New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO: 543/Med12/224P

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

AND

IN THE MATTER of disciplinary proceedings against **DR N** a Medical Practitioner of X

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HEARING: Held on 11 March 2013 and 29 April 2013

TRIBUNAL: Mr B A Corkill QC (Chair)

Dr P Jacobs, Professor W Gillett, Dr K Wallis and Ms A Hauk-Willis (Members)

Ms K Davies (Executive Officer)
Ms J Kennedy (stenographer)

APPEARANCES: Ms J Hughson and Ms R Kent, for the Professional Conduct Committee

Mr M McClelland, for the practitioner

Introduction:

1. A Professional Conduct Committee (PCC) laid a professional conduct charge against Dr N in relation to an assertion that she acted inappropriately and/or contrary to the best interests of her patients with regard to the prescribing and/or dispensing of Misoprostol. It was asserted this was contrary to the provisions of the Contraception Sterilisation and Abortion Act 1977 (the CSA Act) and otherwise inappropriate in respect of three patients. It was also alleged there were failures to document the prescribing and/or dispensing of Misoprostol in respect of those three patients, and in respect of a fourth patient.

2. Following submissions given on 11 March 2013, the Tribunal gave directions which ensured the patients involved were aware of the nature of the charges and as to the nature of their information which the Tribunal would be required to consider. The hearing resumed on 29 April 2013. Having regard to reports from the two medical practitioners who had communicated with the patients, the Tribunal was satisfied that all appropriate steps had been taken in relation to the patients to inform them of the information and matters before the Tribunal.

3. Comprehensive name suppression orders were made in respect of the patients involved, persons other than Dr N involved in the events which were reviewed, and as well as the relevant institutions.

4. The charge is as follows:

> *"**Particulars of Charge of Professional Misconduct***
> *Pursuant to section 81(2) of the Act the Committee charges that Dr N ("Dr N") registered medical practitioner [ ] acted inappropriately and/or contrary to the best interests of her patients in that she:*
>
> *1. Prescribed and/or dispensed misoprostol (Cytotec) [ ] in a manner contrary to legal pregnancy termination procedures specified in the Contraception, Sterilisation, and Abortion Act 1977 and/or otherwise inappropriately on the following occasions:*
>
> *a. On [ ] at X to Patient A; and/or*

b. On [ ] at X to Patient B; and/or

c. On [ ] at XY to Patient C.

2. Before prescribing and/or dispensing misoprostol (Cytotec) to Patient A on or about [ ] Dr N failed to:

a. undertake appropriate clinical assessments and/or tests to determine if Patient A's pregnancy was a non-viable pregnancy; and/or

b. exclude the risk of Patient A's pregnancy being ectopic; and/or

c. ensure Patient A had adequate support available to her in the event she took the misoprostol (Cytotec) which Dr N had prescribed for and/or dispensed to her.

3. Prescribed and/or instructed Nurse E by telephone to dispense misoprostol (Cytotec) to Patient B on [ ] without Dr N:

a. first having seen Patient B herself in a consultation; and/or

b. undertaking appropriate clinical assessments and/or tests to determine if Patient B's pregnancy was a non-viable pregnancy; and/or

c. Excluding the risk of Patient B's pregnancy being ectopic.

4. Failed to document in her patient's clinical notes the prescribing and/or dispensing of misoprostol (Cytotec) on or about:

a. [ ] to Patient A (56 tabs dispensed pursuant to prescription dated [ ]); and/or

b. [ ] to Patient B (8 tabs); and/or

c. [ ] to Patient C (16 tabs); and/or

d. [ ] to Patient D (2 tabs).

The conduct alleged in particulars 1-4 separately and/or cumulatively amount to professional misconduct under section 100(1)(a) and/or (b) of the Act."

Legal principles:

5. The burden of proof was on the PCC.

6. As to standard of proof, the appropriate standard is the civil standard, that is proof to the satisfaction of the Tribunal on the balance of probabilities, rather than the criminal

standard. The degree of satisfaction called for will vary according to the gravity of the allegations. The greater the gravity of the allegations the higher the standard of proof.

7. Section 100 of the Health Practitioners Competence Assurance Act 2003 (HPCA Act) defines the grounds on which a health practitioner may be disciplined. The Tribunal has now had ample opportunity to consider the test for professional misconduct under the section, and the approach to it is well settled – examples of the correct approach are found in *Nuttall* (8/Med04/03P); *Aladdin* (12/Den05/04D and 13/Den04/02D) and *Dale* (20/Nur05/09D).

