



**BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA**

HPDT NO: 1319/Med22/547P

UNDER the Health Practitioners Competence Assurance Act 2003
("the Act")

IN THE MATTER of a disciplinary charge laid against a health practitioner
under Part 4 of the Act

BETWEEN **A PROFESSIONAL CONDUCT COMMITTEE** of the Medical
Council of New Zealand

AND **DR POANERE TAPUKURA RAIRI**, of Auckland, a
Registered Medical Practitioner

Practitioner

HEARING Held in Auckland on 17 and 18 April 2023

TRIBUNAL Ms A J Douglass (Chair)
Ms A Kinzett, Dr K Eggleton, Dr W Rainger and Dr K Good (Members)

IN ATTENDANCE Ms A Crosby, Executive Officer
Ms K O'Brien, Stenographer

APPEARANCES Mr R Stewart and Ms H Goodhew for the Professional Conduct
Committee
Mr R Walters for the Practitioner

DECISION OF THE TRIBUNAL
14 August 2023

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Introduction

- [1] Dr Poanere Rairi is a registered medical practitioner practising as a General Practitioner (GP) in Auckland.
- [2] The Professional Conduct Committee (PCC) of the Medical Council of New Zealand (Medical Council) has laid a Charge (the Charge) against Dr Rairi for inappropriately prescribing medications to Dr [A], a former colleague at his practice.
- [3] The PCC says that between 27 August 2018 and 25 March 2020 Dr Rairi prescribed Dr [A] 61 prescription items including Tramadol, Codeine phosphate and Benzodiazepines (including Lorazepam and Clonazepam) as well as Zopiclone. Some of these medications are Class C controlled drugs and all of them have a risk of addiction and misuse.
- [4] The PCC alleges that Dr Rairi's conduct is a departure from the Medical Council's professional standards for prescribing practice and is conduct that is malpractice and / or negligence in his scope of practice pursuant to s 100(1)(a) of the Health Practitioners Competence Assurance Act 2003 (the Act) and has brought, or is likely to bring discredit to the medical profession pursuant to s 100(1)(b) of the Act.
- [5] The amended Charge is set out in the Schedule attached to this decision.¹
- [6] Dr Rairi has admitted the particulars of the Charge and the underlying facts, as set out in the Agreed Summary of Facts (ASOF).²
- [7] With respect to particular 1, Dr Rairi has admitted that he wrote the prescriptions for Dr [A] shown in Appendix A of the Charge. His close working relationship with Dr [A] made it inappropriate for him to treat her because it

¹ Notice of Amended Charge dated 30 March 2023.

² Document 1, Agreed Summary of Facts dated 30 March 2023.

blurred boundaries and created the potential for his clinical objectivity to be affected.

- [8] With respect to particular 2, Dr Rairi admits he prescribed medications with a potential for misuse and dependence after being notified of Dr [A]'s substance use disorder on 21 November 2019.
- [9] Despite Dr Rairi's admissions it remains for the Tribunal to establish that each of the particulars of the Charge are established and that the conduct as alleged by the PCC amounts to professional misconduct.
- [10] At the conclusion of the hearing the Tribunal found the Charge established and indicated the decision and orders on penalty, costs and name suppression.
- [11] We set out the reasons for our decision and the orders made below.

Background

- [12] Dr Rairi was born in the Cook Islands. In 1993 he moved to Fiji to study. In 1995 he finished his diploma in primary care. He returned to the Cook Islands for a year before returning to Fiji to finish his studies. He graduated in 2003 with a Bachelor in Medicine and Surgery (MBBS) from the University of the South Pacific, Fiji.
- [13] In 2004 he moved to Auckland with his wife and son. He worked in a Primary Health Organisation (PHO) as a clinical advisor for five years, while the family settled in New Zealand and he studied towards his registration. He completed both Australian qualifications and in December 2012 he registered with the Medical Council of New Zealand as a medical practitioner in the general scope of practice.

- [14] Since 2012 he has worked in General Practice. In April 2016 he opened the MaxCare Medical Centre (the Medical Centre) in Otahuhu and he has been working there as a non-vocational registered GP and Medical Director ever since.
- [15] During this time Dr Rairi was the only GP working at the Medical Centre, apart from occasional help from locum doctors.
- [16] In April 2018 he was introduced to Dr [A] who was at that time working for another provider and she had some part-time availability to work for the Medical Centre.
- [17] Dr [A] had started the General Practitioner Education Programme (GPEP). As Dr Rairi was not a Fellow of the Royal New Zealand College of General Practitioners (RNZCGP) he could not supervise Dr [A]. However, she sought general experience in practice and the opportunity to work with Dr Rairi.
- [18] From 8 June 2018 until 11 March 2019 Dr [A] worked part-time as a GP (non-training Registrar) under an independent contractor agreement.³
- [19] From 27 August 2018 Dr [A] was enrolled at the Medical Practice as a casual patient.
- [20] From March 2019 Dr [A] stopped working at the Medical Centre. On around 13 August 2019 Dr [A]'s contract with the Medical Centre was re-established and she continued to work part-time for the practice.
- [21] Unbeknownst to Dr Rairi, on 30 July 2019 Dr [A] appeared before the Tribunal on charges of professional misconduct relating to self-prescribing between 2011 and 2017 for her own use in her own name and in the names of family members.

³ Agreed Bundle of Documents (ABOD), p 75, Independent Contract Agreement dated 21 May 2018 (signed on 8 June 2018).

These prescriptions included all of the drugs mentioned in relation to this Charge to which Dr Rairi now faces.

- [22] In a decision dated 30 October 2019⁴ the Tribunal found the charge of professional misconduct established. Dr [A] was found to be in breach of her ethical obligations and accepted standards of practice in relation to an extensive amount of prescription medicines and controlled drugs for her own use. Dr [A] was censured, fined \$5,000, conditions were placed on her practice for three years and a contribution to costs.
- [23] On 21 November 2019 Dr Rairi received an email letter from the Health Case Manager of the Medical Council's Health Committee regarding Dr [A]'s health and an order imposing conditions upon Dr [A]'s scope of practice, which included supervision by a vocationally registered general practitioner
- [24] On 25 November 2019 Dr Rairi terminated Dr [A]'s employment at the Medical Centre as the practice did not have a vocationally registered GP who could supervise her.
- [25] During the relevant time Dr [A] was under the care of another GP, Dr Argent.
- [26] On 2 March 2020 the Medical Council received notification from Dr [A]'s Health Case Manager that Dr Rairi had been prescribing Tramadol to [A] for an acute migraine attack.
- [27] On 13 May 2020 the Medical Council notified Dr Rairi that the information received from the Health Committee and Dr [A] and Dr Rairi's prescribing data from the Ministry of Health for the period August 2018 to April 2020 when they worked together raised concerns about Dr Rairi's prescribing practice.

⁴ *PCC v Dr A* 1046/Med18/431P.

[28] On 4 June 2020 Dr Rairi wrote to the Medical Council disputing that Dr [A] prescribed to him in 14 instances and that that it was only in 3 instances.

[29] Further correspondence between the Medical Council and Dr Rairi ensued.

[30] On 27 October 2021 the PCC determined that a disciplinary charge be brought against Dr Rairi.

[31] On 30 March 2023 the initial Charge was subsequently amended, and an Agreed Summary of Facts (ASOF) based on Dr Rairi's admissions was signed by him.

Relevant law

Professional misconduct

[32] The primary purpose of the Tribunal's disciplinary powers is the protection of the public by the maintenance of professional standards.

[33] Section 100 of the Act defines the grounds on which the health practitioner may be disciplined. Dr Rairi has been charged with professional misconduct under both s 100(1)(a) and / or (b) of the Act as follows:

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;

[34] In *B v Medical Council of New Zealand*⁵ the Court stated:

The structure of the disciplinary processes is set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical and responsible practitioners. But the inclusion of lay representatives in a disciplinary process and the right of appeal to this court indicates that usual professional practice, while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not permitted to lag. The disciplinary process is in part one of setting standards.

[35] The Tribunal and the Courts have considered the term "professional misconduct" under s 100(1)(a) on many occasions. In *Collie v Nursing Council of New Zealand*,⁶ Gendall J described negligence and malpractice as follows:

Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.

[36] "Malpractice" is defined in the *Collins English Dictionary* as:⁷

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

[37] Malpractice is defined in the *New Shorter Oxford English Dictionary*:⁸

1. Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer ... 2. Gen. A criminal or illegal action: wrongdoing, misconduct.

[38] Section 100(1)(b) of the Act creates another route by which a finding of professional misconduct may be made. This is where the practitioner's conduct has or is likely to bring discredit on the particular health profession. In *Collie v Nursing Council of New Zealand*,

⁵ Elias J, HC Auckland HC 11/96, p 15 noted at [2005] 3 NZLR 810.

⁶ [2001] NZAR 74 at [21].

⁷ Collins English Dictionary (2nd Edition).

⁸ Shorter Oxford English Dictionary (1993 ed), as cited in *Dr E 136/Med07/76D* at [12]–[14].

Gendall J considered the meaning of conduct likely to bring discredit on the nursing profession as follows:⁹

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

Burden and standard of proof

[39] The burden of proof is on the PCC. This means that it is for the PCC to establish that the practitioner is guilty of professional misconduct.

[40] The PCC must produce evidence that establishes the facts on which the Charge is based to the civil standard of proof; that is, proof which satisfies the Tribunal that on the balance of probabilities the particulars of each 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.¹⁰

Threshold test for disciplinary sanction

[41] There is a well-established two-stage test for determining professional misconduct in this jurisdiction.¹¹ 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 health practitioner's acts or omissions can reasonably be regarded as being negligence and / or malpractice or, having brought or are likely to bring discredit to the practitioner's profession; and

⁹ *Collie v Nursing Council of New Zealand* [2001] NZAR 74 at [28].

