the Tribunal is of the view that a decision should be made on this particular. The Tribunal finds that there was malpractice on Mr N's part in his dealings with the MCNZ in the way alleged. He was making submissions to the MCNZ in response to its inquiries into certain matters raised in a letter dated 10 August 2017, a copy of which was not provided to the Tribunal. Mr N did refer to his having been prescribing to himself and to members of his family as set out in the attachments to a certain letter referred to and the Tribunal infers that these were matters to which the Charge refers. The elaborations by Mr N in his letter of submission of 22 August 2017 alluded to the same things as he has mentioned in his evidence to the Tribunal. The letter of 13 September 2017 was in fact addressed to the PCC, the committee appointed by the MCNZ, but nothing hinges on that difference. Again there other references in that letter which indicate that Mr N was addressing the matters to which the Charge refers.

[127] Whatever the reason for his advices, Mr N has failed to disclose, as he acknowledged in the Agreed Summary of Facts, the extent of his addiction issue or the extent of his relapse in the context of his consecutive treatments at the [Clinic] and the [Private Hospital].

[128] Any inquiry by the MCNZ as the registration authority, or by a professional conduct committee appointed by it to enquire into matters of concern, must be treated significantly seriously. Those inquiries call for complete accuracy and honesty in their responses from the practitioner. It is only if that happens that the MCNZ or the professional conduct committee can be properly and accurately informed about the matters on which it has to make decisions.

[129] Mr N failed to do that in this instance as he was required to do under the extract from *Good Medical Practice* to which the Tribunal was referred reading:[13]

> *"You must co-operate fully with any formal inquiry or inquest (although you have the right not to give evidence that may lead to criminal proceedings been taken against you). When you provide information you must be honest, accurate, objective and the information provided must be based on clear and relevant clinical evidence.*"

[130] In addition there is the obligation for medical practitioners to work cooperatively, and be honest open and constructive in their dealings, with the MCNZ.

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[13] Paragraph 59.

[131] The Tribunal finds there has been malpractice by Mr N in the scope of his practice and conduct bringing discredit to his profession in this respect and this particular separately warrants disciplinary sanction.

[132] The circumstances concerning particular 15 were that on 7 February 2018 the PCC requested Mr N's medical records from his general practitioner, Dr R. Around 12 February 2018 Mr N telephoned Dr R and requested that he remove from Mr N's notes a record that he had made of Dr T's name and email address. That was done on 12 February 2018 and Dr R acknowledged to the PCC that he had acceded to Mr N's request and deleted those details.

[133] The PCC relied on the provision in *Good Medical Practice* for full cooperation with any formal inquiry by the MCNZ and the further provision that doctors[14]

> "*must not withhold relevant information from any formal inquiry or inquest, or attempt to contact or influence complainants or witnesses except where directed by the relevant authority*".

[134] No separate submissions were made by counsel for Mr N in this respect other than the general one that this particular could be dealt with cumulatively with other particulars. In his statement of evidence Mr N said that he requested removal of that information from Dr R's files

> "*to protect information that [he] had been assured was private and confidential under [ ]law and here in New Zealand.*"

[135] He said he had been told on admission to the [Private Hospital] that his information and records would never be divulged to anyone unless he was under suspicion of having committed a criminal offence and that the [Private Hospital] file was so secure that, even when he asked [Private Hospital] himself to release it, the Hospital was extremely reluctant to do so and he had to pay a fee.

[136] Mr N accepted that he ought not to have asked Dr R to remove Dr T's details and he regretted doing so.

[137] The Tribunal does not accept Mr N's position on this matter. Although he was not under suspicion of having committed a criminal offence, he must have known that information that might have come from Dr T and the [Private Hospital] could have been prejudicial to the investigation on him by the PCC. Otherwise, he would not have requested removal of those details. In making

[14] Paragraph 60.

that request Mr N was trying to withhold information that would have been material to the inquiries that the PCC was making and would have inhibited those legitimate inquiries into his behaviour.

[138] This was in the context of an inquiry by a professional conduct committee appointed by the registration authority responsible for him, the MCNZ. Mr N had a responsibility to fully comply with the inquiries made for the reasons mentioned above, namely so that a fully informed decision could be made by it.