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

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

> 1. "*The immoral, illegal or unethical conduct or neglect of professional duties. Any instance of improper professional conduct*."

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

> "*Law*. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer … 2 *gen* criminal or illegal action: wrongdoing, misconduct."

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

12. Negligence and malpractice were discussed by Gendall J at paragraph 21 in *Collie v Nursing Council of New Zealand* [2000] NZAR 74. His Honour said:

> "*Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by*

> *competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.*"

13. Similarly, it is for the Tribunal to decide whether the conduct, if established, would be likely to bring discredit on the medical profession. In the same case Gendall J stated at paragraph 28:

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

14. In *IRG v Professional Conduct Committee of the Psychologists Board* [2009] NZAR 563, the Court of Appeal emphasised at paragraph 49 *"that the intention in enacting section 100 in its current form was to move away from an approach that differentiated between levels of seriousness in the charge. The differentiation is now likely to be reflected in the penalty, not the charge."*

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

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

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

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

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

17. The correct approach to threshold is that described in the Court of Appeal in *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774, which endorsed the earlier statement of Elias J in *B v Medical Council* (noted at [2005] 3 NZLR 810). She made the important point that the threshold is "*inevitably one of degree*". The Court of Appeal expressed the issue in this way at paragraph 80:

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

18. In determining whether the departure is significant enough there must be positive reasons to justify such a conclusion.

19. The Tribunal accepts and applies the above principles, in this case.

The hearing:

20. The hearing was able to proceed on the basis of an Agreed Summary of Facts, which referred to documents contained in an agreed bundle of documents.

21. The Agreed Summary of Facts stated:

> ***Professional Background***
>
> *1. Dr N is a registered medical practitioner. She is registered in the General Scope of Practice with the Medical Council of New Zealand ("the Council"). Dr N holds an active, current Annual Practising Certificate (APC) with the Council. Her current APC is valid to 30 November 2013.*
>
> *2. Dr N is participating in an approved recertification programme for doctors registered in the general scope of practice, administered by bpacNZ.*
>
> *3. Dr N is qualified MB ChB ([], Otago).*
>
> *4. Dr N owns a [ ]. [ ]. Dr N attended [ ] usually on a [ ] afternoon [ ] and through to the early evening although from time to time she was required to be present [ ] outside of those hours. [ ]*

5. [ ]

6. [ ]

7. Dr N is a Certifying Consultant under the Contraception, Sterilisation and Abortion Act 1977 ("the CSA Act").

Background to the Charge

8. In mid-2011 a Professional Conduct Committee (PCC) was appointed under section 71 of the Health Practitioners Competence Assurance Act 2003 ("the HPCA Act") to investigate a complaint about Dr N which the Medical Council of New Zealand had received in May 2011 from Dr Peter Crampton, Pro Vice-Chancellor, Division of Health Sciences, University of Otago. The complaint related to concerns which had been raised about Dr N by a fifth year medical student, Dr L.

9. Having considered the information before it, in August 2012 the PCC determined to lay a charge of professional misconduct against Dr N before the Tribunal.

10. The charge (amended) before the Tribunal alleges professional misconduct when the particulars are considered individually and cumulatively as follows:

Dr N ("Dr N") registered medical practitioner of [ ] acted inappropriately and/or contrary to the best interests of her patient/s in that she:

1. Prescribed and/or dispensed misoprostol (Cytotec) in a manner contrary to legal pregnancy termination procedures specified in the Contraception, Sterilisation, and Abortion Act 1977 and/or otherwise inappropriately on the following occasions:

a. On [ ] at the X to Patient A; and/or

b. On [ ] at the X to Patient B; and/or

c. On [ ] at the XY to Patient C.

2. Before prescribing and/or dispensing misoprostol (Cytotec) to Patient A on or about [ ] Dr N failed to:

a. undertake appropriate clinical assessments and/or tests to determine if Patient A's pregnancy was a non-viable pregnancy; and/or

b. exclude the risk of Patient A's pregnancy being ectopic; and/or

c. ensure Patient A had adequate support available to her in the event she took the misoprostol (Cytotec) which Dr N had prescribed for and/or dispensed to her.