¹⁰ *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1 (SC) at [112].

¹¹ *PCC v Nuttall* 08/Med04/03P; *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA), as applied in *Johns v Director of Proceedings* [2017] NZHC 2843 at [78].

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

[42] In *Martin v Director of Proceedings*¹² the High Court has said that the threshold should not be regarded as “unduly high” but that “a notable departure from acceptable standards” is required; and that the threshold is to be reached with care, having regard to both the purpose of the Act and the implications for the practitioner.¹³

Professional standards and guidelines

[43] When assessing the standards reasonably expected of a medical practitioner the Tribunal has regard to the professional and ethical obligations set by the Medical Council. The relevant Medical Council statements for prescribing practice include:

- (a) *Good Medical Practice* (December 2016);
- (b) *Providing Care to Yourself and Those Close to You* (November 2018);
- (c) *Good Prescribing Practice* (November 2016); and
- (d) *Prescribing Drugs of Abuse* (April 2010).

Evidence

[44] The PCC proved the Charge based on the Agreed Bundle of Documents (Bundle/ABOD). The Bundle included the complaint documentation and correspondence between Dr Rairi and the Medical Council; the Medical Centre documents, including Dr [A]’s contractual arrangements with the practice and her enrolment as a casual patient from 27 August 2018.

¹² [2010] NZAR 33.

¹³ *Martin v Director of Proceedings* [2010] NZAR 333, Courtney J at [32].

[45] The Bundle included: medical and prescribing records from the Ministry of Health between 27 August 2018 to 25 March 2020, the period of time in which Dr [A] was a “casual” patient of Dr Rairi; Dr [A] and Dr Rairi’s responses to the PCC; a Performance Assessment Committee (PAC) report dated 19 July 2021; Medsafe data sheets; and the relevant Medical Council statements.

[46] Dr Rairi provided his prepared brief of evidence (Dr Rairi’s statement) at the penalty stage. He gave evidence for the purpose of answering questions from the Tribunal.¹⁴

[47] The following is the Agreed Summary of Facts signed by Dr Rairi.¹⁵

Background

Professional and personal background

1. Dr Rairi is a medical practitioner who lives in Auckland. He graduated with an MBBS Bachelor of Medicine and Surgery from the University of South Pacific, Fiji in 2003 and was registered in the general scope of practice with the Medical Council of New Zealand (the **Council**) on 10 December 2012.
2. From 2012 to 2016 Dr Rairi worked at the Mount Wellington Integrated Health Centre.
3. From 2013 Dr Rairi also worked at the EastCare Accident & Medical Centre in Botany, and he continues to work alternating Sundays there now.
4. In April 2016, Dr Rairi founded the MaxCare Medical Centre (**MMC**) in Otahuhu, and has been working as a General Practitioner and Medical Director there ever since.
5. In addition, Dr Rairi has been working towards expanding the services provided in Otahuhu, according to an integrated care model to better suit the community’s needs. This work has involved purchasing new premises and establishing new legal entities including a not-for-profit trust. Midwifery, psychology and nurse practitioner services are already up and running, including social services related to housing, budgeting and WINZ advocacy; a cardiovascular nurse service; family planning.

¹⁴ Document 5, Statement of Dr Poamere Tapukura Rairi; Transcript, p 65.

¹⁵ Document 1, Agreed Statement of Facts.

6. Dr Rairi does not have any previous history with the Health Practitioners Disciplinary Tribunal (the **Tribunal**).

Dr [A]

7. By an independent contractor agreement dated 21 May 2018 (but signed on 8 June 2018) MMC engaged Dr [A] to provide GP services at MMC. Dr [A] was engaged part time as a general practitioner (non-training registrar). From that date Dr Rairi had a close relationship with Dr [A] as envisaged by the November 2016 Council Statement on providing care to yourself and those close to you.
8. Dr [A]'s contract with MMC was terminated on 11 March 2019 but she was later re-engaged on substantially the same contractual terms on or around 13 August 2019.
9. Dr Rairi was the only other doctor working at MMC during the relevant time periods (with the exception of locums).
10. Dr [A] felt she had a collegial relationship with Dr Rairi during the periods she worked at MMC.
11. In July 2019 the Tribunal found Dr [A] guilty of professional misconduct for:
 - a. Writing prescriptions in her own name for her own use including the drugs tramadol hydrochloride, zopiclone, codeine phosphate, citalopram hydrobromide, lorazepam, mirtazapine, and triazolam.
 - b. Writing prescriptions for the supply of the drugs zopiclone, triazolam, and codeine phosphate for her own use in the names of family members, and knowing that the named persons were not the intended recipient.
 - c. Writing or presenting Medical Practitioner Supply Orders for codeine phosphate, zopiclone, tramadol, triazolam and lorazepam and obtained those drugs for her own use.
 - d. Consuming various controlled drugs without adequate independent medical oversight.
 - e. Misleading or attempting to mislead her employer, and the Council, by advising them she had not picked up a prescription dispensed to her.
12. The Tribunal ordered Dr [A] be censured, fined, and conditions were placed upon her return to practice. The relevant conditions included that:
 - a. Dr [A] take part in an educational programme focused on the Council

statements *Providing care to yourself and those close to you* and *Good Prescribing Practice* along with professional boundaries and ethics in medicine;

- b. For a period of three years Dr [A] was required to advise her present and any future employers of the Tribunal's decision and its orders;
 - c. For a period of three years Dr [A] was required to comply with all requirements of the Council's Health Committee.
- 13. In mid-September 2019, Dr [A] told Dr Rairi that the Medical Council's Health Committee was enquiring into her wellbeing and that depending on the outcome she may require supervision. Dr Rairi assumed the enquiry related to the stress she was under at the time but did not ask Dr [A] what the enquiry related to.
- 14. On 5 November 2019, the Medical Council's Health Committee considered information about Dr [A]'s health. The Committee decided Dr [A] was fit to practice only if certain conditions were observed. In an order dated 14 November 2019, the Registrar imposed those conditions on Dr [A]'s scope of practice.
- 15. On 21 November 2019, Dr [A]'s health case manager emailed a letter to Dr Rairi advising him of the Health Committee's decision. The letter attached the Registrar's order imposing conditions upon Dr [A]'s scope of practice.
- 16. The conditions on Dr [A]'s scope of practice required her to receive onsite supervision by a vocationally registered general practitioner, hair and blood testing, and to maintain various forms of engagement with the Council's Health Team. The reasons for the conditions were also set out, and included:
 - a. an independent assessor reported that Dr [A] is fit to practise, if certain conditions are met;
 - b. Dr [A]'s disordered personality traits have impacted her ability to perform the functions required for the practice of medicine, in terms of her professional behaviour, and her clinical practice;
 - c. the assessor advised that Dr [A] needs strict supervision and external monitoring and treatment to manage these personality traits, to ensure these do not continue to impact adversely on her practice;
 - d. Dr [A]'s substance use disorder is only in partial remission, and the Committee needs assurance that her prescription medication and alcohol use are remaining within safe limits.

17. Dr Rairi received the email but did not read it closely or pay sufficient attention to its contents. He did not read the attachment that set out the Health Committee's order in full.
18. On 25 November 2019 Dr Rairi terminated Dr [A]'s employment at MMC because MMC did not have a vocationally registered general practitioner who could supervise her.

Notifications and investigation

19. On 2 March 2020, the Council received an internal notification from Dr [A]'s health case manager. This notification stated Dr Rairi had been prescribing tramadol to Dr [A] and included a letter from Dr Rairi explaining he saw Dr [A] on "14 October [2019] and 22 January 2020 for an acute migraine attack". Dr Rairi indicated in the letter he prescribed Dr [A] "Tramadol 50mg TDS/PRN and Alternate Tramadol SR 100mg daily."
20. A PCC was established under s 71 of the Act as a result of the above notification.
21. On 27 October 2021, the PCC determined that a disciplinary charge (the **Charge**) be brought against Dr Rairi.

Medical background to medicines referred to in the charge

22. Many of the medicines referred to in the charge are prescription medicines that come with a risk of addiction or misuse. Where stated, some are Class C controlled drugs.

Tramadol hydrochloride

23. Tramadol Hydrochloride is a prescription only pain medication which has low dependence potential; however, it carries risks such as respiratory depression when used concomitantly with drugs of the benzodiazepine family.

Codeine phosphate

24. Codeine phosphate is a prescription-only pain medication and is only recommended by Medsafe when other pain treatment options are not effective. It poses a risk of abuse, misuse and addiction which can lead to overdose and life-threatening respiratory depression.

Benzodiazepines

25. Dr Rairi prescribed benzodiazepine medications to Dr [A], in particular lorazepam, and clonazepam. Benzodiazepines and their derivatives carry a risk of addiction and misuse.

- a. Lorazepam is primarily used for therapy of anxiety disorders. In general, it is recommended that lorazepam, like any benzodiazepine should be prescribed for short periods only e.g., two to four weeks. Lorazepam is a Class C controlled drug.
- b. Clonazepam is often used to treat epilepsy, muscle spasms and panic disorders. Clonazepam is a Class C controlled drug.
- c. All benzodiazepines are central nervous system depressants and concurrent use with other central nervous system depressants can increase the risk of coma or death.

Zopiclone

- 26. Zopiclone is a non-benzodiazepine medication usually prescribed for the short-term treatment of insomnia in adults. Its use beyond four weeks is considered off-label. Long term use of zopiclone can be associated with dependency.

