**BEFORE THE HEALTH PRACTIONERS DISCIPLINARY TRIBUNAL**

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|---|---|
| **HPDT NO** | **1097/Med19/455P** |
| **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 HPCA Act |
| **BETWEEN** | **A PROFESSIONAL CONDUCT COMMITTEE** appointed pursuant to s 71 of the HPCA Act<br>**Applicant** |
| **AND** | **Dr T** of [X]**,** registered medical practitioner<br>**Practitioner** |

**Hearing held at Havelock North on 2 and 3 March 2020**

**Tribunal:** Ms M Dew QC (Chair)
Ms S Baddeley, Dr B Bond, Dr D Ngan-Kee, Assoc Prof D Read (Members)
Ms D Gainey (Executive Officer)

**Appearances:** Mr H Wilson and Mr S Middlemiss for the Professional Conduct Committee
Mr M McClelland QC and Ms R Daley for the practitioner

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# DECISION OF THE TRIBUNAL

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## Introduction

[1] Dr T is a registered medical practitioner. In 1986, he graduated as a Doctor of Medicine from the []. Dr T was first registered with the Medical Council of New Zealand (the **Medical Council**) in [ ] in a provisional scope of practice, and in 1987 in a general scope of practice. Dr T became a Fellow of the Royal New Zealand College of General Practitioners in [ ].

[2] At all material times, the practitioner worked as a general practitioner at [ ] Medical Centre, [X]. At various times, the practitioner also worked as a general practitioner at [ ] an urgent care facility providing afterhours care. The practitioner was also gazetted to prescribe methadone and a Duly Authorised Officer under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Between 2006 and 2015, the practitioner was a police medical doctor.

[3] In February 2015, the practitioner applied to the Medical Council to renew his annual practising certificate. In that application he disclosed that over the previous three years he had developed a dependency on cannabis which he was using to treat [ ]. In March 2015, the practitioner was referred to the Health Committee of the Council (**Health Committee**).

## The Charges

[4] The Charges principally arise out of the practitioner's dealings with the Medical Council over his compliance with conditions on his practice and a voluntary undertaking related to drug testing over the period 2016 and 2017. There are two other allegations of inappropriate prescribing during 2017.

[5] The first Notice of Charge before the Tribunal is dated 4 October 2019 (**Charge 1**).[1] This charge alleges breaches of urine testing conditions that were put on the practitioner's scope of practice, his failure to comply with a set drug testing programme, breaches of his voluntary undertaking, and the two instances of inappropriate prescribing.

[1] Amended Notice of Charge dated 4 October 2019.

[6] The second Notice of Charge before the Tribunal is dated 12 December 2019 (**Charge 2**). This charge relates to an allegation that the practitioner created a false patient profile to submit his own urine samples for drug screening to subvert the requirements of the conditions on his scope of practice.

[7] In December 2019, the PCC applied to have the charges heard together in one hearing. This application was not opposed by the practitioner. The Tribunal ordered the two charges to be heard together on the basis that the charges cover related circumstances during 2016 and 2017.

[8] The Particulars of Charges 1 and 2 are set out in appendices A and B **attached.**

**The hearing**

[9] The hearing proceeded on the basis of an Agreed Summary of Facts for both sets of charges and an Agreed Bundle of Documents. The Agreed Bundle contained the practitioner's disclosure of his dependency in his application for the 2015 practising certificate, the relevant correspondence between the practitioner and the Medical Council over the period 2015 to 2018, the practitioner's urine testing results over the relevant period and patient records related to the inappropriate prescribing allegations.

[10] The PCC called evidence from two witnesses:

(a) The PCC's expert witness, Dr Fraser Todd, gave evidence primarily as to the interpretation of the results of the urine tests undertaken by the practitioner and the likely impairment caused by the practitioner's cannabis use.

(b) Ms R also gave evidence for the PCC. She worked at the practitioner's medical practice from February 2005 to 31 October 2017, as a receptionist and then Practice Manager. Ms R gave evidence about the practitioner's return to practice in October 2016, and about his alleged prescribing of medications in her name in 2017. Ms R's evidence was taken as read.

[11] The practitioner did not attend the hearing. Mr McClelland QC advised the Tribunal at the hearing that the practitioner did not attend on the advice of his psychiatrist, Dr Gil Newburn.

[12] Dr S, a colleague of the practitioner, did give evidence on penalty on behalf of the practitioner. Dr S spoke of the service the practitioner had provided to the patient community throughout his career, and, to vulnerable patients. Dr S supported the practitioner's return to practice.

**Charge 1 – Agreed Facts**

[13] The factual background set out below is based on the Agreed Summary of Facts filed with the Tribunal dated February 2020.

[14] On 25 February 2015, the practitioner submitted an application to the Medical Council to renew his Annual Practising Certificate in which he disclosed that:

(a) He had [medical condition].

(b) Over the previous three years, he had developed a dependency on cannabis which he was using to treat his [ ]..

[15] On 24 March 2015, the practitioner was referred to the Health Committee of the Medical Council of New Zealand (**Health Committee**). Mr Garth Wyatt was allocated as the practitioner's Health Case Manager.

*Health Committee Monitoring*

[16] Mr Wyatt arranged for the practitioner to be assessed by Dr Sam McBride, a dual diagnosis psychiatrist on behalf of the Health Committee. On 9 April 2015, he met with Dr McBride. After the meeting, Dr McBride provided the Health Committee with preliminary information that the practitioner was dependent on cannabis and used cannabis on a daily

basis, including when he was on call. In his report to the Health Committee, Dr McBride diagnosed the practitioner with Cannabis Use Disorder and [ ].

[17] On 12 May 2015, the Health Committee met to consider the practitioner's disclosure of his addiction to cannabis and Dr McBride's report. The practitioner provided submissions in advance of the meeting and attended in person. The practitioner advised the Committee that he did not consume cannabis or any other substance during work hours. The Health Committee determined that the practitioner should undertake fortnightly random urine screening for 6 weeks to monitor the decreasing presence of cannabinoid in his urine with this reducing to random monthly urine testing for 12 months. The practitioner was thanked for his bravery in coming to speak to the Committee.

[18] On 17 May 2015, the practitioner signed an agreement with the Health Committee including the following:

(a) The practitioner would not undertake any on-call practice;

(b) The practitioner would maintain therapeutic relationships with his general practitioner and a psychologist;

(c) The practitioner would be abstinent from cannabis and all substances of abuse; and

(d) The practitioner would comply with a random urine drug testing programme as specified by the Health Committee.

[19] On 19 May 2015, the Health Team Administrator at the Medical Council, wrote to the practitioner about the process for urine testing. Enclosed with the letter was a copy of the Health Committee's protocol for urine testing.

[20] On the same day, the Council also wrote to the doctor who had agreed to witness the practitioner's urine samples being provided, about the process for urine testing. Enclosed with the letter was a resource folder containing the urine screening protocol and other

documents relating to the procedure for collection and testing of the specimen and maintaining a secure chain of custody. The requirements of the Health Committee's urine screening protocol included:

(a) urine samples are to be tested by Canterbury Health Laboratories;

(b) a legally secure chain of custody to be maintained;

(c) testing to be in accordance with the procedures recommended in AS/NZS 4308 2008 "*Recommended Practice for the Collection, Detection and Quantitation of Drugs of Abuse in Urine*"; and

(d) all urine samples to be screened for creatinine concentrations.

[21] In accordance with his agreement with the Health Committee and the random drug testing programme, the practitioner provided a urine sample for testing on 21 May 2015. The sample tested positive for Carboxy-THC, indicating cannabis use. This sample was within the six-week timeframe for monitoring decreasing use.

[22] On 3 June 2015, the practitioner signed an updated agreement with the Health Committee. The agreement was updated to include the name of the practitioner's psychologist but was otherwise the same as the agreement signed on 17 May 2015.

[23] In accordance with his agreement with the Health Committee and the random drug testing programme, the practitioner provided urine samples for testing on 5 June 2015, and 24 June 2015. The samples both tested positive for Carboxy-THC, indicating cannabis use. These samples were within the six-week timeframe for monitoring decreasing use.

[24] Over the next few months, the practitioner went overseas on holiday.

[25] On 10 October 2015 and 17 October 2015, the practitioner met with Juanita Heath, a Clinical Psychologist, who conducted a neuropsychological assessment. Ms Heath's report

stated that the assessment results suggested that the practitioner was likely to have difficulty? Ms Heath suggested the practitioner undergo supervision and/or a formal practice review.

[26] On 16 November 2015, Dr McBride provided the Health Committee with a further report on the practitioner. Dr McBride reported that the practitioner continued to use cannabis, although his use had reduced and no longer occurred in situations where he was engaged in clinical work. Dr McBride also reported that the practitioner may be [ ] which could make it difficult for him to work with organisations and experience a change to routine.

[27] From 20 November 2015, the Committee's urine screening changed from being random to pre-arranged on a fortnightly basis. [ ]

[28] On 25 November 2015, the Council Medical Adviser, Dr Steven Lillis, visited the practitioner's practice at the request of the Health Committee, and following the suggestion made by Ms Heath, to undertake an assessment of risk to patient safety. Dr Lillis's report concluded that:

(a) He had no concerns about the practitioner's reasoning or his ability to undertake complex consultations;

(b) The practitioner's clinical notes were at a standard expected of a vocationally registered general practitioner; and

(c) He found no concerns to report to the Health Committee.

[29] In accordance with the practitioner's agreement with the Health Committee and the random drug testing programme, he provided urine samples for testing on the following dates:

(a) 20 November 2015;

(b) 3,17 and 31 December 2015;

(c) 21 January 2016;

(d) 11 and 25 February 2016;

(e) 18 and 31 March 2016;

(f) 14 April 2016;

(g) 5 and 19 May 2016.

[30] The samples from 20 November to 19 May 2016, all tested positive for Carboxy-THC, indicating cannabis use.

*Voluntary undertaking*

[31] After 8 March 2016, the practitioner was advised that he would no longer receive reminders about the fortnightly urine tests. In May 2016, the practitioner advised the Health Committee that he was going overseas for an extended period and did not have a return date. He was not practising medicine while on leave.