3. *Prescribed and/or instructed Nurse E by telephone to dispense misoprostol (Cytotec) to Patient B on [ ] without Dr N:*

   a. *first having seen Patient B herself in a consultation; and/or*

   b. *undertaking appropriate clinical assessments and/or tests to determine if Patient B's pregnancy was a non-viable pregnancy; and/or*

   c. *Excluding the risk of Patient B's pregnancy being ectopic.*

4. *Failed to document in her patient's clinical notes the prescribing and/or dispensing of misoprostol (Cytotec) on or about:*

   a. *[ ] to Patient A (56 tabs dispensed pursuant to prescription dated 29 March 2011); and/or*

   b. *[ ] to Patient B (8 tabs); and/or*

   c. *[ ] to Patient C (16 tabs) ; and/or*

   d. *[ ] to Patient D (2 tabs).*

Admitted Facts

Cytotec

11. *Cytotec, the brand name for the drug misoprostol, is a synthetic prostaglandin which has ulcer healing, gastric acid antisecretory and mucosal protective properties. Cytotec is indicated for the prevention of ulcers and erosions induced by non-steroidal anti-inflammatory drugs, for the treatment of duodenal and gastric ulcers, for the treatment of erosive gastroduodenitis associated with peptic ulcer disease and also in the prevention of stress-induced upper GI mucosal bleeding and lesions in post-surgical ICU patients (Medsafe Data Sheet, Cytotec).*

12. *Another pharmacologic effect of Cytotec is that it "has been shown to produce uterine contractions which may endanger pregnancy" (Medsafe Data Sheet, Cytotec).*

13. *In the Medsafe Data Sheet for Cytotec under the heading "Contraindications" it is stated "Misoprostol is contraindicated in women who are pregnant, or in patients in whom pregnancy has not been excluded……. Misoprostol should not be administered to anyone with a known hypersensitivity to misoprostol or any other ingredient of the product, or to other prostaglandins." Under the heading "Warnings and precautions" it is stated "Use in Pregnancy (Category X)" "Misoprostol is contraindicated in women who are pregnant because it induces uterine contractions and is associated with abortion, premature birth and foetal death. Miscarriages caused by misoprostol may be incomplete, which could lead to potentially dangerous bleeding, hospitalisation, surgery, infertility or death. Use of misoprostol has*

been associated with birth defects…..Women of childbearing potential should not be started on misoprostol until pregnancy is excluded, and should be fully counselled on the importance of adequate contraception (i.e. oral contraceptives or intrauterine devices) while undergoing treatment. Women should be advised not to become pregnant while taking misoprostol. If a woman becomes pregnant while taking misoprostol, use of the product should be discontinued."

14. *Under the heading "Adverse Effects" and the subheading "Postmarketing surveillance" "pregnancy, puerperium and perinatal conditions" it is stated "Abnormal uterine contractions, uterine rupture/perforation, retained placenta, amniotic fluid embolism, incomplete abortion, premature birth and foetal death have been reported when misoprostol was administered in pregnant women or in patients in whom pregnancy has not been excluded." Under "congenital, familial and genetic disorders" the adverse effects are recorded as "birth defects".*

15. *There are [ ] Guidelines for the use of misoprostol but only in relation to its use for difficult IUD insertions. There are no [ ] Guidelines in relation to the use of misoprostol for any other "off label" obstetric or gynaecological uses. Misoprostol is not approved anywhere for obstetric or gynaecological use. Its approved use is for prevention of gastric and duodenal ulcers associated with the use of non-steroidal anti-inflammatory drugs. However misoprostol is commonly used as a secondary drug for medical abortions carried out in a licensed abortion facility as referred to below.*

Abortion in New Zealand

16. *Abortion in New Zealand is governed by the Contraception, Sterilisation and Abortion Act 1977 and certain provisions in the Crimes Act 1961.*

17. *There are two methods for performing abortions in New Zealand. One method is medical abortion which process uses medication to induce an abortion. The treatment usually consists of one Mifegyne tablet containing 200mg of mifepristone. This acts by blocking the effects of progesterone, a hormone which is needed for pregnancy to continue. This is followed 24-48 hours later by oral, buccal or vaginal administration of four tablets each containing 200mg Cytotec (misoprostol). This is a different type of hormone (a prostaglandin) that helps to expel the pregnancy. The second method used for performing an abortion in New Zealand is surgical abortion.*

18. *There are extensive guidelines on the use of medical abortions in New Zealand (Guidelines for the Use of Mifepristone for Medical Abortion in New Zealand, Abortion Supervisory Committee, August 2004). This publication contains detailed information about the process that should be followed and when a woman should be permitted to be*

discharged early from the licenced institution in which medical abortions must be carried out. This includes: (at pg 13):