Treating and prescribing medications to Dr [A]

- 27. Dr [A] became a casual patient at MMC on 27 August 2018 (the date of her first consultation with Dr Rairi) but did not complete the part of the form that sought permission to send consultation notes to her enrolled GP, or her GP's name.
- 28. Dr Rairi was aware that Dr [A] had her own regular GP.
- 29. MMC's Medtech32 notes show Dr Rairi saw Dr [A] for consultations on 28 occasions between 27 August 2018 and 25 March 2020.
- 30. Ministry of Health dispensing data shows a total of 127 medications were dispensed to Dr [A] under Dr Rairi's name between 27 August 2018 and 6 April 2020.
- 31. Dr Rairi disputes much of Dr [A]'s evidence and believes she has falsified records and issued many prescriptions under his name by manipulating security flaws in the Medtech32 system. Dr Rairi says that the records and prescriptions are a mix of genuine records and falsified records, and he can't be certain which are which.
- 32. However, Dr Rairi accepts on the balance of probabilities that the 61 prescriptions as set out in **Appendix A** were genuinely from him. These included lorazepam, clonazepam, codeine, tramadol and zopiclone.
- 33. The clinical notes for Dr Rairi's consultations with Dr [A] rarely stated the duration of symptoms and were brief. In addition:

- a. On 27 August 2018 Dr Rairi did not explain Dr [A] using 25mg of lorazepam in four days. Dr Rairi provided no comment on this in the notes, and prescribed both lorazepam and clonazepam.
 - b. On 7 January 2020 Dr Rairi prescribed zopiclone, codeine, rizatriptan and clonazepam without any specific comment.
 - c. Dr Rairi's notes did not mention prophylactic medications for migraine or long-term anxiety medications such as antidepressants. Non-medical options such as time off work, counselling, psychotherapy, exercise and sleep hygiene were also not addressed.
34. During the relevant time, Dr [A]'s registered general practitioner was Dr Argent. Dr Argent also consulted with, and prescribed for Dr [A] during the relevant period. This included prescriptions for zopiclone and lorazepam during the time period Dr Rairi was also prescribing these medications for her.
 35. Dr Rairi entrusted Dr [A] with the role of coordinating her care between himself and Dr Argent; but he did not put in place any systems to coordinate her care over and above that.
 36. Dr Rairi prescribed codeine phosphate, zopiclone, and lorazepam to Dr [A] after receiving the health case manager's email of 21 November 2019.
 37. If Dr Rairi had kept an accurate record of the actual amounts of opioids (tramadol and codeine), benzodiazepines (clonazepam and lorazepam) and sedatives (zopiclone) prescribed he would have had early warning of medication overuse and on suspecting misuse he could have discussed the issue with the patient, her GP and made a referral to CADS. Instead, he treated acute migraine and acute anxiety well outside NZ guidelines thus enabling drug misuse and dependence.

Clinical notes

38. Dr Rairi's clinical notes did not sufficiently record an explanation for the high quantities of medications with the potential for misuse.

Acknowledgments

39. Dr Rairi has reflected on his treatment of Dr [A] and now accepts that the relationship they had was a close relationship that made it inappropriate for him to treat her in the way he did because it blurred boundaries and there was an obvious potential for his clinical objectivity to be affected.
40. Dr Rairi has also reflected on how he prescribed for Dr [A] and he now considers it painfully obvious with the benefit of hindsight that he should have refused to give Dr [A] any further prescriptions after 21 November 2019,

particularly those that had any potential for misuse, abuse, and dependence. Dr Rairi accepts that he should have insisted Dr [A] went back to her regular GP.

41. Dr Rairi accepts he was at fault. As a result he admits the disciplinary charge as amended and accepts his conduct amounted to professional misconduct.

Liability - Tribunal's consideration of the Charge

Particular 1 - Inappropriate prescribing to Dr [A]

[48] We have reviewed the ASOF, the available evidence and the submissions of counsel to consider each particular and sub-particular of the Charge.

[49] Particular 1 including four sub-particulars alleges that between 27 August 2018 and 25 March 2020 Dr Rairi prescribed the 61 medications to Dr [A] set out in Appendix A to the Charge.

[50] Many of the medicines referred to in the Charge are prescription medicines that come with the risk of addiction of misuse, and included Lorazepam, Clonazepam, Codeine, Tramadol and Zopiclone, and some of them are Class C controlled drugs.

[51] Dr Rairi has admitted that his close working relationship with Dr [A] made it inappropriate for him to treat her because it blurred boundaries and created the potential for his clinical objectivity to be affected.¹⁶

[52] Mr Walters, counsel for the practitioner, submitted that although Dr Rairi has accepted that he wrote these prescriptions, he disputes much of Dr [A]'s evidence and believes she has falsified records and issued many prescriptions under his name by manipulating security flaws in the electronic records, known as the MedTech 32 system. Dr Rairi says that the records and prescriptions are

¹⁶ ASOF at [39].

a mix of genuine records and falsified records, and he cannot be certain which are which.¹⁷

[53] Mr Walters submitted that Dr Rairi is not certifying the accuracy of all of these prescriptions. When the Charge was initially laid there were 149 prescriptions. It was only after a thorough audit of the supporting triage notes, whether there were any fees charged for consultation, whether there were any anomalies in the records for that day and what Dr Rairi can recall around the surrounding circumstances that he has accepted these prescriptions were made by him.

[54] Dr Rairi has however, accepted on the balance of probabilities that the prescriptions as set out in Appendix A were genuinely from him.

Particular 1(a) – Close relationship

[55] We are satisfied that Dr Rairi had a close relationship with Dr [A] that commenced when Dr [A] was engaged by the Medical Centre in May 2018 and that continued thereafter.

[56] Dr [A] worked at the Medical Centre as an independent contractor between 8 June 2018 and 11 March 2019, and again between 13 August 2019 and 25 November 2019.

[57] During the period of the Charge Dr [A] was either a patient of Dr Rairi and / or working as an independent contractor.

[58] By 27 August 2018, when Dr [A] enrolled as a casual patient with the practice, Dr Rairi had already engaged Dr [A] to provide GP services at the Medical Centre.¹⁸

¹⁷ ASOF at [31].

¹⁸ ABOD, p 285, Independent Contract Agreement dated 21 May 2018 (signed on 8 June 2018).

[59] The Medical Council's statement on *Providing Care to Yourself and Those Close to You* states that it expects doctors will not provide care to themselves or those close to them in the vast majority of clinical situations.

[60] A doctor may only provide care to those close to them in exceptional circumstances and when the overall management of the care is monitored by an independent registered health practitioner. This is because the doctor may lack clinical objectivity when providing care to themselves or those close to them.

[61] The definition of "those close to you" is as follows:¹⁹

Those Close to You:

Any other individuals who have a personal or close relationship with you, whether familial or not, **where the relationship is of such a nature that it could reasonably be expected to affect your professional and objective judgement.** Council recognises that those close to you will vary for each doctor. [Emphasis added.]

[62] The statement goes on to explain how clinical objectivity can be compromised when providing care to those close to you. Relevantly, it includes examples:

- You may be inclined to care and treat problems that are beyond your skill or competence and / or be expected or placed under pressure to do so by someone you are close to.
- You may wrongly assume that you are privy to all relevant information about those close to you and that asking questions and taking a full history or conducting a medically indicated examination, is unnecessary.
- You may not have all the relevant clinical information (records or notes) relating to your patient and this may result in poorer patient outcomes.

... Consequently, you may not provide the best quality treatment, despite your intention to provide family members and / or those close to you with good care.

¹⁹ ABOD, p 285, Medical Council of New Zealand, *Statement on Providing Care to Yourself and Those Close to You* (November 2016).

[63] The statement goes on to specify the situations where a doctor must not provide care to those close to them:

- Prescribing or administering medication with a risk of addiction or misuse.
- Prescribing psychotropic medication.
- Prescribing controlled drugs as specified and described under the Misuse of Drugs Act 1975.²⁰
- Issuing repeat prescriptions where you do not have appropriate information available to review the suitability of the repeat prescription.
- See also section on “Repeat Prescription” in the Medical Council’s statement on *Good Prescribing Practice*.

[64] In Dr Rairi’s statement he said that when he read the Medical Council’s statement on providing care to yourself and those close to you in the past that he understood it applied to treating friends and family and anyone else he might have had a close and personal relationship with. He says that at the time he did not understand that it applied to his colleague, Dr [A]. He described his relationship with her was “not close” and that it was not personal, and it was quite a strained collegial relationship at most. In his statement, Dr Rairi says:

Nevertheless, I have reflected on it and I do now understand how the working relationship made it inappropriate to treat Dr [A] in the way that I did, because it blurred boundaries and there was obvious potential for my clinical objectivity to be affected.

I apologise for that unreservedly.²¹

[65] We are satisfied that the circumstances of Dr Rairi’s prescribing meets the criteria of “a close relationship” as set out in the Medical Council’s statement. While the Medical Council statement does not specify a collegial relationship, we accept Dr Rairi’s relationship with Dr [A] as a colleague was of such a nature

²⁰ Schedules 1, 2 and 3 of the Misuse of Drugs Act 1975 contains a list of substances that are classified as Class A drugs (drugs that pose a very high risk of harm), Class B drugs (drugs that pose a high risk of harm) and Class C drugs (drugs that pose a moderate risk of harm).

²¹ Document 5, Statement of Dr Poanere Tapukura Rairi at [536]-[538].

that it could reasonably be expected to affect Dr Rairi's professional and objective judgement.

[66] Dr Rairi should not have provided Dr [A] with regular care. Despite this Dr Rairi saw Dr [A] as a casual patient for periods of time between 27 August 2018 and 25 March 2020.²² These consultations overlapped with the period of time that Dr [A] worked in the practice.

[67] Particular 1(a) is established.