[32] On 18 August 2016, while overseas, the practitioner signed an undertaking in which he undertook to comply with the following conditions required by the Medical Council:

(a) Not to practise medicine until the results of a urine test done within one week of his return from overseas had been considered by the Health Committee, and the Health Committee considered that the result was consistent with remaining abstinent from cannabis.

(b) That the Registrar of the Council would review the undertaking on advice from the Chair of the Health Committee that the practitioner had remained abstinent.

(c) The practitioner accepted that the Council would take steps to monitor his compliance with the undertaking.

(d) The practitioner agreed that he must abide by the undertaking until the Council released him from it.

(e) He understood that if he breached the undertaking, the Council would issue a Section 35 Notification of Risk of Harm.

[33] In or around late September 2016, the practitioner returned to New Zealand. On 3 October 2016, he provided a urine sample for testing. The urine sample tested positive for Carboxy-THC with a Carboxy-THC: Creatinine ratio of 12 ug/mol.

[34] On 5 October 2016, the practitioner emailed Mr Wyatt at the Council and commented on the results of the urine sample from 3 October 2016 *"that will be the joint I shared at my class reunion … I note the very low THC ratio – similar to when I was off weed 4 months ago."*

[35] On 11 October 2016, the practitioner, through counsel, wrote to the Medical Council Registrar, Mr Dunbar. The practitioner accepted that he needed help to address his cannabis dependency and had arranged to meet an experienced addiction counsellor. The practitioner submitted that he was safe to return to practice with appropriate conditions, including committing to seeing an addiction counsellor and regular urine testing. The practitioner also provided a letter from the Chief Medical Officer, Primary Care, at the local District Health Board. This letter advised that the practitioner had 1400 registered patients in his practice with high clinical needs including mental health and addiction issues. The Chief Medical Officer asked the Council to consider the effect which preventing the practitioner from practising would have on his patients and the local community.

[36] On 13 October 2016, the practitioner, through counsel, wrote a further letter to Mr Dunbar. The letter explained that his practice was at a crisis point as there was no locum available, and he was the only doctor in [ ] gazetted to prescribe Methadone. The letter stated there was no capacity to absorb his patients into other practices. The practitioner advised that he intended to return to practice on Friday 14 October 2016.

[37] On 14 October 2016, the practitioner, through counsel, advised that he had not returned to practice. That same day the practitioner provided a urine sample for testing. The

urine sample tested positive for Carboxy-THC with a Carboxy-THC: Creatinine ratio of 5ug/mmol. This sample was within six weeks of the class reunion the practitioner had referred to earlier in the month.

[38] On 17 October 2016, the practitioner advised that he would not be returning to practice that day and did the same on each day through to 21 October 2016.

[39] On 19 October 2016, Dr N emailed Mr Dunbar enclosing information from the PHO saying *'keeping [the practitioner] out of practice is creating patient risk'.*

[40] On 20 October 2016, the practitioner provided a urine sample for testing. The urine sample tested positive for Carboxy-THC with a Carboxy-THC: Creatinine ratio of 4 ug/mmol.

[41] On 25 October 2016, the practitioner wrote to the Council attaching the results of his urine samples on 3 October, 14 October, and 20 October. The practitioner's counsel submitted that the reducing cannabis level shown in the tests '*is entirely consistent with abstinence*'. The practitioner's counsel wrote that the practitioner would return to work that day and would continue to practice subject to the conditions previously proposed. The practitioner's counsel also enclosed a letter of support from another local GP.

[42] On 25 October 2016, the practitioner returned to practice, in breach of his voluntary undertaking dated 18 August 2016.

[43] On 3 November 2016, the practitioner provided a urine sample for testing. The urine sample tested positive for Carboxy-THC with a THC-Creatinine ratio of 2ug/mmol. On 17 November 2016, the practitioner provided a urine sample for testing. The urine sample tested negative for Carboxy-THC.

*Conditions imposed on the practitioner's scope of practice*

[44] On 21 November 2016, the Medical Council wrote to the practitioner to inform him that it had imposed conditions on his scope of practice under section 69(2) of the HPCA Act 2003. The conditions included, that the practitioner will have fortnightly urine testing or such

other timing as the Health Committee agrees, and the results are required to show levels consistent with abstinence.

*Urine samples provided outside Health Committee protocol*

[45] On 1 December 2016, the practitioner provided a urine sample for testing. The practitioner asked his GP to send the urine sample to the laboratory at the local District Health Board for testing. The test did not comply with the Health Committee's testing protocol as it did not comply with the Standard AS/NZS 4308:2008 for drugs of abuse testing in urine, a secure chain of custody was not maintained, and creatinine levels were not monitored. The test result was Carboxy-THC not detected.

[46] On 12 December 2016, the practitioner signed a further agreement with the Health Committee. The agreement included:

(a) He will maintain therapeutic relationships with his general practitioner, psychologist, and addiction counsellor;

(b) He will be abstinent from cannabis and all substances of abuse; and

(c) He will comply with a fortnightly urine drug testing programme as specified by the Health Committee.

[47] On 16 and 29 December 2016, the practitioner provided urine samples for testing. The practitioner again asked his GP to send the urine samples to the laboratory at the local District Health Board for testing. The tests did not comply with the Health Committee's testing protocol for the same reasons as the previous test. The test results were cannabinoids not detected.

[48] On 4 January 2017, the Council received the practitioner's test results from the samples provided on 1 December 2016 and 16 December 2016. The Council contacted the practitioner's GP about the urine sample. The GP told the Council that the practitioner has asked him to send the urine sample to Southern Community Laboratories for testing. The

Council reminded the GP of the requirement for the samples to be tested in accordance with the agreed protocol.

[49] On 12 January 2017, the Council received the test results for the practitioner's sample provided on 29 December 2016. The Council emailed the GP and the practitioner to remind them of the need for the urine samples to be sent to Canterbury Health Laboratories for testing.

[50] The practitioner responded that day, writing that he had just provided a urine sample and the sample had been sent to the laboratory at the local District Health Board '*for several reasons*' without further explanation. The test did not comply with the Health Committee's testing protocol for the same reasons as the previous tests. The test result was Carboxy-THC not detected.

[51] On 16 January 2017, the Council's Professional Standards Coordinator and the practitioner's counsel were notified that the results from the urine samples taken on 16 and 29 December 2016, did not comply with the Health Committee's urine screening protocol.

[52] On 27 January 2017, the practitioner provided a urine sample for testing. His lawyer emailed the Council to say that the sample provided that day would be sent to a local laboratory as there was no courier services for the sample late on a Friday afternoon. The test did not comply with the Health Committee's testing protocol for the same reasons as the previous test. The test result was Carboxy-THC not detected.

[53] On 9 February 2017 and 23 February 2017, the practitioner provided urine samples for testing. The urine samples were tested in accordance with the requirements of the Health Committee's testing protocol. The urine samples tested negative for Carboxy-THC.

*Breach of conditions on scope of practice*

[54] On 9 March 2017, the practitioner provided a urine sample for testing. The urine sample was tested in accordance with the requirements of the Health Committee's testing protocol. The urine sample tested positive for Carboxy-THC with a Carboxy-THC: Creatinine

ratio of 3ug/mmol. This breached the condition on the practitioner's scope of practice which required his test results to show levels consistent with abstinence.

[55] On 1 April 2017, the practitioner sent the Council a letter explaining the circumstances surrounding the failed drug test and his use of cannabis on 5 March 2017. The practitioner explained that he had been assisting his terminally ill [family member] which had caused him [ ].

[56] On 6 and 20 April 2017, the practitioner provided urine samples for testing. The urine samples were tested in accordance with the requirements of the Health Committee's testing protocol. The urine samples both tested negative for Carboxy-THC.

[57] On 4 May 2017, the practitioner provided a urine sample for testing. The urine sample was tested in accordance with the requirements of the Health Committee's testing protocol. The urine sample tested positive for Carboxy-THC with a Carboxy-THC: Creatinine ratio of 7 ug/mmol. This breached the condition on the practitioner's scope of practice which required his test results to show levels consistent with abstinence.

[58] On 9 May 2017, the practitioner emailed the Council and commented on the test results for the sample dated 4 May 2017: '*I'd like to comment at length but the legal department says not to. That said, I would like to say it has been an incredibly stressful fortnight*.'

[59] On 18 May 2017, 1 June 2017, 15 June 2017, 29 June 2017, the practitioner provided urine samples for testing. The urine samples were tested in accordance with the requirements of the Health Committee's testing protocol. The urine samples all tested negative for Carboxy-THC.

[60] On 20 July 2017, the practitioner provided a urine sample for testing. The urine sample was tested in accordance with the requirements of the Health Committee's testing protocol. The urine sample tested positive for Carboxy THC with a Carboxy-THC: Creatinine ratio of 4ug/mmol. This breached the condition on the practitioner's scope of practice which required his test results to show levels consistent with abstinence.

[61] No further urine test results were provided by the practitioner to the Health Committee after the urine sample collected on 20 July 2017. During this period, the practitioner was overseas until 24 August 2017 and not practising. The practitioner had instructed his legal adviser to notify the Health Committee of his absence.

[62] The practitioner accepts that the positive test results on 9 March, 4 May and 20 July 2017 and his failure to provide fortnightly urine testing once he returned to New Zealand on 24 August 2017 amount to breaches of the conditions imposed on his scope of practice.

*Inappropriate prescribing*

[63] On 19 April 2017, the practitioner prescribed Fluorometholone (trade name FML) eyedrops 0.1% 5ml and Chloramphenicol (trade name Chlorafast) eyedrops 0.5% 10ml in Ms R's name. Ms R was the receptionist at the medical practice at the time. The practitioner presented the prescription at [] Pharmacy and he was dispensed both prescriptions. The cost of the prescriptions ($10) was charged to the practitioner's account at his request. The eye drops were intended for his own use.

[64] On 30 June 2017, the practitioner prescribed Tenoxicam (trade name Tilcotil) x 30 20mg tablets in Ms R's name.

[65] On 17 July 2017, the practitioner prescribed hypertension medication for a patient which was intended for the patient's brother in [ ]. The intended recipient of the medication was not a patient under the practitioner's care and the practitioner had not personally assessed him.