[139] The Tribunal finds that there has been malpractice on Mr N's part in his scope of practice and conduct on his part which brings discredit to his profession separately warranting disciplinary sanction to maintain standards and protect the public. It rejects the submission on Mr N's behalf that this particular did not warrant disciplinary sanction separately from the rest.

[140] In summary, the Tribunal finds each particular of the Charge and any sub particulars made out and separately (except for particulars 5 and 9) and cumulatively warranting disciplinary sanction. Submissions were then made on penalty.

Penalty

[141] Having stated the appropriate principles, the PCC referred to cases said to be comparable. It then submitted that the appropriate orders were for censure; conditions with details given; and costs.

[142] The submissions for Mr N referred to this as having been a case where there can be no real concern about the health and safety of the public and there was no suggestion or evidence of any harm having occurred. The submissions, and the evidence from Mr N himself, referred to the background and the different particulars of the Charge. It was emphasised that despite ongoing major stressors in his life, particularly in relation to the health issues faced by , [RN], Mr N had not relapsed after his travel overseas to the [Private Hospital] when he overcame his addiction. It was submitted that this was not a case warranting penalty orders beyond those of censure, conditions and costs. Reference was made to the principles applicable.

[143] A bundle of references was produced and these spoke of his trustworthiness and loyalty, his diligence and caring. One colleague said he was "*a genuinely good*

person to the core, whether looking after his patients or his family." Another spoke of the offending as he had read of it as appearing very much to be out of character for Mr N and commended his "*insight and self-motivation to address*" his addiction issues by taking medical health assistance in [ ]. The implication in the Charge and particulars of deceit and intent to mislead were not personality traits that one colleague had ever observed saying that Mr N "*is not a deceitful or dishonest person.*" Reference was made to Mr N's specialty and the importance that public confidence is maintained in the service he provides (in the context of his application for non-publication of his name).

[144] Also produced (again more in the context of non-publication of name, but taken into account) was a contemporary letter from a clinical psychologist.

[145] The available penalties for the Tribunal are:[15]

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.

[146] The principles behind penalty orders of the Tribunal as clearly set out on the basis of authorities[16] 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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[15] Section 101 of the HPCA Act.

[16] *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 3354; *Katamat v PCC [*2012] NZHC 1633 at [49] and *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.

[147] In *A v* Professional *Conduct Committee*[17] the High Court said that four points could be expressly and a fifth by implication from the authorities namely:

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

[148] The Court went on:[18]

> *"Finally, the Tribunal cannot ignore the rehabilitation of the practitioner: B v B (HC Auckland, HC 4/92, 6 April 1993) Blanchard J. Moreover, as was said in Giele v The General Medical Council [2005] EWHC 2143, though '... the maintenance of public confidence ... must outweigh the interests of the individual doctor', that is not absolute – 'the existence of the public interest in not ending the career of a competent doctor will play a part."*

[149] The Tribunal is also mindful of the remarks of Randerson J in *Patel v Dentists Disciplinary Tribunal*[19]. That case involved an appeal by a dentist whose name had been removed from the register by the Dentists Disciplinary Tribunal in relation to charges arising from his treatment of an elderly couple for whom he carried out crown and bridge work, accepted by the Court as being "*grossly incompetent and completely unacceptable.*"[20]

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[17] *A v Professional Conduct Committee* [2008] NZHC 1387 at [81].
[18] At [82].
[19] Auckland High Court, AP77/02, 8 October 2002.
[20] At [32].

[150] In discussing the purpose of disciplinary proceedings the Court said:

> *"[28] The Dentist Act does not provide any guidance on this subject but I am satisfied that the following statement of principle by Eichelbaum CJ in Dentice v Valuers Registration Board [1992] 1 NZLR 720, 724-725 is apposite in this case:*
>
> > *"Although, in respect of different professions, the nature of the unprofessional or incompetent conduct which will attract disciplinary charges is variously described, there is a common thread of scope and purpose. Such provisions exist to enforce a high standard of propriety and professional conduct; to ensure that no person unfitted because of his or her conduct should be allowed to practise the profession in question; to protect both the public and the profession itself against persons unfit to practise; and to enable the professional calling, as a body, to ensure that the conduct of members conforms to the standards generally expected of them; see, generally, Re A Medical Practitioner [1959] NZLR 784 at pp 800, 802, 805 and 814. In New Zealand, such provisions exist in respect of medical practitioners, barristers and solicitors, dentists, architects, pharmacists, real estate agents and a number of other professions and callings, as well as valuers…"*

[151] The Tribunal accepts the submissions from both parties that the situation does not call for any order for cancellation of Mr N's registration or for suspension.