Particular 1(b) - Not completing an adequate assessment of Dr [A]'s medical history prior to prescribing

[68] We are satisfied that Dr Rairi did not complete an adequate assessment of Dr [A]'s medical history prior to prescribing for her.

[69] The Medical Council's statement on *Good Prescribing Practice* sets out clear expectations for prescribing. It also states that a doctor should only prescribe medications when they have adequately assessed the patient's condition and have taken an adequate patient history. Dr Rairi failed to properly assess Dr [A] and relied on her to co-ordinate her care with her existing GP.²³

[70] Dr Rairi's acknowledged lack of objectivity meant he prescribed Zopiclone, Clonazepam, Lorazepam, Codeine phosphate, Tramadol (among other things) upon request and without full visibility of Dr [A]'s history of substance abuse or concurrent prescriptions from other prescribers. During this time Dr [A] was receiving regular prescriptions for Zopiclone from her existing GP, Dr Argent.²⁴

²² ABOD, [88-108], Clinical Notes and ASOF at [29].

²³ ASOF at [33]-[35] and [37].

²⁴ These were typically in quantities no larger than 14 tablets for each prescription; ASOF at [35].

[71] The Medical Council's statement on *Good Prescribing Practice*²⁵ includes the following:²⁶

Providing Good Clinical Care

2. When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:

- Adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate;
- Providing or arranging investigations or treatment when needed; and
- Taking suitable and prompt action when needed, and referring the patient to another practitioner or service when this is in the patient's best interests.

[72] If the doctor determines a patient requires a medication or treatment, the doctor may only do so when they "have adequate knowledge of the patient's health and are satisfied that the medication or treatment are in the patient's best interests".²⁷

[73] We are satisfied that Dr Rairi did not complete an adequate assessment of Dr [A]'s medical history prior to prescribing to her. He failed to adhere to the standards for providing good clinical care as set out in the Medical Council's statement on *Good Medical Practice*.

[74] There is nothing in Dr Rairi's clinical notes or the enrolment form completed by Dr [A] that suggests any assessment was undertaken of Dr [A]'s medical condition.

[75] The "Casual Patient Form" completed by Dr [A] on 27 August 2018 did not give the Medical Centre permission to send any consultation notes to her current GP.

²⁵ Medical Council of New Zealand *Good Prescribing Practice* (December 2016).

²⁶ ABOD, p 255.

²⁷ ABOD, p 256.

[76] Nor do the clinical notes show that Dr Rairi undertook a clinical assessment, including Dr [A]’s medical history. This was borne out by Dr Rairi’s position in relation to Dr [A] that he was not aware of her addiction or her personality traits. Dr [A] did not provide her consent for Dr Rairi to share information with Dr Argent.²⁸

[77] As acknowledged by Dr Rairi, continuity of care was “an issue.”²⁹ He could have instead insisted that Dr [A] go back to Dr Argent’s sole care.

[78] Dr Rairi naively assumed that he understood Dr [A]’s relevant medical history as he said that he trusted her. In retrospect this was by his own admission, a mistake. As a result, he provided Dr [A] with continued and easy access to medications with a risk of addiction and misuse. This created a very real risk of harm to Dr [A] in circumstances where she was already unwell.

[79] Dr Rairi’s failure to complete an adequate assessment of Dr [A]’s medical history prior to prescribing for her is established under particular 1(b).

Particular 1(c) – Class C controlled drugs and risk of addiction or abuse

[80] Dr Rairi should not have prescribed Class C controlled drugs or medications that carried a risk of addiction or misuse.

[81] Dr Rairi has admitted to issuing 61 prescription items to Dr [A] as set out in Appendix A to the Amended Charge. This included prescriptions for potentially addictive medications such as Tramadol, Codeine, Benzodiazepines and Zopiclone.³⁰ It also included the Class C controlled drugs, Clonazepam and Lorazepam.

[82] Particular 1(c) is established.

²⁸ ABOD, p 83.

²⁹ Document 4, Submissions on Liability for Dr Rairi, at [23].

³⁰ ASOF at [22]-[26], [32] and [39].

Particular 1(d) – Record keeping

[83] We are satisfied that Dr Rairi kept insufficient or in some circumstances no clinical records for the medications prescribed and of the consultations with Dr [A].

[84] With respect to keeping records, and as part of good clinical care, doctors must keep clear and accurate patient records. *Good Medical Practice* states:³¹

Keeping Records

5. You must keep clear and accurate patient records that report:

- Relevant clinical information;
- Options discussed;
- Decisions made and the reasons for them;
- Information given to patients;
- The proposed management plan;
- Any medication or other treatment prescribed.

[85] There were instances where he did not record notes after consultations, however Dr Rairi failed to sufficiently explain the reasons for dispensing the potentially addictive medicines.³²

[86] Mr Stewart, counsel for the PCC submitted that Dr Rairi compromised Dr [A]’s continued care. Even though she had not provided consent to contact Dr Argent, he could have insisted to her that she go back to Dr Argent and therefore create some opportunity for appropriate communication with Dr [A]’s existing GP. This did not happen.

³¹ ABOD, p 256. New Zealand medical Council, *Good Medical Practice* (December 2016).

³² ASOF at [33] and [38].

[87] Accordingly, we are satisfied that each of particulars 1(a)-(d) inclusive are separately and cumulatively established as negligence in Dr Rairi's scope of practice and is conduct that brings disrepute to the medical profession.

Particular 2 – Prescribing after notification of Dr [A]'s substance use disorder

[88] Particular 2 alleges that after being notified of Dr [A]'s substance use disorder on 21 November 2019, Dr Rairi continued to prescribe inappropriate amounts of Codeine phosphate, Zopiclone and Lorazepam as set out in Appendix A.³³

[89] On 21 November 2019 Dr [A]'s Health Case Manager emailed Dr Rairi advising him of the Health Committee's decision that Dr [A] was only fit to practise if certain conditions were observed.³⁴ As Dr Rairi noted, the conditions required Dr [A] to be supervised by a vocationally registered GP. In addition, however, Dr [A]'s conditions also required her to have hair and blood testing and attend and participate in treatment.

[90] We accept Dr Rairi's statement and the evidence he gave at the hearing that while he acknowledges receiving an email from the Medical Council with two attachments, he did not fully read the statement.^{35 36}

[91] Dr Rairi says that while he acknowledges receiving the email and opening the first attachment, being the letter from the Medical Council, he omitted to open the second attachment – the Health Committee's Order. The Health Committee outlined Dr [A]'s substance use disorder, which Dr Rairi says he was not aware of because he did not read it closely or pay sufficient attention to its contents.³⁷

³³ This did not include Tramadol.

³⁴ ASOF at [15].

³⁵ Transcript, p 45 and following.

³⁶ ABOD, p 42, Email from Medical Council to Dr Rairi attaching letter from Health Committee explaining conditions imposed on Dr A's scope of practice dated 21 November 2019 and Order of the Medical Council of New Zealand's Health Committee, p 45.

³⁷ ASOF at [17].

[92] Dr Rairi did however take steps to terminate Dr [A]’s employment. On 25 November 2019 he indicated to Dr [A] this was due to:

- (a) The requirement that Dr [A] be supervised by a vocationally registered GP; and
- (b) The requirement that Dr [A] provide the Medical Council with pre-approved hours that she would be working at the clinic.

[93] Our review of the evidence shows that Dr [A] was employed from 21 May 2018 to 19 March 2019. During this time:

- (a) there were twenty-eight prescriptions of which six had no invoice and in Dr Rairi’s evidence there was sometimes a different signature;³⁸
- (b) Dr [A] was not employed for the period of prescription items numbers 29 to 47 shown in Appendix A of the Charge; and
- (c) Prescription items 49 to 61 was a further period in which Dr [A] was employed by the Medical Centre. Again, for six of the 12 prescription items there is no record of an invoice being generated.

[94] Following the Health Committee’s notification on 21 November 2019, Dr Rairi continued to prescribe Codeine phosphate, Zopiclone and Lorazepam to Dr [A]. This included prescriptions on 7 January 2020 and 25 March 2020 in the same quantities as Dr Rairi had previously prescribed prior to the notification of Dr [A]’s substance use disorder. This was followed by a repeat dispensed on 6 April 2020.

[95] Mr Walters submitted that although Dr Rairi has admitted this aspect of the Charge, he did not intend for the repeat prescriptions to be included and that this was due to the default settings in the MedTech 32. Dr Rairi then did not

³⁸ Appendix A to Amended Charge, Prescription items for Dr A, 1-19.

notice that the repeat was included on the 25 March 2020 prescription and as a result the repeat of the medication was dispensed again on 6 April 2020.

[96] While there may not have been an intention by Dr Rairi to repeat prescribe, he was still responsible for the prescriptions. These prescription items continued to be prescribed by Dr Rairi despite the Medical Council's notification regarding Dr [A] and his responsibility to act on that notification.

[97] This conduct is contrary to a doctor's obligation in *Good Prescribing Practice* and *Prescribing Drugs of Abuse* to never prescribe indiscriminately, excessively or recklessly.

[98] The Tribunal is satisfied, on the balance of probabilities, that despite being notified of Dr [A]'s substance use disorder on 21 November, Dr Rairi continued to prescribe inappropriate amounts of Codeine phosphate, Zopiclone and Lorazepam to Dr [A] as set out in Appendix A.

[99] We are satisfied that particular 2 is separately established as negligence and this conduct brings discredit to the profession.

Professional misconduct

[100] The Tribunal is satisfied that the one Charge of professional misconduct including two particulars, separately and cumulatively, is established as professional misconduct as set out in particular 3 of the Charge.

[101] Counsel for the PCC submitted that not only was Dr Rairi's conduct negligence but also it was malpractice in Dr Rairi's scope of practice under s 100(1)(a) of the Act.