*Suspension*

[66] On 17 November 2017, the practitioner was suspended from medical practice on an interim basis by the Medical Council. He has not practised since that date.

*Partial Admission of Charge 1*

[67] The practitioner admits all of the facts as set out in the Agreed Summary of Facts, detailed above. He also admits the breach of conditions on his scope of practice between November 2016 and July 2017, as set out in Particular 1 and 2 of Charge 1 and that this is contrary to section 100(1)(f) of the HPCA Act, being a breach of conditions of his practice.

[68] However, the practitioner otherwise denies that his conduct set out in Charge 1, Particulars 3, 4 and 5(a) and (b) regarding his failure to comply with the drug testing programme, breach of voluntary undertaking and inappropriate prescribing in the name of Ms R. The practitioner denies Particulars 5(c) and 6 of the charge. The practitioner does not accept that his conduct in relation to these Particulars amounts to professional misconduct either separately or cumulatively.

[69] Finally, the practitioner accepts Particular 7 of the Charge 1 regarding his inappropriate prescribing to the unnamed person in [ ] and that this conduct amounts to professional misconduct.[2]

**Charge 2 – Agreed Facts**

*Mr Y patient profile*

[70] In or around 2001, the practitioner created a patient profile in his practice management system at [ ] Medical Practice using a pseudonym. This was for use by patients who required sensitive tests and in a small community did not want this information known by hospital and laboratory staff. The patient profile listed the patient's name as 'Mr Y' and/or 'Mr Y' and the patient's date of birth as [x].

[71] The address listed on the patient profile was [ ], which was the address of the practitioner's practice, [ ] Medical Centre. There was no National Health Index (**NHI**) number associated with the Mr Y patient profile. At various times between 2001 and 2017, the

[2] The partial admission of the Charge as presented to the Tribunal and set out in this decision does vary from the Agreed Statement of Facts, Document 1, which was presented to the Tribunal at the outset of the hearing.

practitioner used the name Mr Y and/or the patient profile for Mr Y to submit samples to laboratories for testing.

*Conditions imposed on the practitioner's scope of practice*

[72] The practitioner was subject to the conditions imposed on his scope of practice during 2016 and 2017 as referred to above in relation to Charge 1 above. He was expected to submit his urine tests to the Health Committee on a fortnightly basis. To protect his privacy, the Health Committee assigned the practitioner the pseudonym *'L Amant'* for testing his urine samples.

[73] On 29 June 2017, the practitioner had submitted a urine sample that had tested negative for Carboxy-THC. The test results were provided to the Health Committee Case Manager.

[74] On 10 July 2017, the practitioner submitted his own urine sample for drug testing under the *Mr Y* profile. The result was positive for Carboxy-THC with a Carboxy-THC:Creatinine ratio of 26ug/mmol. The test results were not provided to the Health Committee.

[75] On 20 July 2017, the practitioner provided a urine sample for testing under the pseudonym *L Amant* in accordance with his agreement with the Health Committee. The urine sample tested positive for Carboxy THC with a Carboxy-THC: Creatinine ratio of 4ug/mmol. The results were provided to the Health Committee Case Manager.

[76] On 20 July 2017, the practitioner also submitted his own urine sample for drug testing under the *Mr Y* profile. The result was positive for Carboxy-THC with a Carboxy-THC: Creatinine ratio of 6ug/mmol. The test results were not provided to the Health Committee Case Manager.

[77] The practitioner provided no further urine test results to the Health Committee after the urine sample collected on 20 July 2017, under the name *L Amant*.

[78] During August 2017, the practitioner went on holiday overseas and asked his then legal adviser to advise the Health Committee of the dates when he would be away. The practitioner was not practising medicine while he was overseas.

[79] On 4 October 2017, the practitioner submitted his own urine sample for drug testing under the *Mr Y* profile. The result was positive for Carboxy-THC with a Carboxy-THC:Creatinine ratio of 9ug/mmol. The test results were not provided to the Health Committee.

[80] On 13 October 2017, the practitioner submitted his own urine sample for drug testing under the *Mr Y* profile. The result was positive for Carboxy -THC with a Carboxy-THC:Creatinine ratio of 4ug/mmol. The test results were not provided to the Health Committee.

[81] On 17 November 2017, the practitioner was suspended on an interim basis, as a result of his failure to provide urine samples.

*Denial of Charge 2*

[82] The practitioner confirms and admits the facts in this Agreed Summary of Facts are true and accurate. However, he otherwise denies Charge 2 on the basis that his conduct was not for the purposes of subverting the conditions of his scope of practice. He therefore denies the conduct amounts to professional misconduct.

**Legal principles under the HPCA Act**

[83] The relevant disciplinary provisions of the HPCA Act, are contained in section 100 of the Act:

> **"100 Grounds on which health practitioner may be disciplined**
>
> (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that –

> (a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or
>
> (b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred;
>
> …..
>
> (f) the practitioner has failed to observe any conditions included in the practitioner's scope of practice"

[84] In relation to sections 100(1)(a) and 100(1)(b) of the HPCA Act, there is a well-established two stage test for determining professional misconduct. [3] The two steps are:

(a) First, did the proven conduct fall short of the conduct expected of a reasonably competent health practitioner operating in that vocational area? This requires an objective analysis of whether the practitioner's acts or omissions can reasonably be regarded by the Tribunal as constituting malpractice, negligence or otherwise bringing, or likely to bring, discredit on the profession; and

(b) Secondly, if so, whether the departure from acceptable standards has been significant enough to warrant a disciplinary sanction for the purposes of protection of the public and/or maintaining professional standards?

[85] There has been some uncertainty about the legal test to apply to a charge under section 100(1)(f) in previous Tribunal decisions. In *Chum*, the Tribunal noted that the legal test was "open to argument".[4] In at least two previous decisions, the Tribunal applied the traditional two-step approach to proving professional misconduct under section 100(1)(a) and 100(1)(b) to section 100(1)(f). [5]

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3 *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA), as applied in *Johns v Director of Proceedings* [2017] NZHC 2843.

4 *Chum 895/Phys17/379P* at [17].

5 *Bhatia* 344/Med10/151P and *Ranchhod* 337/Med10/161P.

[86] However, subsequently the matter has been argued and considered in *Harypursat*, which has declined to apply the two step-test of professional misconduct to s100(1)(f) charges, stating:[6]

> "In relation to section 100(1)(f) of the Act, this disciplinary ground is akin to a strict liability offence, if there has been a failure to observe a condition on practice, then the ground on which the practitioner may be disciplined is established. This does not require a two-step test as for professional misconduct offences. The PCC need only establish that a condition was in place and that the practitioner failed to observe it".

[87] Counsel for the PCC and the practitioner accept that the approach set out in *Harypursat* is correct and that it ought to be applied in the present case.[7]

[88] The standard of proof is the civil standard of proof; that is proof which satisfies the Tribunal that on the balance of probabilities the particulars of the charge are more likely than not. The Tribunal must apply a degree of flexibility to the balance of probabilities taking into account the seriousness of the allegation, and the gravity of the consequences flowing from a particular finding.[8]

[89] The Tribunal is required to consider each Charge separately and then within each Charge separately consider whether the Particulars may amount to professional misconduct, in the context of each of the overall charges.[9] The Tribunal has been careful to ensure that it views the two separate charges distinctly at the liability phase of this hearing.

**Medical Council Standards of Practice and Regulations**

[90] The Medical Council *Statement of Good Medical Practice* (December 2016) relevantly requires doctors to:

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6 975/Med18/413P.

7 It was confirmed in oral submissions that the practitioner agreed with the PCC on the issue of strict liability under section 100(1)(f), Transcript dated 2 March 2020, page 87, line 33.

8 *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1 (SC) at [112].

9 *Chan v Medical Practitioners Disciplinary Committee* (CA 70/96, 8 August 1996); *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513. Noting that Charge 1, Particular 1 is not part of any professional misconduct consideration as it is the strict liability matter under s100(1)(f) of the Act.

(a) "Acting honestly and ethically" work cooperatively with, and be honest, open and constructive in your dealing with managers, employers, the Medical Council, and other authorities"; and

(b) "Your health". You must tell the Council's Health Committee if you have a condition that may affect your practice, judgment, or performance. The Committee will help you decide how to change your practice if needed. You should not rely on your own assessment of the risk you may pose to patients".

[91] The Medical Council's *Statement on providing care to yourself and those close to you*, provides that the Council expects all doctors to have their own general practitioner as you may lack clinical objectivity about the correct diagnosis and treatment when you assess and treat yourself. The Medical Council acknowledges and defines "exceptional circumstances" in which a doctor treating themselves or those close to them may be necessary, being urgent situations that require immediate action or working in particular communities which makes access to another practitioner difficult.

[92] The Medical Council's *Statement on Good Prescribing Practice* also makes it clear medications must not be prescribed for the doctor's own convenience, and that doctors are to keep a clear, accurate and timely patient record.

[93] Finally, Regulation 39 of the Medicines Regulations 1984, provides that no doctor is permitted to prescribe prescription medication to an individual unless it is for the treatment of a patient under their care.[10]

**Witness evidence**

*PCC Expert - Dr Todd*

[94] Dr Todd is a Fellow of the Australian and New Zealand College of Psychiatrists and a Fellow of the Chapter of Addiction Medicine. He has worked clinically for many years with

[10] Regulation 39(1)(a)(i).

people suffering from cannabis dependence. He is currently the Senior Clinical Lecturer at the National Addiction Centre with the University of Otago and a Senior Clinical Advisor for Matua Raki - Te Pou.

[95] Dr Todd provided his evidence to the Tribunal as an expert subject to the Code of Conduct for Expert Witnesses, Tribunal Practice Note 3. Dr Todd has previously been asked to provide an expert opinion to the PCC in July 2017, when it first investigated the practitioner's conduct. This evidence was particularly in relation to interpretations and explanation of the urinary cannabis tests and a neuropsychiatric assessment for the practitioner.

[96] Dr Todd had reviewed the urine and hair drug tests for the practitioner between May 2015 and June 2017 and an extract from the report of Ms Heath, Clinical Psychologist dated November 2015 containing an assessment of the practitioner's cognitive function.