[152] The offending, however, is serious and of concern. First, is the extent of the self-medication prescribed by Mr N and the period over which he was prescribing oxycodone, some of which was for himself. Secondly, are the significance of the drugs prescribed for family members, especially young people. In some cases these were major drugs of dependence and could have led to severe consequences for his young family. Apparently there was no monitoring of the use of these drugs by family members and, in respect of the extensive list of medications for EN, it appears she was simply taking these herself without oversight.

[153] The PCC has not presented the case on the basis that the drugs prescribed by Mr N were not for his family members but were for his own use. Mr N is, however, seemingly an intelligent and perceptive person who should have known of the

restrictions on, and possible serious consequences from, his prescribing drugs of this kind for his family members.

[154] The Tribunal has taken account of the stresses and complications in Mr N's family, particularly in relation to [RN]. These will have put stresses on him and [EN] and go some way to explaining his resort to drugs and alcohol. They do not excuse, however his having prescribed these high-powered drugs of dependence to family members or his failure to take into account the necessity for them to be objectively assessed by another medical practitioner for medications in their best overall interests. There is significant concern about the duplication of drugs with those already prescribed by general practitioners for the family members and the risks that this had of compromise to the health of his family members.

[155] Compounding that Mr N has failed to document the prescribing or any of his reasons for it such that there was some record for any reference by someone else who might be needing to treat, or otherwise prescribe for, those family members.

[156] The Tribunal has noted Mr N's reason behind his having answered "*no*" to the question in his 2008 APC Application but, as noted above, the completion of that question in that Application was in an entirely different context from the one in which he was, through [EN], assured he did not need to disclose his medical or mental health issues. It is not part of the Charge against Mr N, but the Tribunal notes that the advice that Mr N was given concerning his disclosure of his health and mental health condition did not work in his best interests. It may have been better that he had been advised to make full disclosure at the time so that Mr N could have been given whatever medical and other help was available, including assistance from the Health Committee of the MCNZ.

[157] As to the 2014 Application, the Tribunal notes that there was no follow-up to the absence of answers to a number of questions in the form of Application for APC by Mr N and that is a mitigating factor.

[158] Those matters of application for APC are, however, sufficiently serious in themselves that the Tribunal considers they should be an order for fine in respect of those matters which it fixes at $2,000.00. There must be a deterrence element in the imposition of that fine penalty to ensure that the profession understands

the importance and significance of completing the questions in an APC application and the need for accuracy and complete openness in so doing.

[159] Further compounding factors were the matters referred to in particulars 13 and 15, the inaccuracy in the representations by Mr N to the MCNZ in 2017 concerning his medical condition and treatment and recovery involved and his having attempted to prevent the PCC from obtaining contact details of Dr T who had treated him in the [Private Hospital].

[160] Those are all matters of concern and all merit an order for censure which is made below.

[161] The evidence before the Tribunal is that Mr N has been a good surgeon with a commendable career. Dr Connolly said in his evidence that he had spoken in depth with Mr N about the matters the subject of the disciplinary charge and knew from this that Mr N was immensely embarrassed and distressed that he had found himself in the situation in which he is. He said he had no doubt that Mr N acted as he did in a genuine, albeit misguided, endeavour to assist those for whom the prescribing was directed. It is also established that he has not handled stress or anxiety well in the context of his family environment and particularly the medical condition and consequences of it for , [RN].

[162] The Tribunal accepts the PCC submission that conditions should be ordered as these will go some way towards helping Mr N's medical and mental health issues and his responses to these; and proper rehabilitation into practice. It will also assist in his understanding the ethics behind, and need for, good clinical record-keeping.