[102] We consider that the nature of this Charge more squarely fits under the umbrella of negligence. Dr Rairi's conduct fell below the standards reasonably expected of

a health practitioner in the circumstances of the person appearing before the Tribunal.³⁹

[103] Dr Rairi, by his own admission, was apparently not aware of Dr [A]’s substance use disorder and personality traits. We accept that if he was not fully aware he should have made himself aware of the situation. Despite this, there was no illegal or immoral intention on his part which would make his conduct fall into the categorisation of malpractice.

[104] The Tribunal is satisfied that Dr Rairi’s conduct as set out in particulars 1 and 2 amounts to professional misconduct under s 100(1)(a) as negligence in his scope of practice.

[105] Dr Rairi’s conduct also has brought, and it likely to bring discredit to the medical profession.⁴⁰ Reasonable members of the public, informed and with the knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the medical profession has been lowered by Dr Rairi’s failure to adhere to the medical profession’s prescribing standards.

Is the disciplinary threshold met?

[106] The Tribunal cannot make a finding of professional misconduct by reason only that it considers Dr Rairi has acted negligently contrary to professional standards of reasonable prescribing practice.

[107] The second step of our assessment requires the Tribunal to be satisfied that the health practitioner’s acts or omissions are significant enough to require a disciplinary sanction. The disciplinary threshold is not an unduly high one.⁴¹

³⁹ *Cole v Professional Conduct Committee* [2017] NZHC 1178 at [41].

⁴⁰ *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28].

⁴¹ *Martin v Director of Proceedings* [2010] NZAR 33 at [30]-[32].

[108] The PCC drew the Tribunal's attention to a number of cases involving inappropriate prescribing by medical practitioners that has justified imposition of a penalty.⁴²

[109] We find that Dr Rairi ought to have been aware of Dr [A]'s substance use disorder and despite receiving the Medical Council notification, he continued to prescribe addictive medications.

[110] Dr Rairi's prescribing was contrary to *Good Prescribing Practice* as a doctor prescribing potentially addictive medications needs to be satisfied that the prescription items remain clinically indicated on an ongoing basis.

[111] Dr [A]'s substance use disorder, and her prior history, should have raised red flags for Dr Rairi that medications were likely to only be used for non-therapeutic purposes. However, this is neither reflected in Dr Rairi's consultation notes nor in the prescribing data.

[112] Moreover, the Health Committee's letter made it plain that Dr Rairi needed to review what Dr [A] was being prescribed by other doctors. If he had done this, he would have seen that Dr [A] was being prescribed Lorazepam and Zopiclone by other doctors at that same time including Dr [A]'s existing GP and others who had been involved in her care.

[113] Dr Rairi's clinical objectivity was already compromised due to providing care to a colleague. His failure to then take heed of the Health Committee's notification and stop prescribing to Dr [A] was a serious departure from expected standards of medical practice.

⁴² For example, *Dr M 941/Med17/382P*; *Dr E 136/Med07/76D* (*Dr E v Director of Proceedings and Anor* HC Wellington CIV-2007-485-2735, Ronald Young J. The Tribunal's finding in relation to one particular of prescribing analgesics was overturned, and the overall fine reduced); *Dr Emmerson 887/Med16/358P* and *Dr M 1089/Med19/454P*; *Dr S 449/Med11/197P*; *PCC v Dr Thorne 753/Med15/320P*; and *PCC v Dr Brock-Smith 16/Med05/08P*.

[114] In terms of the second step of our assessment, we are satisfied that Dr Rairi's conduct warrants disciplinary sanction for the purpose of protecting the public and maintaining professional standards.

Penalty

Penalty principles

[115] The Tribunal must now go on to consider the appropriate penalty under s 101 of the Act. The penalties may include:

- (a) Cancellation of the practitioner's registration;
- (b) Suspension of the registration for a period not exceeding three years;
- (c) An order that the practitioner may only practise with conditions imposed on employment, supervision or otherwise;
- (d) Censure;
- (e) A fine of up to \$30,000; and
- (f) An order that the costs of the Tribunal and / or the PCC to be met in part or in whole by the practitioner.

[116] The Tribunal adopts the principles contained in *Roberts v Professional Conduct Committee*,⁴³ where Collins J identified the following eight factors as relevant whenever the Tribunal is determining an appropriate penalty. In particular, the Tribunal should always consider the penalty that:

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

⁴³ [2012] NZHC 3354 per Collins J at [44]-[51].

- (b) facilitates the Tribunal's important role in setting professional standards;
- (c) may punish the practitioner, though this is not the objective of any penalty;
- (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".

PCC submissions

[117] Mr Stewart submitted the appropriate penalty is as follows: censure; conditions on Dr Rairi's scope of practice for a period of three years and a contribution towards costs.

[118] Counsel for the PCC accepted that Dr Rairi's degree of culpability in respect of what was now an Agreed Summary of Facts in relation to this amended Charge did not warrant imposition of a fine.

Practitioner's submissions

[119] Mr Walters submitted that the only penalty that was warranted were conditions on Dr Rairi's practice for a period of one year rather than three years, as submitted by the PCC.

[120] At the penalty hearing, Dr Rairi made himself available to answer questions from the Tribunal in relation to his extensive brief of evidence. While Dr Rairi's evidence was not tested in cross-examination by the PCC due to the agreed facts

(ASOF) already before the Tribunal, Dr Rairi's evidence and statement provided some context for him to explain his actions.

[121] Dr Rairi explains in his statement that as it turned out Dr [A] had a chaotic personal life. She was under severe financial strain, and she was going through an acrimonious marriage breakup, all while trying to work through GPEP and support her children. He wanted to help her. However, Dr Rairi had no idea about Dr [A]'s background of prescribing drugs of addiction to herself and in the name of family members.⁴⁴

[122] He was unaware that prescriptions for Dr [A] were apparently being made under his name to Dr [A]'s children as early as one month into her employment at the Medical Centre. He acknowledged that prescriptions were recorded under his name and he speculated that they were accessed and printed from his account by Dr A, again with a signature that was not his.⁴⁵ There were repeat prescriptions for Zopiclone, Tramadol, Lorazepam, and Codeine. Dr Rairi stated that it was not his practice to issue repeat prescriptions for these medications.

[123] Dr Rairi said that when he did prescribe to Dr [A], she had presented with urgency, and often in tears.⁴⁶ He trusted her, and was reassured by her apparently real symptoms. He was genuinely trying to help her.

[124] Mr Walters submitted that Dr Rairi did not "twig" that a "close personal relationship" could also include a collegial relationship. He accepted however that during this period of time he was in a doctor / patient relationship with Dr [A] and therefore he also was in breach of the *Prescribing and Good Practice Guidelines*. His relationship with Dr [A] was not "close" in the ordinary sense of the word, and it certainly was not personal. She was not a friend or family either; in fact it was quite a strained collegial relationship.

⁴⁴ Document 5, Statement of Dr Poanere Tapukura Rairi at [29]-[35].

⁴⁵ Document 5, Statement of Dr Poanere Tapukura Rairi at [374]-[382].

⁴⁶ Document 5, Statement of Dr Poanere Tapukura Rairi at [515].

[125] Mr Walters submitted that Dr Rairi is a good doctor. A Practice Assessment Committee (PAC) was formed at the same time as the PCC.⁴⁷ While the PAC report made some constructive comments about room for improvement, they were not about any issues that were relevant to Dr Rairi's treatment of Dr [A].

[126] The PAC report noted that Dr Rairi actually had a high standard of record keeping,⁴⁸ and his use of anxiolytic benzodiazepines and opioids was below the national average. The Committee stated:

The PAC was impressed by the quality of his practice both the premises and levels of care. Dr Rairi has high status in his community because of his gentle caring approach, passion and dedication.

[127] Mr Walters submitted that Dr Rairi was not the "monster" that the PCC made him out to be. He is a diligent GP and as noted by the PAC "has a strong calling in general practice".⁴⁹

[128] Mr Walters submitted that the overall context was that Dr Rairi was genuinely trying to choose the best for Dr [A]. This was in the context of stressful and tragic matters that had happened in his family; he was building a practice; he was working six days a week; he was dealing with a challenging colleague who would often simply not turn up for work; and then to top it all off a pandemic started as well.⁵⁰

[129] Dr Rairi explained that he worked very hard and had not had a holiday since he started up his practice.

⁴⁷ ABOD, p 137; Dr Rairi's Statement at [472].

⁴⁸ ABOD, p 156.

⁴⁹ ABOD, p 156.

⁵⁰ Document 10, Submissions on Penalty for Dr Rairi at [30].

Comparable cases

[130] There are several cases involving doctors who have inappropriately prescribed to patients with whom they have a close relationship in respect of the Medical Council standard, *Prescribing to Those Close to You*. These cases include:

- (a) In *Dr N*⁵¹ Dr N prescribed medication to her husband over a period of six years. This included controlled drugs, psychotropic medication and drugs of dependence without appropriate monitoring or oversight. Dr N also failed to keep accurate records of her treatment of her husband. As a result of her treatment her husband's health was compromised, requiring several days admission to ICU. Almost all particulars of the charge were admitted. Dr N was censured and fined \$5,000. Conditions were imposed, including that Dr N advised future employers of the Tribunal's decision and that her prescribing be monitored for two years.
- (b) In *Dr E*,⁵² Dr E diagnosed his partner with depression and prescribed her antidepressant – psychotropic medicine on about 30 occasions, a hormone replacement nine times and other medication twice. He also failed to keep proper records of his consultations and treatment. Dr E was fined \$7,500, censured and had conditions imposed. The fine was reduced to \$5,000 on appeal.⁵³
- (c) In *Dr N*,⁵⁴ an orthopaedic surgeon was charged with prescribing medicines that posed risk of addiction to himself and family members. Over an 11-year period Dr N self-prescribed on 150 occasions including Oxycodone, Codeine, Tramadol, Citalopram, and Propranolol. He also prescribed medicines that posed a risk of addiction to his immediate family over a seven-year period and failed to document treatment. Dr N was censured, fined \$2,000 and had conditions imposed. These conditions included that he participate in an education programme, his

⁵¹ 941/Med17/382P.