[97] In summary, Dr Todd reported:

(a) The practitioner's urine screen results from May 2015 for the next 11 months, showed his cannabis use was likely to have increased slightly but steadily over that period;

(b) From April 2016 until November 2016, his cannabis use reduced steadily;

(c) The positive urine results in March 2017 and May 2017, suggest a brief period of light to moderate use, which likely represent single episodes of use;

(d) The impact of cannabis use on cognitive function will vary depending on age, duration of use and use at the time of testing. However, the characteristic impairments include attention, working memory, planning and decision making, memory and processing speed.

(e) It is difficult to correlate any cognitive impairment to daily functioning of a medical practitioner. The only reliable way of assessing this is direct observation in a clinical setting.

(f) The neurological assessment of the practitioner in October 2015 was likely during a period of moderate use of cannabis by Dr T. Many findings in Ms Heath's report are typical of impairments associated with acute and chronic cannabis use but are likely to have improved as its use was significantly reduced over the course of 2017.

(g) To judge any on-going impairment, direct observation and supervision would be necessary.

*Ms R*

[98] Ms R worked in the practitioner's medical practice from 2005 through to her resignation in late 2017. In the last years of her employment, her role was Practice Manager. Ms R gave evidence about the period in October 2016 when the practitioner had not been able to return to the practice after a period overseas and a positive urine test. Ms R referenced her concern at the time for patients given his absence that month.

[99] Ms R also gave evidence that in July or August 2017, she had checked her own patient records held at the Medical Centre and she discovered three prescriptions that she did not recall ever receiving; the two for FML and Chlorafast eye drops on 19 April 2017 and one for Tilcotil 20mg tabs on 30 June 2017.

[100] She telephoned the two pharmacies involved and both confirmed that the medical practitioner had been in to collect the prescriptions on each occasion. As a result of her inquiries, Ms R notified the Medical Council. She also spoke to the medical practitioner and asked him why he had done this. Her evidence was that he did not deny he had written the prescriptions in her name but responded to her words to the effect *"they were not for hard drugs or morphine or anything".* Ms R was concerned that this attitude missed the point that he had done so without her consent.

[101] The practitioner did not cross examine Ms R on her evidence.

## Legal submissions on liability

*Charge 1 – Breaches of Conditions, compliance with drug testing, and voluntary undertaking*

[102] The PCC submitted that the following two cases would assist the Tribunal in assessing whether the practitioner's conduct in this case amounts to professional misconduct and warrants disciplinary sanction:

(a) In *Streat*,[11] the doctor was charged with breaching a voluntary undertaking she had given to the Medical Council. The Tribunal considered the requirements of the Good Medical Practice policy, and expressed its view that when such an undertaking is given, in the context of earlier difficulties with alcohol, the practitioner should have honoured that undertaking, and the failure to do so would bring discredit to the medical profession. The Tribunal also found that the disciplinary threshold was met as given the failure to comply with the voluntary undertaking did in fact bring risk to the public and discredit to the profession. As such, sanction was necessary to maintain standards and professional misconduct was established.

(b) In *Harypursat*,[12] the practitioner was charged with breaching a voluntary undertaking which he gave to the Medical Council. The Tribunal held that the breach of the voluntary undertaking amounted to negligence and malpractice and was likely to bring discredit to the profession. The Tribunal was satisfied that the conduct amounted to professional misconduct as it was a "significant and serious departure from accepted standards of conduct by a General Practitioner".

[103] Counsel for the PCC submits that even the medical practitioner's earlier voluntary agreements in June 2015 and December 2016, made with the Health Committee, were of a similar status to a voluntary undertaking given to the Medical Council. Like a voluntary

[11] 630/Med13/269P.
[12] 975/Med18/413P.

undertaking, it remains a written and signed agreement with the Health Committee entered into voluntarily by a practitioner and the breach of such an agreement is a serious matter.

[104] In relation to the inappropriate prescribing, Mr Wilson referred the Tribunal to the following cases:

(a) *Cooper:*[13] The Tribunal found that the practitioner had written prescriptions in his patients' names for the purpose of restocking his practice. The prescriptions were made without the patients' knowledge, and they did not receive the medications. The Tribunal noted that this created risks for the patients involved, as their medical records at MedSafe were not accurately maintained. The Tribunal found that the practitioner's conduct was negligent and not acceptable practice.

(b) *Dr A:*[14] Dr A was charged with prescribing medications in her own name and in the name of family members which were intended for her own use. The Tribunal was concerned that the patients whose names were used in the prescriptions would have inaccurate records which could affect their future treatment. The Tribunal also noted that Dr A's self-prescribing actions meant that her own records would be inaccurate, and jeopardised her doctor's professional reputation, as well as her own.

[105] The PCC accepted that these cases involved the wrongful prescribing of controlled drugs or other drugs of abuse, which is not present in the current case.

[106] In relation to Charge 1, Particulars 1 and 2, the practitioner submits that his slips or lapses should properly be an accepted part of his recovery and that relapse is acknowledged as a likely part of any recovery from drug dependency. It is submitted that the practitioner's cannabis use and his lapses from his conditions on practice, compliance with testing and

[13] 872/Med16/351P.
[14] 1046/Med18/431P.

voluntary undertakings, should have remained health issues rather than being escalated to conduct matters.

[107] In relation to Particular 3, it was further submitted for the practitioner that his use of alternative testing procedures in the local testing laboratory, was for a variety of legitimate reasons when either his GP was away unwell or there was not a courier service available to take the sample to the Canterbury DHB Laboratory as required under the protocol. Mr McClelland submitted that this was a failure of process only and administrative non-compliance with the protocol should not be escalated to professional misconduct.

[108] In relation to Particular 4, regarding the practitioner's return to practice on 25 October 2016, it is submitted the context of this voluntary undertaking must be considered. It is submitted that the practitioner did honour the undertaking up to a point as he did not return to practice immediately on his return to New Zealand in early October 2016. However, it is submitted that it was only after repeated attempts to engage with the Medical Council and the support of the Medical Officer of the local DHB, for his return to assist high needs patients, that the practitioner considered that it was necessary to return to practice on 25 October 2016.

[109] The practitioner accepted that by returning on that date he had breached his undertaking as his 3 October 2016 urine test was positive. However, he believes the Medical Council failed to take account of his later improved tests consistent with reduced cannabis use and the needs of his vulnerable patients.

[110] Finally, in relation to Particulars 5 and 6, dealing with inappropriate prescribing, the practitioner submits that prescribing eye drops for his own use rather than Ms R's is not sufficiently serious to result in a professional misconduct finding. In relation to Particular 5(c), the practitioner says that that the Tilcotil prescription has not been produced and the hearsay statement of the pharmacy about the practitioner's collection of this prescription should not be relied upon to establish this aspect of the charge.

[111] Counsel for the practitioner referred the Tribunal to the case of *Dr N*.[15] In that case, Dr N wrote prescriptions for fluoxetine in the name of his wife, when they were actually intended for his wife's friend (Ms I) to treat her depression. Dr N was Ms I's doctor. Dr N prescribed in this way because Ms I was reluctant to present a prescription in her own name at a local chemist due to her profile in the local community. In addition, Dr N also signed a prescription for five ampoules of Kenacort 40mg/ml in his wife's name when it was not prescribed for her own personal use, but for another specific patient for the balance to be used as stock. The Tribunal held that while the facts were made out, they did not amount to professional misconduct warranting sanction. On appeal, the High Court saw no reason to depart from the Tribunal's assessment in respect of the prescribing.

[112] Counsel for the practitioner submits for the practitioner that his prescribing was considerably less serious than Dr N's prescribing of Fluoxetine and Kenacort and accordingly it cannot reach the disciplinary threshold.

*Charge 2 – Subverting conditions on practice*

[113] The PCC acknowledge that there are no previous cases that are directly analogous to the present charge of "subverting" conditions. The PCC submitted that the following cases may be of assistance to the Tribunal in demonstrating the level of seriousness with which the Tribunal has treated attempts by practitioners to mislead their regulatory authorities, particularly in the context of monitoring of a health practitioner's addiction:

(a) *Streat:*[16] One of the particulars of the charge of professional misconduct against Dr Streat was her denial of consuming alcohol after being confronted with breath test results indicating that she had. The Tribunal held that when the practitioner did drink alcohol, and had been found to do so, it was incumbent on her to own up and admit what occurred. The Tribunal found that Dr Streat's denial "was a complete lack of judgement" and "showed dishonesty and lack of integrity on her part". The Tribunal found the particular amounted

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15 900/Med16/369P.

16 630/Med13/269P.

either separately or cumulatively to professional misconduct and noted that her dishonesty in denying having consumed alcohol is something that goes to the maintenance of standards and is something that puts the public at risk.

(b) *Litchfield (formerly Grave):*[17] Amongst other things, Mr Litchfield was charged with professional misconduct in relation to a urine sample he was required to provide to his registration authority to obtain an annual practising certificate. The practitioner had a condition on his scope of practice which required him to undertake random drug and alcohol testing. Mr Litchfield obtained a sample from another person that he provided for the purpose of a test. The Tribunal had "no hesitation" in finding that the practitioner's behaviour was malpractice, bought discredit to the profession, and warranted disciplinary sanction.

[114] Counsel for the practitioner submitted that the PCC had no evidence for the "subversion" allegation and that the Tribunal should not make findings based on speculation, or which have no evidentiary basis. Mr McClelland submitted that it was an extremely serious allegation to allege a medical practitioner had acted to "subvert," meaning to undermine the power and authority of the Medical Council. Counsel made reference to the accepted fact that the practitioner had created the "Mr Y" profile many years prior to the events in the charge, as he had used it to achieve confidentiality for a variety of patients since 2001. The practitioner does not accept that he created the "Mr Y" profile to subvert the authority of the Medical Council and there was no prohibition on the practitioner seeking to carry out his own urine testing. The fact that he did submit a 20 July 2017 positive sample to the Medical Council through the Health Committee protocol in the same period is said to be evidence of his willing compliance.