[163] Mr N has had an acknowledged addiction to opiates and he continued to practise during the time when he had that addiction with self-prescribing in order to support that addiction. That addiction has been an ongoing issue with relapses and, while there is no evidence of imminent risk of relapse, it is important that Mr N has appropriate regulatory oversight to lessen any risk of relapse in the interest of public safety. The conditions will remind Mr N and other practitioners of the rules around prescribing for family members and the circumstances when this is permitted, such as in an emergency.

[164] The conditions are articulated in detail below but in general terms for the period of three years from when Mr N commences practice following the coming into

effect of this decision he may only practice in accordance with these conditions, namely:

a) Within 18 months he is to complete an educational programme set by the Medical Adviser to the MCNZ on the subject of medical ethics, good prescribing practice, and clinical record keeping. This is to be, including the cost of setting up the programme and ensuring compliance, at Mr N's cost.

b) He is to remain for that three-year period subject to the supervision of the Health Committee of the MCNZ and to comply at his cost with any requirements of that Committee. The Tribunal strongly recommends that the Health Committee establish such drug testing programme as it considers will appropriately monitor Mr N's compliance with the requirements of the Health Committee.

c) That for two years of that period:

   i) Mr N's prescribing is to be reviewed by the Professional Standards team of the MCNZ for any self-prescribing or prescribing to family members, such reviews taking place every 6 months during that period;

   ii) Mr N is to notify the MCNZ within 48 hours if an emergency situation has required him to treat himself or someone close to him (including prescribing);

   iii) Mr N is to advise any current and future employer(s) of the Tribunal's decision and its orders. That condition is needed to keep such employer(s) properly informed of Mr N's position.

Costs

[165] The PCC sought an order for costs against Mr N. It referred to principles for any such order as stated by the courts and various cases in which a percentage contribution had been ordered.

[166] The PCC provided an estimate of its costs for or investigation and prosecution amounting to a little over $82,000.00; but it acknowledged that, because certain particulars were withdrawn, that reduces its overall costs to $73,024.62 as set out in a Schedule provided to the Tribunal. The Tribunal must also consider the resourcing costs for the Tribunal's involvement in the matter which were

estimated to total $25,124.00. This gives a total to be considered of some $98,148.00.

[167] The submissions for the parties as to the percentage of costs to be ordered generally referred to a contribution of 30%. This is the sum of $29,444.00. The Tribunal considers that the appropriate sum to be ordered against Mr N is approximately 35% of the sum of $98,000.00 that is the sum of $35,000.00, to be divided as to 75% to the PCC and 25% to the Tribunal, being the approximate percentage proportion of their costs.

Non-publication of name

[168] Mr N made an application for non-publication of his name, particulars of his affairs and any identifying details. The submissions on his behalf referred to the interest of any person and the public interest and the desirability that an order be made. Similar cases were referred to, *Dr S,*[21] *Dr M,*[22] *Dr T*[23] *and Dr A.*[24] Reference was made to the effect that publication of his name would have on , [RN]; and reference of deep concern for Mr N's [ ], DN, who also suffers significant mental health issues. There were produced supporting medical reports from the general practitioner for [RN], Dr R, and the psychiatrist for Mr DN, Mr S. It was said that Mr N's [ ], ON and IN, seemingly do not have any knowledge of the disciplinary matter and that Mr N was hopeful that there would be no need for them to be confronted with this.

[169] The submissions for Mr N then also spoke of "*collateral harm to his private orthopaedic practice and those who practise with him"*. Detail was given about this orthopaedic practice and it was said that Mr N's name has from the outset been synonymous with that of the practice. The submissions said that a risk existed that publicity of Mr N's name in this matter would harm the practice as a whole and the other members who practise with him, quite aside from his own practice.

[170] Reliance was then placed on the mental health impacts of publicity on Mr N himself given his history, with reference to reports from Mr N's psychiatrist, Dr

[21] 994/Med18/417P.
[22] 941/Med17/382P.
[23] 636/Med14/272P.
[24] 1046/Med18/431P.

F, and a clinical psychologist, S, both of which have been read carefully by the Tribunal. Mr N did not himself allude to these matters in his statement of evidence.

[171] The PCC did not oppose the application for non-publication of Mr N's name and said it would abide the decision of the Tribunal. Reference was made to the principles applicable including that there was normally something more than embarrassment needed to support any such order. The PCC is conscious of the information concerning RN and the effect that publication of [Mr N's] name and identifying details might have on her.