⁵² 136/Med07/76D.

⁵³ *Dr E v Director of Proceedings and Anor* HC Wellington CIV-2007-485-2735, 11 June 2008.

⁵⁴ 1089/Med19/454P.

prescribing was monitored for two years, and that he advise any current and future employers of the Tribunal's decision.

[131] The only case involving inappropriate prescribing to a colleague brought to our attention was *PCC v Emmerson*.⁵⁵ Dr Emmerson prescribed drugs of dependence, including Class B and C controlled drugs not only to family but also to a colleague, over a 28-month period without appropriate monitoring or oversight. In addition, Dr Emmerson was found to have consumed methamphetamine and cannabis. The Tribunal censured Dr Emmerson and cancelled her registration. The Tribunal's findings were upheld by the High Court.⁵⁶

[132] In relation to inappropriate prescribing outside of a close relationship, the following cases are relevant:

- (a) In *Dr S*,⁵⁷ the doctor supplied medicine to a restricted person, as well as prescribing opioids and morphine to patients in a manner that deviated significantly from the practise of his peers. The Tribunal noted there was a significant degree of gullibility, lack of awareness and some irresponsibility which breached professional standards. The Tribunal considered a rehabilitative approach was appropriate. Dr S was censured and had conditions put in place including that he engage with a psychologist, continue with a mentor, receive education in computer skills, and discuss his quarterly prescribing reports with his mentor.
- (b) In *Dr Thorne*,⁵⁸ a GP was found guilty of inappropriate prescribing to patients with a history of drug dependency and continued to prescribe these medications despite incidences of overdosing. Dr Thorne was censured, suspended for six months and had conditions imposed upon his resumption of practise.

⁵⁵ 887/Med 16/358P.

⁵⁶ *Emmerson v PCC* [2017] NZHC 2847.

⁵⁷ 449/Med 11/197P.

⁵⁸ 753/Med 15/320P.

- (c) In *Brock-Smith*,⁵⁹ Dr Brock-Smith was pressured by a patient with a drug addiction history. Dr Brock-Smith prescribed controlled drugs to a restricted person on at least two occasions and wrote prescriptions for a false patient to enable the restricted person to obtain these drugs. Dr Brock-Smith was censured, fined \$7,000 and ordered to practise with conditions.

Aggravating and mitigating features

[133] We consider that the main aggravating feature of Dr Rairi's inappropriate prescribing was that he created a direct risk to Dr [A]'s health as a vulnerable patient with a history of addiction. Dr Rairi did not take adequate precautions prior to, and while, prescribing medications such as Lorazepam, Clonazepam, Codeine, Tramadol and Zopiclone to Dr [A]. His clinical notes also fell below accepted standards, particularly in light of Dr [A]'s history.

[134] Whether it was negligent or simply naive, Dr Rairi facilitated Dr [A]'s easy access to medications in circumstances where her usual GP was also prescribing and managing Dr [A]'s access to these medications.

[135] The Tribunal does not accept as submitted by counsel for the PCC that the extent of the conduct – Dr Rairi prescribed 61 medications to Dr [A] over one and a half years (as set out in Appendix A) – was an aggravating factor. These prescription items have been admitted by Dr Rairi.

[136] In relation to mitigating features, the PCC has accepted that Dr Rairi has been co-operative albeit at a late stage. His agreement to the ASOF meant that the PCC's witnesses were not required to attend the hearing. Counsel for the PCC submits that Dr Rairi's co-operation should be balanced against his failure to initially co-operate with the Medical Council's inquiries and the PCC's subsequent investigation.⁶⁰

⁵⁹ 16/Med 05/08P.

⁶⁰ ABOD, pp 133-136. Dr Rairi's response to the PCC investigation dated 3 October 2021.

[137] As a result of the co-operation the number of medications attributed to Dr Rairi in the Charge were essentially halved, from 127 to 61 prescription items. Dr Rairi accepted that he had a “close relationship” with Dr [A] albeit not a “close personal relationship”.

[138] We accept the PCC’s submission that Dr [A]’s own conduct should not be taken as a significant mitigating factor. Dr Rairi acted in a supervisory capacity to Dr [A]. The onus was on him to ensure his prescribing met professional standards. General practitioners will often be faced with drug-seeking behaviour, and it is fundamental that they ensure they have the skill and understanding to respond appropriately to minimise harm to the patient, including a colleague.

Tribunal’s findings on penalty

[139] The Tribunal has considered the relevant penalty principles, the comparable cases, and the aggravating and mitigating factors in reaching a decision on the appropriate penalty that is proportionate to our finding of professional misconduct by Dr Rairi.

[140] In assessing the appropriate penalty, the Tribunal is mindful of the overarching objectives of the Act for the protection of the public and to maintain high professional standards. Punishment of the practitioner is a secondary purpose of the Tribunal’s assessment of the appropriate penalty.

[141] Dr Rairi has accepted that in mid-September 2019 Dr [A] told him that the Medical Council’s Health Committee was inquiring into her wellbeing and that depending on the outcome she may require supervision. He has admitted that he failed to amend his prescribing for Dr [A] after being notified of her substance use disorder.

[142] Dr Rairi incorrectly assumed the inquiry related to the stress she was under at the time but did not ask Dr [A] what the inquiry related to.⁶¹ The concerning

⁶¹ Dr Rairi’s Statement at [341]; ASOF at [13].

feature here is that Dr Rairi failed to amend his prescribing for Dr [A] after being notified of her substance use disorder and did not make any further inquiries with Dr [A] when she indicated that the Medical Council's Health Committee was involved with her wellbeing.

[143] By 5 November 2019, the Medical Council's Health Committee had considered information about Dr [A]'s health and had decided that Dr [A] was fit to practise only if certain conditions were observed. These conditions were imposed on Dr [A]'s scope of practice.⁶²

[144] Therefore, by 21 November 2019 the email letter to Dr Rairi advising him of the Health Committee's decision to impose conditions on Dr [A]'s practice and the reasons for doing so were of utmost importance.

[145] We also consider that there are mitigating factors in this case which should allow for Dr Rairi's rehabilitation in a constructive and culturally appropriate manner. These purposes can be achieved through censure and conditions on Dr Rairi's scope of practice for a period of two years.

[146] We accept counsel for the PCC's submission that the degree of culpability on Dr Rairi's part does not warrant a fine to be imposed.

[147] The cases cited by counsel for the PCC demonstrate that prescribing to those close to you typically attracts a penalty of censure and conditions.⁶³ In addition those cases involving prescribing to restricted persons often attract sterner penalties such as short periods of suspension.⁶⁴

[148] There are two aspects to Dr Rairi's professional misconduct: first, that he was prescribing drugs of addiction and abuse to his colleague and therefore in breach of the standard *Prescribing to Those Close to You*. Secondly, the inappropriate

⁶² ASOF at [14]; ABOD, p 40.

⁶³ For example, *Dr S 449/Med11/197P*.

⁶⁴ For example, *Dr Thorne 753/Med15/320P*.

prescribing continued and despite the notification from the Medical Council in November 2019 Dr Rairi continued to negligently allow these prescription items to Dr [A] to continue.

[149] Based on the features presented in this case, the Tribunal considers that a penalty of censure and the conditions set out in the Orders below, as agreed to by Dr Rairi, is just, proportionate, and tailored to the professional misconduct by Dr Rairi in the circumstances of this disciplinary charge.

[150] The Tribunal is concerned about the unhelpful correspondence from Dr Rairi to the Medical Council during the PCC's investigation. The Tribunal places weight on the agreed condition that Dr Rairi has a supervisor approved by the Medical Council as chosen by Dr Rairi to provide culturally appropriate collegial support and mentorship.

[151] We encourage Dr Rairi to establish a constructive relationship with the Medical Council so as to avoid future failures in his prescribing practices. This will also allow for his continued valuable contribution to the community that he serves as a general practitioner.

Costs

[152] The Tribunal may order the practitioner to pay part or all of the costs and expenses of and incidental to the PCC's investigation and prosecution in respect of the Charge, and the costs of the hearing by the Tribunal.⁶⁵

[153] When ordering the appropriate amount of costs, the Tribunal must consider the need for the practitioner to make a proper contribution towards the costs. In doing so, the Tribunal takes 50% of the total reasonable costs as a starting point.⁶⁶

⁶⁵ Health Practitioners Competence Assurance Act 2003, s 101(1)(f).

⁶⁶ *Vatsyayann v PCC* [2012] NZHC 1138.

[154] An order for costs in any professional disciplinary proceeding involves the judgement as to the proportion of the costs that should be properly borne by the profession (being responsible for maintaining standards and disciplining its own profession) and the proportion which should be borne by the practitioner who has caused the costs to be incurred.

[155] In these proceedings, the PCC incurred investigation and hearing costs of \$54,828.16.⁶⁷ The Tribunal's estimated costs are \$31,599.59, making a combined total of \$86,427.75.⁶⁸

[156] The PCC submitted that a costs order of 30% would be appropriate in this case to reflect orders in similar cases.