- *Access to a telephone*
- *Reliable transport or money for taxis*
- *Access to toilet, Shower/bath and laundry facilities*
- *Support at home*
- *The ability to cope independently both with pain and with bleeding;*
- *Written information about the process and the drugs used*
- *Preparation for what the pregnancy tissue may look like*
- *The ability to identify problems and knowledge of how to act on them*
- *Residence or other accommodation close to the clinic or hospital – the abortion process may take place 30-60 minutes after administration of misoprostol*
- *Either the ability to communicate clearly in English or a support person who will remain with her who speaks good English, or the clinic can provide staff who speak the language of the patient.*

19. *The Guidelines also state that because misoprostol is not registered for use in abortion, patients must sign an informed consent, which states that the drug is not registered for this purpose, and that the use is evidence-based.*

20. *Section 25 of the Medicines Act permits a practitioner to use any medicine (approved or unapproved) for the treatment of a particular patient in his or her care. The Act puts no restriction on the use of a medicine, even in a situation in which it is contraindicated. However, whether the practitioner uses approved or unapproved medicines, he or she must provide care of an adequate professional and ethical standard.*

21. *For an unapproved medicine or unapproved use, the consumer should be advised of the unapproved status. The consumer should also be advised of the degree and standard of the support for the use of the medicine, and of any safety concerns, or warnings or contraindications regarding its use in their particular condition. (http://www.medsafe.govt.nz/profs/Riss/unapp.asp)*

The CSA Act procedure

22. *There are provisions in the CSA Act which establish a procedure for the authorisation of abortion. The abortion needs to be authorised by two medically qualified and specially approved certifying consultants who are satisfied that one of the grounds justifying abortion exists.1*

23. *The grounds for abortion are set out in the Crimes Act 1961 and include (amongst other things):2*

- *That the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl; or*
- *That there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped; or*

24. *Where a certificate is issued to that effect, the person actually carrying out the procedure need not form a belief about the existence of the grounds for the abortion.*

25. *There is also a legal requirement to offer counselling to the person seeking the abortion.3 All abortions must also be performed in a licensed institution.4*

26. *There are specific offence provisions in the C S A Act, including performing an abortion elsewhere than in a licensed institution and performing an abortion otherwise than in pursuance of a certificate issued by two certifying consultants.5*

27. *There are also specific record keeping and reporting provisions in the Act.*

[ ] practice for woman with positive pregnancy test wanting termination

28. *The accepted practice at [ ] for a woman with a positive pregnancy test who does not wish to continue the pregnancy is as follows:*

- *Discussion with the woman regarding pregnancy options and if the woman is clear she does not wish to continue the pregnancy and has grounds for referral for a termination of pregnancy then she should be referred for termination of pregnancy.*

- *The C S A Act requires referral to a licensed institution and for the woman to see two certifying consultants.*

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[1] Contraception, Sterilisation and Abortion Act 1977, s 33
[2] Crimes Act 1961 s 187A
[3] Contraception, Sterilisation and Abortion Act 1977 s 35
[4] Contraception, Sterilisation and Abortion Act 1977 s 18
[5] Ibid s 37

- *A referral to a licensed clinic requires a referral letter from the patient's doctor, an antenatal blood test, a pregnancy ultrasound scan (USS) (to determine gestation, viability of pregnancy and that the pregnancy is intrauterine and not ectopic) and swabs taken from the cervix and vagina to exclude infection; and*

- *Discussion with the woman regarding contraception after the abortion.*

29. *Given her status as a Certifying Consultant under the CSA Act and her level of experience as a general practitioner and [ ] doctor, Dr N was at all material times aware of:*

    - *the law relating to abortion in New Zealand and the applicable processes.*

    - *relevant [ ] processes and guidelines used when a woman presents to a clinic wanting a termination of pregnancy, and in relation to the use of misoprostol (for difficult IUD insertions).*

    - *the Medical Council Guidelines relating to Good Prescribing Practice; and*

    - *the Medical Council's Statement in relation to the Maintenance and Retention of Patient Records.*

PATIENT A

30. *On [ ] Dr N handwrote on a pre-printed [ ] prescription pad a prescription for Cytotec for a patient identified in the charge as Patient A (and identified by NHI number A on the prescription) which she signed, stamped and dated. Dr N did not specify the quantity of Cytotec (200mcg) tablets to be dispensed under the prescription. At the time she handwrote the prescription Dr N had not seen Patient A in a consultation either at her [ ]or at [ ].*

31. *On [ ] at 9.34am the prescription was faxed from [ ] to the XXX in X. Dr N was at her practice [ ] at the time the prescription was faxed to the XXX. At that time XXX received a lot of prescriptions from [ ]; the Pharmacy used to have a contract with the [ ] and although the contract was not renewed the Pharmacy had continued to dispense exclusively to [ ].*