[115] The practitioner does accept that his failure to submit urine tests after 20 July 2017, was a breach of the conditions but that he has not been charged with those later breaches in Charge 1 or 2. The Tribunal was urged by the practitioner's counsel not to make findings based on speculation and hearsay.

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[17] 875/MRT16/363P.

**Tribunal consideration - Charge 1**

*Particulars 1 and 2 – Breach of conditions by returning four positive urine tests – March to July 2017*

[116] The practitioner admits that as from 21 November 2016, he was under the Medical Council imposed condition to provide urine testing results that showed levels consistent with abstinence from cannabis.

[117] The practitioner also admits that on four occasions between 9 March 2017 and 20 July 2017, he provided urine samples that all returned positive for cannabis use and that after 20 July 2017 he ceased providing urine samples in breach of the condition.

[118] The Tribunal finds these particulars are established on the evidence produced and based on the practitioner's own admissions. The HPCA Act section 100(1)(f) specifically marks out any breaches of conditions as conduct that may warrant disciplinary sanction. It is a serious matter for a practitioner to breach such a condition and on multiple occasions over a period of five months.

*Particular 3 – Non-compliance with drug testing programme - December 2016 - January 2017*

[119] The practitioner admits the factual allegations set out in this Particular 3 but denies that the conduct meets the threshold for professional misconduct. The practitioner accepts that the five urine samples over the period from 1 December 2016 to 27 January 2017 were not tested in accordance with the Health Committee's requirements.

[120] The samples were required to be tested by Canterbury Health Laboratories, and that to maintain a legal and secure chain of custody, specimens had to be collected, and the correct procedures adhered to. This required the local doctor, who witnessed the urine test, to courier the specimen directly to Canterbury Health Laboratories. However, the five urine tests taken over December 2016 and January 2017 were tested via the laboratory at [ ] District Health Board. This was contrary to the Health Committee protocol.

[121] The practitioner submits that his failure to adhere strictly to the terms of the drug testing protocol on these occasions is not sufficiently serious in the circumstances to warrant a disciplinary finding being made against him. It is submitted that in some instances there were reasons why the protocol could not be strictly adhered to, and that there is no suggestion that he was failing to comply with the protocol to avoid his urine specimens being tested positive, or for some other malevolent intent. It is submitted that reasonable members of the public, informed of all the factual circumstances, could not reasonably conclude that the reputation and good standing of the medical profession was lowered by the practitioner's conduct.

[122] The Tribunal does not accept this submission. We have no difficulty in finding the practitioner's failure to comply with the drug testing protocol on five separate occasions over a period of two months was a serious breach of his professional obligations. He had entered into agreements with the Medical Council Health Committee in June 2015 and December 2016, that he would comply with the required protocols. The practitioner was well aware of the requirements of the protocol and must be expected to have understood the importance of the chain of custody and specific testing laboratory protocol. The repeated breaches of the protocol cannot be excused. The drug testing programme was in place to assist his recovery, ensure his health was adequately monitored to avoid putting the public at risk all of which enabled him to retain his ability to practice. The obligation to follow the programme strictly is therefore critical.

[123] This conduct amounts to both negligence and malpractice. It is also likely to bring discredit to the medical profession, as the public are entitled to expect that health practitioners will comply with agreements made with their registration authority.

[124] The Tribunal considers that this non-compliance with the drug testing programme, on multiple occasions, is a serious departure from acceptable standards and that it is significant enough to warrant a disciplinary sanction.

*Particular 4 – Breach of voluntary undertaking by returning positive urine tests in October 2016*

[125] The practitioner accepts that he did breach the terms of the voluntary undertaking given to the Medical Council by returning the three positive urine tests indicating cannabis use, on three dates on 3, 14 and 20 October 2016. This prevented him from returning to his medical practice after his return from a period of travel overseas. It left his patients and Medical Centre unexpectedly without his cover in October 2016.

[126] The practitioner also accepts that he returned to practice in breach of the voluntary undertaking when he returned to his practice without Medical Council approval on 25 October 2016.

[127] The PCC maintain that overall, this conduct is cumulatively a serious breach of the undertaking. However, the practitioner denies that this is conduct that meets the level of a serious departure from acceptable standards required for professional misconduct. It is submitted there are reasonable explanations for this breach during this October 2016 period, including:

(a) His reducing cannabis levels over October were consistent with abstinence;

(b) There was a serious risk to his patients by his absence and his return to practice was supported by his senior colleagues in the local DHB and the impact on patients was confirmed to the Medical Council; and

(c) The delay by the Medical Council in acting to approve his return to practice despite his reducing cannabis levels placed him in an unfair position that left him having to make a decision to return to practice as a result of his belief that it was in the best interests of patients.

[128] Mr McClelland, for the practitioner, submits that as such, the breach fell well short of reaching the disciplinary threshold. His actions were neither malpractice nor negligence, and his conduct did not bring discredit to the medical profession.

[129] Dr Todd, the expert witness, concluded that based on the urine tests provided by the practitioner, he appears to also stop using cannabis for most of the period between November 2016 to June 2017 (with the exception of two brief periods of use).

[130] The Tribunal was not satisfied that overall, this conduct was sufficiently egregious to warrant a disciplinary sanction. The practitioner had given the voluntary undertaking while he was away overseas in August 2016. On his return to New Zealand, he undertook the urine testing and reported relatively low positive test results. His counsel wrote to the Medical Council on 11 October 2016, seeking his return to practice, acknowledging the need for him to address his dependence by treatment and providing a strongly supportive letter from the Chief Medical Officer at the local DHB. This letter referred to the urgent patient related needs supporting the practitioner's return to work.

[131] Over the course of the following weeks in October further representations were made to the Medical Council, by his counsel and other doctors supporting his return. It is apparent from this correspondence that there was a genuine and urgent concern about risks to the practitioner's patients and other patient groups he serviced in the community. In this context, the practitioner made a decision to return to work without approval from the Medical Council.

[132] This decision by the practitioner is not condoned by the Tribunal. The vulnerable nature of the population served by the practitioner does not imply that that population is any less deserving of care from practitioners consistent with all requirements of the Medical Council than any other population. It is also noted that he put himself in this difficult position by his own actions in not ensuring he was drug free on returning to New Zealand after a holiday. However, in all the circumstances the Tribunal is not satisfied that this amounts to sufficiently serious negligence or malpractice as to warrant a finding of professional misconduct.

*Particulars 5 and 6 – Inappropriate prescribing re Ms R – April 2017*

[133] The practitioner accepts Particulars 5(a) and (b) in relation to the prescribing of eye drops in Ms R's name but does not accept that his conduct as particularised in these paragraphs amounts to professional misconduct either separately or cumulatively.

[134] The practitioner accepts that he prescribed Tenoxicam in Ms R's name. However, he denies the prescription was for himself and therefore denies Particular 5(c). Tenoxicam is a non-steroidal anti-inflammatory drug. Counsel for the practitioner submits that the PCC has not produced a copy of that prescription, nor any record that it was dispensed and the Tribunal should not draw any adverse inference given the lack of documentation and direct evidence of the dispensing related to Particular 5(c).

[135] Ms R denied any recollection that the Tenoxicam was medicine given to her. Ms R hearsay evidence was that the pharmacist at the [ ] Pharmacy confirmed that the practitioner asked him to put the prescription under Ms R's name and he had done that.

[136] The PCC accepts the three prescriptions were not for controlled drugs or drugs of abuse. However, it is submitted that the practitioner's conduct fell below the expected standards of the medical profession, and the prescribing was solely for his own convenience and appears to have given little thought to the need for accuracy in both his and Ms R's patient records. The PCC submits that the practitioner's conduct amounts to negligence and conduct likely to bring discredit to the medical profession, and cumulatively with the other aspects of the charge, warrants disciplinary action.

[137] The Tribunal is satisfied that the practitioner prescribed medications for eye drops as charged on 19 April 2017 that were not intended for her and to this extent Particulars 5(a) and (b) are established. However, in relation to Particular 5 (c) the Tribunal was not satisfied that there was sufficient evidence that the Tenoxicam had been prescribed and was not intended for Ms R. The lack of documentary evidence of the prescription left the Tribunal uncertain of this third aspect of Particular 5.

[138] The Tribunal is further satisfied that Particular 6 is established, as the practitioner's prescribing, as established in Particulars 5(a) -5(b), was contrary to the Medical Council *Statement on providing care to yourself and those close to you* and the *Statement on Good Prescribing Practice*.

[139] However, overall Particulars 5 and 6 are not established either separately or cumulatively as professional misconduct. The Tribunal considers that the practitioner's actions while negligent and falling short of the conduct expected of a reasonably competent doctor, are not a significant enough departure to warrant a disciplinary sanction. These were not drugs of abuse and there is no evidence of any material risk of patient harm or a repeated pattern of conduct.

*Particulars 7 and 8 – Inappropriate prescribing to an unknown patient – July 2017*

[140] The practitioner accepts Particular 7 of the disciplinary charge and that it amounts to professional misconduct. The Tribunal is also satisfied that Particulars 7 and 8 amount to professional misconduct.

[141] While the practitioner offered the explanation that this was done as a favour for a patient's brother in [ ], he prescribed a hypertension medication to someone that was not a patient of his and who he had not examined. This conduct falls well below the standards expected for acceptable medical practice and the Medical Council *Statement on Good Prescribing Practice*. This conduct amounts to both negligence and malpractice and is likely to bring discredit to the medical profession.

**Tribunal consideration of Charge 2**

[142] This Charge relates to the practitioner's use of the "Mr Y" patient profile to submit his own urine samples for testing on four dates being 10 and 20 July 2017 and 4 and 13 October 2017. Each of the tests returned positive for cannabis and none were submitted to the Health Committee.

[143] During this July 2017 period, the practitioner did submit one final urine test to the Health Committee on 25 July 2017, which also tested positive. He did not submit any other urine tests to the Health Committee after July 2017.

[144] The PCC submits that the practitioner's conduct in using the false Mr Y patient profile for testing his urine over this period was done for the purpose of subverting the requirements of the conditions imposed on his scope of practice by the Medical Council on 21 November 2016. It is said that the practitioner's attempt to subvert the conditions to avoid a positive result being sent to the Health Committee posed a risk to patient safety. As such, the PCC submitted that the practitioner's conduct amounts to malpractice or negligence warranting disciplinary sanction.