[157] Mr Walters submitted that costs should lie where they fall. We consider this submission unrealistic and not in keeping with the cost principles that are applied in this jurisdiction.⁶⁹ Mr Walters submitted that the PCC investigation led to an incorrect picture of Dr Rairi being incorrectly blamed for 127 prescription items which were ultimately reduced to 61 items, that is over half of the initial allegations.

[158] Mr Walters further submitted that the resulting amended Charge led to one of an entirely different character to that in the original Charge and that Dr Rairi has had a considerable degree of success.

[159] We also take into consideration that Dr Rairi admitted the amended Charge and signed an ASOF, even though this was just five days prior to the scheduled

⁶⁷ Document 7, PCC Submissions on Penalty, Costs and Non-Publication Orders, Appendix A – PCC Cost Estimate.

⁶⁸ Document 8, HPDT Estimate of Costs Expended in Relation to the Disciplinary Hearing Against Dr Rairi.

⁶⁹ These costs principles are set out in the Tribunal's recent Practice Note regarding costs and the reasonableness of an award of costs. Tribunal Practice Note No. 7 effective for Charges laid from 1 April 2023 (and therefore does not apply to this Charge).

defended hearing. This enabled considerable reduction in hearing time from five to two days due to Dr Rairi's co-operation.

[160] The degree of co-operation and amended Charge will be reflected in a reduction from 50% to a 30% contribution by the practitioner of the estimated total costs of the PCC and the Tribunal of \$86,427.75, to be fixed at \$26,000.

[161] The Tribunal is satisfied that this amount is just and proportionate to the overall costs of the PCC's investigation and the disciplinary hearing.

Applications for permanent non-publication orders

Practitioner's application

[162] Mr Walters on behalf of Dr Rairi applied for non-publication of Dr Rairi's name and identifying details.⁷⁰

[163] In support of Dr Rairi's interim application, he had provided an affidavit in support⁷¹ letters from people in the community and colleagues.⁷²

[164] The PCC was opposed to Dr Rairi's application for a permanent non-publication order.

Legal principles

[165] The Tribunal's power to order non-publication is governed by s 95(2) of the Act. The test under s 95(2) requires the Tribunal to be satisfied that it is desirable to make one or more of the orders listed.

[166] Section 95 of the Act provides:

⁷⁰ Document 12, Application for Permanent Non-Publication Orders on behalf of Dr Poanere Tapukura Rairi.

⁷¹ Document 13, Affidavit of Dr Poanere Tapukura Rairi dated April 2023.

⁷² Document 14, Application for Interim Suppression and Identifying Details of the Applicant dated 29 April 2022.

95 Hearings to be public unless Tribunal orders otherwise

- (1) Every hearing of the Tribunal must be held in public unless the Tribunal orders otherwise under this section or unless section 97 applies.
- (2) If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on application by any of the parties or on its own initiative) make any 1 or more of the following orders:
 - ...
 - (d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person.

[167] The starting point in any consideration of name suppression is the fundamental principle of open justice, a principle which is reflected in s 95(1) of the Act which requires the proceedings to be held in public unless the Tribunal orders otherwise.⁷³

[168] The Tribunal has a duty to hold every hearing in public under s 95(1) of the Act unless the Tribunal is satisfied that it is “desirable” to make an order under s 95(2) of the Act.

[169] The public interest factors to be considered by the Tribunal have been set out in a number of decisions.⁷⁴ These public interest factors include:

- (a) Openness and transparency in proceedings;
- (b) Accountability of the disciplinary process;
- (c) The public interest in knowing the identity of the practitioner charged with a disciplinary offence;

⁷³ *Erceg v Erceg* [2016] NZSC 135, [2017] 1 NZLR 310.

⁷⁴ For example, *Anderson v Professional Conduct Committee of the Medical Council of New Zealand* an Unrep (Wellington High Court), Gendall J, CIV-2008-485-1646, 14 November 2008; *Johns v Director of Proceedings* [2017] NZHC 2843, Moore J at [177].

- (d) The importance of freedom of speech enshrined in s 14 of the New Zealand Bill of Rights Act 1990; and
- (e) Unfairly impugning other practitioners.

[170] A useful description of the competing public and private factors has been provided by the Court in *Anderson v PCC*:⁷⁵

[36] Private interests will include the health interests of a practitioner, matters that may affect a family and their wellbeing and rehabilitation. Correspondingly, interests such as protection of the public, maintenance of professional standards, both openness and transparency and accountability of the disciplinary process, the basic value of freedom to receive and impart information, the public interest in knowing the identity of the practitioner found guilty of professional misconduct, the risk of other doctors' reputations being affected by suspicion, are all factors to be weighed on the scales.

[37] Those factors were also referred to at some length in the Tribunal. Of course, publication of a practitioner's name is often seen by the practitioner to be punitive but its purpose is to protect in advance public interest by ensuring that it is informed of the disciplinary process and of practitioners who may be guilty of malpractice and professional misconduct. It refers also to the principles of openness of such proceedings, and the freedom to receive and impart information.

[171] It is well established that where a charge of professional misconduct is proven the practitioner will be named in the preponderance of cases.⁷⁶ What may be considered desirable at the time of the interim application for non-publication may be considered differently after a substantive hearing where an adverse finding is made.⁷⁷

[172] In *Dr X v Director of Proceedings*,⁷⁸ the Court stated that there must be something more "sufficiently compelling" than stress or "the inevitable embarrassment" of the disciplinary proceedings to justify suppression of a practitioner's identity and to overcome

⁷⁵ High Court, Wellington, CIV-2008-485-1648, 14 November 2008, per Gendall J at [36]-[37].

⁷⁶ *A v Director of Proceedings* HC Christchurch CIV-2005-409-2244, 21 February 2006 at [42] (also known as *T v Director of Proceedings* and *Tonga v Director of Proceedings*), cited in *Johns v Director of Proceedings* [2017] NZHC 2843 per Moore J at [169].

⁷⁷ *Beer v A Professional Conduct Committee* [2020] NZHC 2828, per Edwards J at [40].

⁷⁸ *Dr X v Director of Proceedings* [2014] 1798 Simon France J at [14]-[15].

the imperatives behind publication. The practitioner's or a family member's serious health concerns may be sufficient to warrant suppression of the practitioner's identity.

Analysis

[173] In support of Dr Rairi's application his counsel submitted that publication of his name prior to the outcome of the Tribunal's decision may cause significant harm to his reputation, may adversely affect his family and extended family, Maxcare Medial Centre and all staff of the clinic, and himself.

[174] Mr Walters also submitted that publication would cause a mental health impact on everyone so named, loss of business entities and loss of trust and respect from the community.

[175] We have considered the private interest factors that have been raised by Dr Rairi through his counsel. These include, in particular, matters that affect the practitioner's family and their wellbeing. Those matters do not need to be referred to in the decision.

[176] We acknowledge the stress levels of Dr Rairi, and his personal and family matters. This is the reality of stress that happens through the disciplinary process. That is now resolved. The conditions imposed are focussed on the management of Dr Rairi's stress and wellbeing through culturally appropriate supervision.

[177] We do not accept that there will be significant harm to Dr Rairi's professional reputation, standing in the community and his mental health. In respect of the latter, we have no information from a qualified health professional that puts Dr Rairi's health at significant risk should his name be published.

[178] We are satisfied that the community which Dr Rairi's undoubtedly serves will not be affected detrimentally by having his name published. All communities are entitled to know the name and identifying details of the practitioner who has been found guilty of professional misconduct unless there are compelling factors

to override the presumption of open justice that would make it desirable for Dr Rairi's name and identifying details to be suppressed.

[179] We do not consider that the practitioner's rehabilitation will be affected.⁷⁹ Moreover, we consider that Dr Rairi's breach of professional standards in relation to the inappropriate prescribing to a colleague and the circumstances of how that came about could constructively be used in professional learnings from Dr Rairi's experience.

[180] These are not matters that detract from the public interest in publishing Dr Rairi's name. Dr Rairi should move forward constructively in the knowledge that mistakes have been made in the past and that he remains a competent practitioner, as confirmed in the Performance Assessment Committee report.⁸⁰

[181] There is also a risk of suspicion or impugning other practitioners who work in the Auckland region should Dr Rairi's name not be published.

[182] We consider the public interests here outweigh the private interests on the grounds that have been raised and it makes it desirable that this information is squarely in the public domain.

[183] The practitioner's application for non-publication orders is declined.

PCC's application for Dr [A]

[184] At the conclusion of the hearing, the PCC applied for permanent non-publication of Dr [A]'s name and identifying details.⁸¹ The application by the PCC for Dr [A]'s non-publication was not opposed by the practitioner.

⁷⁹ *Anderson v PCC* HC CIV-2008-485-1646 at [36]; *Johns v Director of Proceedings* [2017] NZHC 2843.

⁸⁰ ABOD, p 137. Performance Assessment Report dated 19 July 2021.

⁸¹ Interim orders for non-publication of Dr Rairi's name and that of Dr A made and continued through the hearing.

[185] Despite allegations advanced at the hearing that Dr [A] falsified Dr Rairi's prescriptions, she is not the subject of this hearing.

[186] Dr [A] is currently subject to name suppression in the previous Tribunal proceedings.⁸²

[187] We consider it desirable that Dr [A]'s name continues to be suppressed as she has been subject to a further investigation by the PCC since 20 January 2023. If this Tribunal does not grant a permanent order for Dr [A] it will effectively prejudice her ability to seek an interim or permanent order if she faces a further disciplinary charge following the current PCC investigation.

Result and orders of the Tribunal

[188] The Tribunal has found the Charge of professional misconduct with two particulars separately and cumulatively established as negligence in the practitioner's scope of practice pursuant to s 100(1)(a) of the Act. This conduct has also brought and is likely to bring discredit to the medical profession pursuant to s 100(1)(b) of the Act and warrants a disciplinary sanction.