[172] Mr N also sought an order for non-publication of the personal health and other details relating to each of [RN], [DN], and his own medical details.

[173] The Tribunal has considered the applications by Mr N and is of the view that orders should be made as sought by him.

[174] First, the personal details about the health and other aspects concerning Mr N himself, RN and concerning [DN] are private and confidential to them; and there is no public interest in having that information publicised.

[175] Secondly the Tribunal is of the view that there are some significant and sufficient compelling reasons why an order for non-publication of the name, particulars of the affairs of, or identifying details of Mr N should be made, having regard to his own health issues and the necessity for his rehabilitation; the condition of , [RN]; the academic and professional positions that, [ON] and [IN], are in and the need for their careers and future not to be impacted by publicity concerning their father; and the effect that any publicity might have on Mr N's [DN]. The detail was all set out in the evidence before the Tribunal and has persuaded it to make the orders accordingly.

Result and orders

[176] The Charge and all its particulars against Mr N are found to be made out as set out above.

[177] Mr N is ordered censured.

[178] Mr N is fined the sum of $2,000.00 in respect of the professional misconduct to which particulars 11 and 12 refer.

[179] An order is made that Mr N may, after commencing practice following the date that this decision takes effect, for a period not exceeding 3 years, practice his profession only in accordance with the following conditions:

a) That within 18 months (or such further time as the MCNZ may allow having regard to resources available) Mr N is to complete at his expense (including the reasonable cost of setting up and ensuring compliance with the programme) an educational programme set up by the Medical Adviser to the MCNZ on the subjects of medical ethics, good prescribing practice and clinical record-keeping.

b) That for that period of 3 years Mr N is to remain subject to the supervision of the Health Committee of the MCNZ and to comply at his cost with any requirements of that Committee. The Tribunal strongly recommends that the Health Committee establish such drug testing programme as it considers will appropriately monitor Mr N's compliance with the requirements of the Health Committee.

c) That for the period of 2 years from the date this decision takes effect:

i) Mr N's prescribing is to be reviewed at Mr N's expense by the Professional Standards team of the MCNZ for any self-prescribing or prescribing to family members, such reviews taking place every 6 months during that period;

ii) Mr N is to notify the MCNZ within 48 hours if an emergency situation has required him to treat himself or someone close to him (including prescribing);

iii) Mr N is to advise any current and future employer(s) of the Tribunal's decision and these orders.

[180] Mr N is ordered to pay the sum of $35,000.00 towards the costs of the PCC in respect of its investigation and prosecution of the Charge and the resourcing costs for the Tribunal to be divided as to 75% ($26,250.00) to the PCC and 25% ($8,750.00) to the Tribunal.

[181] An order is made for non-publication of the personal health and other details as to Mr N himself, [RN], and [DN].

[182] An order for non-publication of the name and identifying details is made of Mr N himself, each of his family members named, namely [EN], RN and IN, [ON], [LN], and [TN]; and [DN].

[183] 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 18th day of May 2020

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David M Carden
Chairperson
Health Practitioners Disciplinary Tribunal

SCHEDULE

CHARGE AS AMENDED (APPENDICES OMITTED)

Pursuant to section 81(2) and 91 of the Act, the PCC charges that between on or around June 2006 and September 2018 [Dr N] conducted himself in an inappropriate and/or unprofessional manner, and/or acted in breach of accepted standards of practice, including but not limited to the Medical Council's Statements: *Good Medical Practice* (June 2008, April 2013, June 2016); *Good Prescribing Practice* (September 2016); *Prescribing Drugs of Abuse* (April 2010); *Statement on providing care to yourself and those close to you* (August 2006, June 2007, June 2013 and November 2016); and *The maintenance and retention of patient records* (August 2008), in the following manner:

Prescribing for himself and/or for his own use

1. From on or about 18 June 2006 to 12 June 2017, Dr N self-prescribed medications, including drugs of dependence, drugs of abuse and/or controlled drugs, for his own use, on the occasions set out at **Appendix A;** and/or