[145] The practitioner states that he created the Mr Y patient profile in 2001 for use by patients who required sensitive tests in a small community who did not want their own identities known (the same reason why the Council created a patient profile for the practitioner when his urine tests were being submitted for testing). The practitioner maintains, through counsel, that while he did use the Mr Y profile for his own testing as alleged, there was nothing suspicious or untoward about doing so as he was able to conduct his own testing. The practitioner does not accept that he had "knowingly created a false patient profile" or was "subverting" the conditions on his scope of practice as alleged in Charge 2.

[146] The evidence produced in the Agreed Bundle of Documents confirmed the practitioner had created the "Mr Y" profile many years previously and had used it for other patients. Therefore, it had not been created inappropriately or dishonestly. This is a legitimate means by which some patient identities are protected. The Medical Council also condoned the creation of a fictious patient name for the practitioner as part of its own urine testing protocol. In these circumstances, we do not see this conduct as inappropriate.

[147] Equally, the Tribunal is not satisfied there is sufficient evidence that this testing was done for the purposes of subverting the requirements of the conditions on his scope of practice. It is clear that the practitioner wanted to monitor his own testing results, but he did

also submit a test to the Health Committee on 25 July 2017, despite his previous positive results that month. The fact remains that the practitioner did breach his conditions on the scope of practice over this period in July 2017, and this has already been captured by the finding in Charge 1, Particulars 1 and 2.

*Summary of established Charges*

[148] By way of summary, there are three aspects of Charge 1 that are established both separately and cumulatively:

(a) Breach of the condition under section 100(1)(f) of the HPCA Act (Particular 1 and 2);

(b) Professional misconduct established in relation to two matters, being;

(i) non-compliance with the drug testing programme, between December 2016 and January 2017 (Particular 3); and

(ii) Prescribing medication to the unknown patient on 17 July 2017 (Particular 7 and 8).

[149] The other Particulars of Charge 1 and Charge 2 are not established.

**Penalty**

[150] Given that the Tribunal is satisfied Charge 1 is established, it must go on to consider the appropriate penalty under section 101 of the HPCA Act. The penalties may include:

(a) Cancellation of registration;

(b) Suspension of registration for a period not exceeding three years;

(c) An order that the practitioner may only practise in accordance with conditions imposed on employment or supervision or otherwise;

(d) Censure;

(e) A fine of up to $30,000; and

(f) An order that costs of the Tribunal and/or the PCC to be met in part or in whole by the practitioner.

[151] The Tribunal accepts that the appropriate sentencing principles are those contained in *Roberts v Professional Conduct Committee*,[18] in which Collins J identified the following eight factors as relevant whenever the Tribunal is determining an appropriate penalty. The Tribunal is bound to consider what penalty:

(a) most appropriately protects the public and deters others;

(b) facilitates the Tribunal's important role in setting professional standards;

(c) punishes the practitioner;

(d) allows for the rehabilitation of the health practitioner;

(e) promotes consistency with penalties in similar cases;

(f) reflects the seriousness of the misconduct;

(g) is the least restrictive penalty appropriate in the circumstances; and

(h) looked at overall, is the penalty "fair, reasonable and proportionate in the circumstances."

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18 [2012] NZHC 3354 at [44]-[51].

*PCC submissions on penalty*

[152] Counsel for the PCC submits that the appropriate penalty in this case is a censure, a fine, and a period of suspension for 6 months to allow for a period of time during which the practitioner can submit urine tests that establish his ongoing abstinence before he commences practice.

[153] In the event suspension was ordered, the PCC also sought the following conditions on the practitioner's return to practice, including:

(a) Before recommencing clinical practice, the practitioner is to provide the Health Committee with urine drug tests results demonstrating 6 months of abstinence from cannabis use.

(b) Before recommencing clinical practice, the practitioner is to undertake an independent dual diagnosis psychiatric assessment as directed by the Health Committee.

(c) For a period of 2 years after recommencing clinical practice, the practitioner is:

(i) to remain abstinent from cannabis and/or other drugs of addiction.

(ii) to agree to monitoring, at his own cost, in a drug testing programme authorised by the Council's Health Committee.

(iii) not to work in sole practice and/or as a locum.

(iv) to comply with any other requirements of the Health Committee, including those identified in the independent dual diagnosis psychiatric assessment.

(d) Within 6 months after recommencing clinical practice, the practitioner is to undertake a re-certification programme about professional conduct to be set by the Council's Medical Adviser.

[154] Alternatively, if suspension was not imposed, the PCC submitted similar conditions should be imposed on his practice from the date he recommenced.

*Practitioner submissions on penalty*

[155] Counsel for the practitioner submitted that any penalty imposed on him must not be punitive-focused, but must achieve the principal objectives of the Act, and in this case encourage, support and assist the practitioner's rehabilitation rather than be a barrier to rehabilitation.

[156] In light of the fact that the practitioner has been suspended and unable to work as a medical practitioner since November 2017, now well over two years, it was submitted there should be no period of suspension, no fine imposed and any contribution to costs should be discounted.

[157] Mr McClelland for the practitioner, was willing to acknowledge some penalty was appropriate providing for the imposition of the following conditions for two years on his return to practise:

(a) That the practitioner undertake an independent psychiatric assessment by a general psychiatrist with knowledge of dependency as directed by the Health Committee.

(b) That he remain abstinent from cannabis and/or other drugs of addiction (other than those prescribed by his general practitioner or psychiatrist).

(c) That he agrees to monitoring, at his own cost, in a drug testing programme authorised by the Medical Council's Health Committee, with appropriate flexibility.

(d) That he will not work in sole practice and not work as a locum in sole practice.

(e) That he will comply with any other reasonable requirements of the Health Committee, including those identified in the independent psychiatric assessment.

(f) Within six months after re-commencing clinical practice the practitioner will undertake a re-certification programme on the subject of professional conduct to be set by the Council's medical adviser.

*Comparable cases*

[158] Counsel for the PCC submits that there is no directly comparable case on penalty, but referred the Tribunal to the cases highlighted previously in liability submissions:

(a) *Harypursat*.[19] This case involved a failure to comply with conditions on practice and professional misconduct for failing to comply with a voluntary undertaking. The Tribunal ordered a censure, suspension for 2 years, and conditions on the practitioner's return to work. Counsel highlighted that in *Harypursat*, the Tribunal considered that a period of suspension was considered necessary to ensure there was an appropriate period of rehabilitation and reflection, to reflect the seriousness of the breach and uphold standards.

(b) *Streat*.[20] This case involved a referral of conviction and professional misconduct for breaching a voluntary undertaking. The Tribunal ordered censure, a 3-month suspension, and conditions upon the resumption of practice. The primary purpose of the suspension was to enable Dr Streat to reflect on her conduct and the importance of getting appropriate treatment and counselling for her addiction, and to put herself in a position where she could make an ongoing useful contribution to society and the medical profession.

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[19] 975/Med18/413P.

[20] 630/Med13/269P.

(c) *Chum,*[21] involved breaches of conditions. The Tribunal censured Mr Chum, imposed a fine of $2,000, and imposed conditions on his practice, considering that was appropriate to send a message to the profession that conditions imposed by an authority must be complied with.

[159] Counsel for the practitioner submits that the practitioner's period of interim suspension from 2 November 2017 to the present day must be taken into account by the Tribunal when considering penalty and referred the Tribunal to the *Mendel*[22] decision in which a practitioner was found guilty of professional misconduct. The PCC sought an 8-month suspension and counsel for the practitioner submitted this would be excessive and disproportionate, asking the Tribunal to consider the 7-month period the practitioner had already been out of practice. The Tribunal found there was no need to suspend the doctor, given the Tribunal's view that the time out of practice had already provided opportunities for reflection.

*Aggravating and mitigating factors*

[160] In considering the appropriate penalty, the Tribunal is also required to consider the aggravating and mitigating factors in this case.

[161] The Tribunal acknowledges the following aggravating factors in relation to the established offending by the practitioner:

(a) *The repeated nature of the conduct.* There is an element of repeated inappropriate behaviour when considering the combined effect of the breach of conditions, failure to comply with the drug testing and inappropriate prescribing which all occurred between late 2016 and mid-2017.

(b) *Attitude of the practitioner/lack of insight.* The practitioner's attitude appears to be that he is better placed to assess his own risk and the needs of his patients than the Medical Council which has statutory responsibility for making those

[21] 895/Phys17/379P

[22] 996/Med17/394P.

decisions. A practitioner who is working with his own addiction is not best placed to make decisions about the risks that they may pose to the public.

[162] The PCC referred to the leniency by the Health Committee and that it worked with the practitioner for a considerable period, before it finally referred this matter to the PCC. It is submitted that this is an aggravating feature of the practitioner's conduct. While the Tribunal accepts that the Health Committee went to considerable efforts to assist the practitioner, we see his failures are related to his on-going struggle with cannabis dependence rather than an aggravating feature.

[163] Equally, the Tribunal does acknowledge the following mitigating factors for which the practitioner deserves credit:

(a) *Cooperation with the PCC.* The practitioner made significant admissions in respect of the Charges which has reduced the time necessary for the hearing to take place.

(b) *No previous disciplinary history.* The practitioner has no prior convictions or adverse findings by this Tribunal. Up until his honest admission on his application for a practising certificate on 25 February 2015, the practitioner had not been the subject of any complaint over his many years of practice.

(c) *Suspension for over 2 years.* The practitioner has been suspended from practice pending the outcome of this hearing since 21 November 2017. He has already suffered a very significant penalty in this respect.

(d) *No patient complaint.* No patient complaint has ever been made about the practitioner's care, treatment or management of them.

(e) *Competence as a practitioner.* Correspondence from other doctors and references produced in support, indicate that the practitioner was highly regarded when he was in sole practice. A practice review by Dr Lillis on 25 November 2015 confirmed that the practitioner was a safe practitioner. In mid-

2016, the practitioner's practice was accredited for foundation standards by the PHO and RNZCGP, consistent with him being a safe practitioner. Throughout, the PHO and HBDHB was supportive of the practitioner, his care for his patients, and his attempts to ensure continuity of care once he was suspended.