[189] The Tribunal makes the following penalty and costs orders pursuant to s 101 of the Act:

- (a) The practitioner is censured to recognise that Dr Rairi failed to adhere to professional standards set by the Medical Council for prescribing drugs of potential addiction and misuse to a professional colleague, contrary to the Medical Council's statements on *Good Medical Practice, Providing Care to Yourself and Those Close to You*, and *Prescribing Drugs of Abuse*, pursuant to s 101(1)(d) of the Act;

⁸² PCC v Dr A Med18/431P.

- (b) The following conditions apply to Dr Rairi's practice for a period of two years from the date of this decision pursuant to s 101(1)(c) of the Act:
- (i) Dr Rairi's prescribing is to be monitored by obtaining dispensing information from the Ministry of Health every three months to ensure compliance with the Medical Council's statement on *Providing Care to Yourself and Those Close to You*.
 - (ii) Dr Rairi will engage with a Medical Council approved supervisor, a vocationally registered General Practitioner, until the completion of the education programme set out in condition (iii) below at a frequency to be determined by the Medical Council. Such supervision is to include collegial support and mentorship, monitoring of self-care and wellbeing in a culturally appropriate manner as determined by Dr Rairi.
 - (iii) Dr Rairi is to undertake a practical education programme focussing on the Medical Council's statements on *Providing Care to Yourself and Those Close to You* and *Good Prescribing Practice*, professional boundaries and ethics in medicine, at Dr Rairi's own cost. This condition is to be completed to the satisfaction of the Medical Council within two years of the date of the Tribunal's decision and will be supervised by the vocationally approved General Practitioner.
 - (iv) Dr Rairi is to advise colleagues, future employers, organisations engaging him as a contractor, business partners, including medical business partners, or shareholders in a company conducting medical practice with him of the Health Practitioners Disciplinary Tribunal's decision and its orders.
- (c) The practitioner is to make a contribution of 30% of the total costs of the PCC estimated at \$54,828.16 and the Tribunal's costs estimated at \$31,599.59, a total of \$86,427.75, to be fixed at \$26,000.

- (d) There will be a permanent non-publication order of the name and identifying details of Dr [A] and if relevant, her children and family members, pursuant to s 95 of the Act.
- (e) The application for permanent non-publication orders for Dr Rairi personally is not granted. The practitioner's current interim non-publication order will continue until 21 days after the date of this decision.

[190] Pursuant to s 157 of the Act the Tribunal directs the Executive Officer:

- (a) To publish this decision, and a summary, on the Tribunal's website; and
- (b) To request the Medical Council to publish either a summary of, or a reference to, the Tribunal's decision in its next available publication to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Dunedin this 18th day of August 2023



A J Douglass
Chair
Health Practitioners Disciplinary Tribunal

SCHEDULE

AMENDED DISCIPLINARY CHARGE

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

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

PARTICULARS OF CHARGE

Pursuant to s 81(2) and 91 of the Act the Committee charges Dr Poanere Tapukura Rairi as follows:

1. Between 27 August 2018 and 25 March 2020 Dr Rairi prescribed medications and/or provided care to Dr [A] as set out in **Appendix A**, in circumstances which were inappropriate in that:
 - a. Dr Rairi had a close relationship with Dr [A] that commenced when Dr [A] was engaged by MaxCare Medical Centre in May 2018 and continued thereafter; and / or
 - b. Dr Rairi did not complete an adequate assessment of Dr [A]'s medical history prior to prescribing for her; and / or
 - c. Various medications prescribed were Class C controlled drugs, and/or medications with a risk of addiction or misuse; and / or
 - d. Dr Rairi kept either insufficient or no clinical notes for medications prescribed and / or consultations with Dr [A]; and / or
2. After being notified of Dr [A]'s substance use disorder on 21 November 2019, Dr Rairi prescribed inappropriate amounts of codeine phosphate, zopiclone, and lorazepam to her as set out in **Appendix A**.
3. The conduct alleged above at particulars 1 and 2 amounts to professional misconduct in that, either separately or cumulatively, 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.

Dated 30 March 2023.

APPENDIX A – PRESCRIPTIONS FOR DR [A]					
No.	Prescription ID	Date of Service	Chemical Name	Formulation	Quantity
1.	28512	27-Aug-18	Lorazepam	Tab 2.5 mg	10
2.	28825	31-Aug-18	Clonazepam	Tab 2 mg	10
3.	28826	31-Aug-18	Lorazepam	Tab 1 mg	10
4.	29197	07-Sep-18	Clonazepam	Tab 2 mg	3
5.	29198	07-Sep-18	Clonazepam	Tab 500 mcg	5
6.	31814	26-Oct-18	Amoxicillin with clavulanic acid	Tab 500 mg with clavulanic acid 125 mg	21
7.	31815	26-Oct-18	Codeine phosphate	Tab 30 mg	40
8.	31816	26-Oct-18	Tramadol hydrochloride	Cap 50 mg	60
9.	33111	19-Nov-18	Codeine phosphate	Tab 30 mg	40
10.	33112	19-Nov-18	Tramadol hydrochloride	Cap 50 mg	60
11.	33113	19-Nov-18	Tramadol hydrochloride	Tab sustained-release 100 mg	10
12.	33114	19-Nov-18	Clonazepam	Tab 2 mg	10
13.	34722	17-Dec-18	Amoxicillin with clavulanic acid	Tab 500 mg with clavulanic acid 125 mg	30
14.	34723	17-Dec-18	Codeine phosphate	Tab 30 mg	40
15.	34724	17-Dec-18	Ondansetron	Tab disp 8 mg	40
16.	35106	24-Dec-18	Docusate sodium with sennosides	Tab 50 mg with sennosides 8 mg	80
17.	35107	24-Dec-18	Tramadol hydrochloride	Cap 50 mg	60
18.	35108	24-Dec-18	Zopiclone	Tab 7.5 mg	30
19.	35366	31-Dec-18	Clonazepam	Tab 2 mg	10
20.	36588	24-Jan-19	Diclofenac sodium	Tab long-acting 75 mg	60
21.	36589	24-Jan-19	Tramadol hydrochloride	Cap 50 mg	60
22.	36590	24-Jan-19	Codeine phosphate	Tab 30 mg	40
23.	36591	24-Jan-19	Ondansetron	Tab disp 8 mg	40
24.	37841	15-Feb-19	Paracetamol	Tab 500 mg - blister pack	100
25.	37842	15-Feb-19	Paracetamol with codeine	Tab paracetamol 500 mg with codeine phosphate 8 mg	100
26.	37843	15-Feb-19	Ondansetron	Tab disp 8 mg	10
27.	37844	15-Feb-19	Codeine phosphate	Tab 30 mg	40

28.	37848	15-Feb-19	Rizatriptan	Tab orodispersible 10 mg	30
29.	1495758	23-Apr-19	Ondansetron	Tab disp 8 mg	30
30.	1495759	23-Apr-19	Zopiclone	Tab 7.5 mg	30
31.	1495760	23-Apr-19	Tramadol hydrochloride	Cap 50 mg	30
32.	1495761	23-Apr-19	Codeine phosphate	Tab 30 mg	60
33.	1495762	23-Apr-19	Rizatriptan	Tab orodispersible 10 mg	30
34.	231030	05-Jun-19	Lorazepam	Tab 2.5 mg	30
35.	231031	05-Jun-19	Tramadol hydrochloride	Cap 50 mg	30
36.	231033	05-Jun-19	Codeine phosphate	Tab 30 mg	60
37.	231036	05-Jun-19	Ondansetron	Tab 4 mg	30
38.	291080	21-Jun-19	Zopiclone	Tab 7.5 mg	30
39.	291081	21-Jun-19	Clonazepam	Tab 2 mg	30
40.	291082	21-Jun-19	Codeine phosphate	Tab 30 mg	60
41.	291083	21-Jun-19	Tramadol hydrochloride	Tab sustained- release 100 mg	40
42.	291084	21-Jun-19	Rizatriptan	Tab orodispersible 10 mg	30
43.	1509934	19-Jul-19	Tramadol hydrochloride	Tab sustained- release 100 mg	40
44.	1509935	19-Jul-19	Codeine phosphate	Tab 30 mg	60
45.	1509936	19-Jul-19	Clonazepam	Tab 2 mg	30
46.	1509937	19-Jul-19	Zopiclone	Tab 7.5 mg	30
47.	1509938	19-Jul-19	Tramadol hydrochloride	Cap 50 mg	60
48.	50255	20-Aug-19	Codeine phosphate	Tab 30 mg	60
49.	50285	20-Aug-19	Tramadol hydrochloride	Cap 50 mg	60
50.	50286	20-Aug-19	Paracetamol	Tab 500 mg - blister pack	100
51.	50287	20-Aug-19	Clonazepam	Tab 2 mg	30
52.	1537130	07-Jan-20	Clonazepam	Tab 2 mg	30
53.	1537135	07-Jan-20	Zopiclone	Tab 7.5 mg	30
54.	1537136	07-Jan-20	Codeine phosphate	Tab 30 mg	60
55.	1537137	07-Jan-20	Rizatriptan	Tab orodispersible 10 mg	30
56.	1550324	25-Mar-20	Codeine phosphate	Tab 30 mg	60
57.	1550325	25-Mar-20	Zopiclone	Tab 7.5 mg	30
58.	1550326	25-Mar-20	Lorazepam	Tab 2.5 mg	30

59.	1550324	06-Apr-20	Codeine phosphate	Tab 30 mg	60
60.	1550325	06-Apr-20	Zopiclone	Tab 7.5 mg	30
61.	1550326	06-Apr-20	Lorazepam	Tab 2.5 mg	30