2. From on or about 12 August 2005 to 15 May 2017, Dr N wrote prescriptions for the supply of oxycodone hydrochloride, a drug of dependence and/or abuse, for his own use, on some of the occasions as set out at **Appendix B**; and/or

3. [Withdrawn]

Prescribing to family members

4. From on or about 28 August 2013 to 30 June 2017, Dr N wrote prescriptions for [EN], including for drugs of dependence, drugs of abuse, and/or controlled drugs, on the occasions set out at **Appendix D**; and/or

5. From on or about 10 June 2012 to 21 May 2017, Dr N wrote prescriptions for RN, including for drugs of dependence, drugs of abuse, and/or controlled drugs, on the occasions set out at **Appendix E**; and/or

6. From on or about 19 January 2011 to 23 May 2017, Dr N wrote prescriptions for IN, including for drugs of dependence, drugs of abuse, and/or controlled drugs, on the occasions set out at **Appendix F**; and/or

7. From on or about 2 January 2015 to 21 May 2017, Dr N wrote prescriptions for ON, including for drugs of dependence, drugs of abuse, and/or controlled drugs on the occasions set out at **Appendix G**; and/or

8. From on or about 8 November 2011 to 8 June 2017, Dr N wrote prescriptions for LN, including for drugs of dependence and/or abuse on the occasions set out at **Appendix H**; and/or

9. From on or about 23 June 2010 to 31 August 2016, Dr N wrote prescriptions for TN, including for drugs of dependence, drugs of abuse, and/or controlled drugs, on the occasions set out at **Appendix I**; and/or

Failure to document treatment

10. Dr N failed to document or to adequately document the treatment and/or medications prescribed to his family members as described at paragraphs 4 to 9 above; and/or

Failure to disclose health issue(s)/addiction(s)

11. In or around May 2008 Dr N failed to disclose and/or misled the Medical Council by answering "no" to the following question in his application for an annual practising certificate (APC), when he did have, and/or had received treatment for, an alcohol and/or drug addiction in 2007:

Since your last APC application have you been affected by a mental or physical condition such as a neurological, psychiatric or addictive (drug or alcohol) disorder, including physical injury due to injury, disease or degeneration?

And/or;

12. In or around May 2014 Dr N failed to disclose his addiction to the Medical Council by failing to answer the following question in his application for an annual practising certificate (PC), when he did have, and/or had received treatment for, an opiate addiction in 2014:

Since your last PC application have you been affected by a mental or physical condition such as a neurological, psychiatric or

addictive (drug or alcohol) disorder, or had an accident causing injury or suffered physical deterioration (due to disease or degeneration) that has the capacity to affect your ability to practise?

And/or;

Misleading the Medical Council and/or obstructing the PCC

13. In written submissions to the Medical Council dated 22 August 2017 and 13 September 2017, Dr N made representations to the Medical Council to the effect that he had suffered an addiction to pain relief and/or opioids and had recovered from that addiction within one calendar year between. In making those representations, Dr N misled or attempted to mislead the Council as to the extent of his addiction issues because:

    a. Dr N knew that he had undergone treatment for addiction at [Clinic] in ; and/or

    b. Dr N knew that he had undergone treatment for addiction at [Private Hospital] in [ ] between; and/or

    c. Dr N was aware that prior to treatment at [Private Hospital] in [ ] he had suffered a relapse of his addiction issue in the preceding one year; and/or

14. [Withdrawn]

15. On 7 February 2018, the PCC requested Dr N's medical records from his GP, Dr R of [ ] Medical. On or around 12 February 2018, Dr N asked that Dr R remove the name and/or contact details of his treating doctor at [Private Hospital], Dr T, in circumstances where:

    a. Dr N was attempting to prevent the PCC from obtaining the contact details of Dr T and/or his medical records from [Private Hospital]; and/or

b. Dr N was aware and/or ought to have been aware that the deletion and/or alteration of his medical records was inappropriate in the circumstances.

The conduct alleged at paragraphs 1 to 15 amounts to professional misconduct in that, either separately or cumulatively, it amounts to malpractice or negligence in relation to Dr N's scope of practice pursuant to section 100(1)(a) of the Act and/or has brought or is likely to bring discredit to the profession, pursuant to section 100(1)(b) of the Act.