(f) *Abstinence from cannabis use.* The practitioner did achieve reasonable periods of abstinence during 2017, which evidence his attempts to comply with conditions.

(g) *Medical assistance sought.* The practitioner has recognised that he needs assistance to address a number of health issues and has engaged Dr Gil Newburn for this purpose.

[164] Counsel for the practitioner also referred to the fact that the PCC's investigation took a long time from November 2017 through to the charges being laid in October 2019 and then finally this hearing in March 2020. The PCC does not accept that this length of time was all caused by the PCC. The Tribunal acknowledges this period has likely caused an additional burden on the practitioner.

*Dr S' evidence*

[165] Dr S provided a reference filed in support of the practitioner, as a colleague and friend. The reference spoke to the practitioner's service to [ ] (a 24 hour facility serving [] city), as a Police Doctor, and in particular his valuable service to vulnerable communities in the region. Dr S had previously been prepared to act as a supervisor for the practitioner if he was able to return to practice.

[166] Dr S also gave evidence in person at the hearing. In particular, he was cross-examined by the PCC as to what the impact on patients would be if the practitioner was to work in his practice but then the practitioner could not maintain abstinence and was suspended. Dr S

agreed that this would create a difficult situation for patients and the practice.[23] Dr S was also asked by the Tribunal about his contact with the practitioner since his suspension and what he knew of the practitioner's level of commitment to return to practice. Dr S stated his contact with the practitioner had been limited over the last two years, that he would need a plan and supervision to come back to work, and that he was uncertain about whether the practitioner had any desire to return to practice.

**Finding on penalty**

[167] The Tribunal has taken into account the relevant sentencing principles, aggravating and mitigating factors and comparable cases.

[168] We are satisfied that the appropriate and proportionate penalty in this case is a censure, a short two-month period of suspension and conditions on the practitioner's practice upon his return to practice.

[169] The censure is to mark the Tribunal's disapproval of the practitioner's conduct that has been established as breach of conditions and professional misconduct.

[170] The short period of suspension of two months is necessary to mark the seriousness of the conduct but is also principally directed towards the practitioner's rehabilitation. While the practitioner has no doubt had ample opportunity to reflect on the impact of his conduct, this short suspension is intended to be time for reflection on this decision and to ensure that he has time to prepare for recommencing practice. The suspension is not intended to be punitive for the practitioner. It is necessary to ensure that he is able to attend to his rehabilitation and it is a protection for the profession and the community that will ensure the practitioner is abstinent from cannabis use before he returns to practise.

[171] We are not able to order the practitioner to take any steps during his suspension. However, we strongly recommend that he take the following steps during the 2-month suspension period to prepare for recommencing practice:

[23] Transcript dated 3 March 2020 at page 191.

(a) Undertake an independent dual diagnosis psychiatric assessment and with a provider approved by the Medical Council's, Health Committee; and

(b) Undergo monitoring in a drug testing programme approved by the Council's Health Committee to progress his recovery towards permanent abstinence from cannabis and/or any other drugs of addiction, other than those prescribed by his general practitioner or other medical practitioner.

[172] Upon recommencing practice after the suspension, the Tribunal orders conditions on the practitioner for a period of two years, all to be met at his own cost. The conditions are largely as sought by the PCC and are detailed in the Orders of the Tribunal set out on the final pages of this decision.

[173] While there is no evidence of any clinical impact as a result of the practitioner's addiction, the Tribunal considers that his cannabis dependence must inevitably carry some risks. The Tribunal understands that it will require a significant effort on the practitioner's part to achieve the conditions set by the Tribunal. The practitioner should be in no doubt that this is a very important final opportunity for him. If he is unable to achieve abstinence and comes before the Tribunal again, that may well permanently impact his career in the medical profession.

[174] Overall we consider this combination of censure, a short period of suspension and conditions achieve a reasonable balance between maintaining professional standards in the profession, protecting the public and at the same time allowing for the rehabilitation of a practitioner who has been a valued member of the profession. We do not consider a fine is appropriate in this case given the toll the practitioner's suspension from practice will have already taken and the inevitable costs of the conditions imposed.

**Costs**

[175] The PCC costs were $76,217 in relation to Charge 1. As Charge 2 was not established the PCC did not seek costs in relation to that charge. The PCC by agreement made with the practitioner seeks 25% of the costs of Charge 1.

[176] The Tribunal estimate costs were $49,899.40 in total based on a four-day hearing. There is some reduction in those costs given that the hearing time was reduced to two days. However, much of the costs of the hearing are not able to be recouped after the hearing commences.

[177] In considering the appropriate quantum of costs, the Tribunal must take into account the need to make a proper contribution towards the costs. In doing so it takes 50% of the total reasonable costs as a starting point, in accordance with the dicta in *Cooray v Preliminary Proceedings Committee.*[24]

[178] In the present case, the Tribunal considers it is appropriate to grant the costs award of 25% as agreed between the parties. A discount of 25% has been accepted by the Tribunal to the practitioner's cooperation with the PCC and the Tribunal and the fact that not all aspects of Charge 1 have been established.

[179] The practitioner must pay a costs contribution of $19,054 to the PCC, and $12,474 to the Tribunal. This has been calculated on the following basis:

(a) PCC costs - Charge 1 - $76,217 reduced to 25% $19,054; and

(b) Tribunal costs $49,899 reduced to 25% $12,474.

[180] The Tribunal acknowledges that this calculation produces an increased figure in costs payable by the practitioner from that expressed at the hearing in the oral indication of penalty. However, we have reviewed the calculation and there was some double counting of the reduction in costs applied and indicated by the Tribunal. We consider this was too generous and the calculation set out in this decision now better reflects our intention and the agreement made between the parties on costs.

24 HC Wellington, AP 23/94, Doogue J, 14 September 1995.

**Name suppression**

[181] Interim suppression orders were made in respect of the practitioner's name and the details of his health conditions, and in respect of the names of Ms R (witness for the PCC) and Ms X (referred to in the evidence).

[182] The practitioner made an application for permanent name suppression. In support, it was submitted that publication of his name would cut across all the rehabilitation steps that he has taken thus far and that there would be a very real risk that publicity would have a significant impact on the practitioner and his ongoing rehabilitation.

[183] Counsel for the practitioner further submitted that in this case there is a compelling interest in the rehabilitation of the practitioner, and there are not sufficiently strong public interest considerations that require publication of his name. In particular, counsel referred to *B v B* in which Blanchard J noted there was much to be said for the view that publication of a practitioner's name is contrary to the spirit of a decision to allow that practitioner to continue to practise and can be counterproductive: "it may simply cause damage which makes rehabilitation impossible or very much harder to achieve".[25]

[184] The practitioner submitted that there was significantly reduced public interest in publication of his name in the present case in circumstances where there was no patient harm or patient safety concerns, he was willing to undertake rehabilitation steps which are ongoing, and where he had not practised medicine for nearly 2.5 years.

[185] In addition, it was submitted that the practitioner's 82-year-old mother (who was referred to in the materials) was aware what was going on and had suffered ongoing stress as a result of these proceedings, which should be taken into account.

[186] The PCC opposed the practitioner's application. The PCC submitted that there is a presumption in favour of openness and, in particular when the practitioner has been found guilty of professional misconduct and is intending to return to practice. In these

[25] HC Auckland HC4/92, 6 April 1993, Blanchard J.

circumstances, there is a public interest in the name of the practitioner, so that patients are able to make an informed decision about the doctor they visit.

[187] The Tribunal has considered the test related to suppression applications set out in section 95 of the HPCA Act, and the Court of Appeal's statement in *Y v Attorney-General*, that is, given the importance of the principle of open justice, there must be sound reasons for finding that the presumption favouring publication is displaced.[26] In deciding whether to grant name suppression, as the Court said in *Y v Attorney-General*, a balance must be struck between considerations of open justice and the interests of the applicant.[27]

[188] In the present case, the presumption of open justice is displaced by the interests of the practitioner, and, in particular the risk that publication will have a detrimental impact on the practitioner's health and rehabilitation. While we remain mindful of the public interest, we consider this can be met by the strict conditions placed on his return to practice that will be monitored closely by the Medical Council and its Health Committee and the knowledge of any future employer of those conditions. We favour providing this practitioner with one final opportunity to complete his rehabilitation given his lengthy service to his community, his evident clinical competence and the lack of any immediate risk to patient safety.

[189] Accordingly, a permanent suppression order will be made in respect of the practitioner and the details of his health conditions. This will not restrict the Tribunal's ability to describe the nature of the cannabis dependency as it has in this decision, which is necessary for an understanding of the charges and this decision.

[190] In addition, permanent suppression orders will be made in relation to the witnesses Ms R and Ms X, as well as Dr SS.

[191] The Medical Council will have the ability to publish on its website in relation to the registration details of the practitioner, the censure and the conditions that have been imposed

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[26] [2016] NZCA 474 at [29].
[27] Ibid at [31].

on his practice and to disclose the conditions ordered in this decision to any future employer, for the period of the conditions.

**Orders of the Tribunal**

[192] The findings on Charges 1 and 2 are as follows:

(a) Established – Charge 1:

(i) Breach of conditions on the scope of practice under s100(1)(f) of the HPCA Act (Particulars 1 and 2);

(ii) Failure to comply with drug testing programme (Particular 3) and inappropriate prescribing in the name of an unknown overseas patient (Particular 7) established as professional misconduct in s100(1)(a) and (b) of the HPCA Act;

(b) Not established – Charge 1: Breach of voluntary undertaking (Particular 4) and inappropriate prescribing in the name of patient (Particulars 5 and 6), are not established as professional misconduct;

(c) Not established – Charge 2: Inappropriately using a false patient profile for the purposes of submitting the practitioner's urine drug screening and subverting the requirements of the conditions on his scope of practice, are not established as professional misconduct under s100(1)(a) or (b) of the HPCA Act.

[193] The penalty orders against the practitioner in relation to the established Charge 1 are made under s101 of the HPCA Act as follows:

(a) An order that the health practitioner is censured;

(b) An order that the health practitioner be suspended for a period of two months from the date of this decision, with the following recommended steps to be taken during the period of suspension at the practitioner's cost:

(i) Undertake an independent dual diagnosis psychiatric assessment as directed by the Health Committee of the Medical Council and with a provider approved by the Health Committee; and

(ii) Undergo monitoring in a drug testing programme approved by the Medical Council's Health Committee to progress his recovery towards permanent abstinence from cannabis and/or any other drugs of addiction, other than those prescribed by his general practitioner or another registered medical practitioner.

(c) An order that the health practitioner must, after commencing practice following the end of his suspension, practice his profession only in accordance with the following conditions, to be met at his cost for a period of not more than two years:

(i) Immediately upon returning to practice, the practitioner must arrange for the independent dual diagnosis psychiatric assessment to be provided to the Medical Council's Health Committee. The assessment is to be conducted by a provider authorised by the Health Committee.

(ii) Immediately on recommencing practice, for a period of eight weeks, the practitioner is to provide to the Health Committee weekly scheduled urine drug tests strictly in accordance with protocols specified by the Health Committee. Those urine drug tests are to show abstinence from cannabis use and/or any other drugs of addiction, except for those that may be prescribed by the practitioner's medical practitioner and notified in advance to the Medical Council.

(iii) After the initial 8-week period of drug testing, the practitioner is to remain abstinent from cannabis and/or other drugs of addiction, save for those that may be prescribed by his medical practitioners and notified in advance to the Medical Council.

(iv) The practitioner is to agree to monitoring, at his own cost, in a drug testing programme authorised by the Health Committee of the Medical Council.

(v) Within six months of recommencing clinical practise, the practitioner is to undertake a re-certification programme on matters to be determined as relevant as set by the Medical Council.

(vi) The practitioner is not to work in any sole practice and/or as a locum; and

(vii) The practitioner is to comply with any other requirements of the Health Committee, including those identified in the independent dual diagnosis psychiatric assessment.

(d) Costs of $12,474 to the Tribunal and $19,054 to the PCC. In broad terms, this is an order to pay 25% of the costs.

(e) The Tribunal directs the Executive Officer to publish this decision and a summary of it on the Tribunal's website. The Tribunal also directs the Executive Officer to request the Medical Council of New Zealand to publish either a summary of, or a reference to, the Tribunal's decision in its principal professional publications to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

[194] A permanent non-publication order is made under s95 of the HPCA Act, in respect of:

(a) the name and any identifying features of the practitioner and the detail of his health conditions, subject to the Medical Council's ability to retain the authority to publish the following:

(i) on its website in relation to the registration details of the practitioner, the censure and the conditions that have been imposed on the

practitioner's practice in a way it considers appropriate that does not disclose the practitioner's health conditions; and

(ii) to disclose the conditions on the practitioner's practice to any future employer for the period of the conditions.

[195] A permanent non-publication order is also made in respect of the names and identifying features of the witnesses Ms R, Ms X and Dr SS and any patients named in this proceeding.

**DATED** at Auckland this 7th day of July 2020

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MJ Dew QC
Chair
Health Practitioners Disciplinary Tribunal

## Notice of Charge 1

Take notice that a Professional Conduct Committee (**Committee**) appointed by the Medical Council of New Zealand (**Council**) pursuant to section 71 of the Health Practitioners Competence Assurance Act 2003 (**Act**) has determined in accordance with section 80(3)(b) of the Act that disciplinary charges be brought against Dr T before the Health Practitioners Disciplinary Tribunal (**Tribunal**).

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

Pursuant to section 81(2) and 91 of the Act, the Committee charges as follows:

**Breach of conditions on scope of practice**

1 On the dates listed below, Dr T failed to comply with conditions included on his scope of practice.

*Particulars:*

a On 21 November 2016, the Council imposed conditions on Dr T's scope of practice requiring him to have fortnightly urine testing or to such other timing as the Health Committee agrees and requiring the results to show levels consistent with abstinence from cannabis.

b Dr T's urine sample collected on 9 March 2017 tested positive for Carboxy-THC, indicating cannabis use.

c Dr T's urine sample collected on 4 May 2017 tested positive for Carboxy-THC, indicating cannabis use.

d Dr T's urine sample collected on 20 July 2017 tested positive Carboxy-THC, indicating cannabis use.

e Dr T ceased providing urine test results to the Health Committee after the urine sample collected on 20 July 2017.

2 The conduct alleged in paragraph 1 is contrary to section 100(1)(f) of the Act.

**Compliance with drug testing programme**

3 Dr T failed to comply with agreements between Dr T and the Council's Health Committee dated 3 June 2015 and 12 December 2016.

*Particulars*

a On 3 June 2015, Dr T entered into an agreement with the Council's Health Committee which required him to comply with a random drug testing programme as specified by the Health Committee.

b The drug testing programme specified by the Health Committee required urine samples to be tested by Canterbury Health Laboratories following the procedures recommended in AS/NZS 4308 2008 *'Recommended Practice for the Collection, Detection and Quantitation of Drugs of Abuse in Urine'*.

c On 12 December 2016, Dr T entered into an agreement which required him to comply with a fortnightly drug testing programme as specified by the Health Committee.

d The drug testing programme specified by the Health Committee required urine samples to be tested by Canterbury Health Laboratories following the procedures recommended in AS/NZS 4308 2008 *'Recommended Practice for the Collection, Detection and Quantitation of Drugs of Abuse in Urine'*.

e At Dr T's request, the following urine samples were not tested in accordance with the Health Committee requirements:

i urine sample collected on 1 December 2016; and/or

ii urine sample collected on 16 December 2016; and/or

iii urine sample collected on 29 December 2016; and/or

iv urine sample collected on 12 January 2017; and/or

v urine sample collected on 27 January 2017.

**Breach of voluntary undertaking**

4 On 25 October 2016, and in the days following, Dr T breached a voluntary undertaking between him and the Council dated 18 August 2016.

*Particulars:*

a On 18 August 2016 Dr T entered into a voluntary undertaking with the Council that he would not practice medicine until the results of a urine test done within one week of his return from overseas was considered by the Council's Health Committee and the Health Committee considered that the result is consistent with remaining abstinent from cannabis.

b Dr T's urine sample collected on 3 October tested positive for Carboxy-THC, indicating cannabis use.

c Dr T's urine sample collected on 14 October tested positive for Carboxy-THC, indicating cannabis use.

d Dr T's urine sample collected on 20 October tested positive for Carboxy-THC, indicating cannabis use.

e On 25 October 2016, Dr T returned to practice.

**Inappropriate prescribing**

5 Dr T prescribed medications under Ms R's name which were not intended for her and/or were intended for Dr T, on the following occasions:

a on 19 April 2017, Dr T prescribed Flurometholone (FML) 0.1% eye drops; and/or

b on 19 April 2017, Dr T prescribed Chloramphenicol (Clorafast) 0.5% eye drops; and/or

c on 30 June 2017, Dr T prescribed Tenoxicam (Tilcotil) 20mg tabs.

6 Dr T's prescribing as described in paragraph 5 above was contrary to:

a the Council's *Statement on providing care to yourself and those close to you*; and/or

b the Council's *Statement on Good Prescribing Practice*; and/or

c acceptable medical practice.

7 On 17 July 2017 Dr T prescribed medication under the name of a patient, in circumstances where:

a the medication was intended for the patient's brother in[ ]; and/or

b the intended recipient of the medication was not under the care of Dr T; and/or

c Dr T had not personally assessed the intended recipient of the medication.

8 Dr T's prescribing as described in paragraph 7 above was contrary to:

a the Council's *Statement on Good Prescribing Practice*; and/or

b acceptable medical practice.

9 The conduct alleged in paragraphs 3 to 8 above separately and/or cumulatively amounts to professional misconduct under section 100(1)(a) and/or section 100(1)(b) of the Act.

**Notice of Charge 2**

Take notice that a Professional Conduct Committee (**Committee**) appointed by the Medical Council of New Zealand (**Council**) pursuant to section 71 of the Health Practitioners Competence Assurance Act 2003 (**Act**) has determined in accordance with section 80(3)(b) of the Act that disciplinary charges be bought against Dr T before the Health Practitioners Disciplinary Tribunal (**Tribunal**).

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

Pursuant to section 81(2) and 91 of the Act, the Committee charges that Dr T acted inappropriately and/or dishonestly in the following ways:

1 Dr T knowingly created a false patient profile in the practice management system at [ ] Medical Practice with the following patient details:

  a Patient name: ‘ []’ and/or ‘Mr Y’

  b Date of birth: [xx]

  c [Address]

2 Dr T used that false patient name and/or patient profile to submit his own urine samples for urine drug screening by Canterbury Health Laboratories and/or Southern Community Laboratories on the following occasions:

  a Urine sample collected on 10 July 2017; and/or

  b Urine sample collected on 20 July 2017; and/or

  c Urine sample collected on 4 October 2017; and/or

  d Urine sample collected on 13 October 2017.

3 Dr T’s conduct as set out in paragraph 2 above was done for the purpose of subverting the requirements of the conditions on his scope of practice.

*Particulars*

a On 21 November 2016, the Council imposed conditions on Dr T's scope of practice requiring him to have fortnightly urine testing or to such other timing as the Health Committee agrees and requiring the results to show levels consistent with abstinence from cannabis.

b Dr T ceased providing urine test results to the Health Committee after a urine sample collected on 20 July 2017.

c Dr T used the tests set out in paragraph 2 above for the purpose of determining not to submit urine samples for testing as required by the conditions on his scope of practice and/or for the purpose of avoiding a positive test result being submitted to the Health Committee.

4 Dr T's conduct, as alleged in paragraphs 1 to 3 above, was contrary to;

a the Council's statement *Good Medical Practice*; and/or

b accepted standards of medical practice.

5 The conduct alleged in paragraphs 1 to 3 above amounts to professional misconduct in that, either separately, or cumulatively, or cumulatively with the charge against Dr T dated 4 October 2019, it:

a amounts to malpractice or negligence in relation to his scope of practice, pursuant to section 100(1)(a) of the Act; and/or

b has brought or is likely to bring discredit to the profession, pursuant to section 100(1)(b) of the Act.