32. *When the prescription was received by the Pharmacy, Ms V noticed that the quantity of tablets required had not been specified on Dr N's prescription. That is, the prescription was for an unknown amount of Cytotec. In circumstances where a doctor has not specified the quantity of a drug he or she has prescribed, and particularly where the drug (such as cyotec) is not one which a pharmacist can make a reasonable*

assumption about the likely quantity, it is Ms V's practice to telephone the prescriber. Ms V telephoned [ ] after receiving the script on the morning of [ ] but she did not speak to Dr N directly that day. Rather Ms V is certain she spoke to one of [ ] nurses, Nurse W, about the prescription. In any event Ms V was advised that Dr N had intended the prescription to be for 56 tablets of Cytotec.

33. *Patient A's clinical records from [ ] show that Nurse W, (who at the relevant time worked at [ ] for 10 clinical hours each [ ] saw Patient A in a consultation in the late morning on [ ].*

34. *Patient A was a fairly regular client at [ ]. At the relevant time she was aged [ ] and [ ] Patient A was known to Nurse W [ ]. Nurse W knew Patient A well enough to stop and talk to her in the street. Patient A was also known to Dr N.*

35. *[ ]. Patient A reported she had had a positive pregnancy test. She was in tears and she told Nurse W that she wanted her pregnancy stopped. Patient A reported to Nurse W that she had [ ] but now she was unintentionally pregnant. [ ]*

36. *Nurse W arranged urgent ante-natal bloods and swabs for Patient A and she rebooked her with Dr N for later that same day, [ ]. Nurse W requested an Intact HCG Assay at 11.35am. She recorded in Patient A's records "pre TOP infection screen and bloods with urgent BHCG requested, copy to [ ]". [ ] is a licensed abortion clinic in [ ].*

37. *Dr N worked an evening clinic on a [ ] from [ ] and she did so on [ ]. Nurse W considered that as Patient A was so distressed she needed a doctor's reassurance that if she needed to stop her pregnancy the law would allow her to do that. This would involve a referral to [ ] for a surgical abortion as medical abortions were not available to [ ] patients because of the time involved. Nurse W considered that a conversation with Dr N would reduce Patient A's distress. Nurse W also decided to fast track her to see Dr N because it would be another week before Patient A could see Dr N at [ ]. Nurse W therefore arranged for Patient A to return to see Dr N after she (Patient A) had finished work. Nurse W recorded in Patient A's records "see back this pm for DR visit".*

38. *At [ ] on [ ] Patient A's Intact HCG Assay result was faxed from [ ] to [ ] for Nurse W's attention. The results were entered into Patient A's clinical record and therefore they were available and able to be accessed by Dr N when she saw Patient A later that day. Patient A's Intact HCG Assay was reported as being [ ]. While this result is low it confirmed Patient A's pregnancy. The normal range for non-pregnant adult females is less that 5 mIU/L. A low beta HCG reading like this could mean there is an early intraunterine pregnancy or a miscarriage or missed miscarriage (blighted ovum so non-viable pregnancy). It could also suggest an ectopic pregnancy.*

39. Dr N arrived at [ ] in the early afternoon. Dr N had a medical student working with her that week and the medical student met her at [ ].

40. Dr L was at that time a fifth year medical student at [ ]. She did her Rural GP attachment over five weeks in [ ], based in [ ]. She spent her final week at [ ] working/observing in the general practice of Dr N's. This was in the week of [ ]. The Rural GP attachment programme is arranged by the [ ]. All of the GP's for whom Dr L worked/observed as part of the Rural GP attachment programme were pre-approved by the Department of General Practice.

41. Dr L worked/observed Dr N at her [ ] throughout the course of the week. She also worked/observed Dr N when she attended at [ ] on the afternoon of [ ] and later that week at the XY at X

42. [ ]. On the afternoon of [ ] Dr N and Dr L were based in one room and Nurse W was based in the other.

43. Dr N and Dr L commenced their clinic at around 14.00 hours. They saw one or two patients in the early afternoon (between 2.00-2.30pm) and then they went into town with Nurse W.

44. The Pharmacy computer records confirm that the pharmacy dispensed 56 tablets of Cytotec for Patient A pursuant to Dr N's prescription dated [ ], at 14.39 hours (2.39pm) on [ ]. The Pharmacy Prescription Copy of the prescription confirms these details. Further, the pharmacy "third part" sticker on the copy of the faxed original script shows the dispensing of "56CYTO" on [ ].

45. When the Pharmacy dispenses a prescription the pharmacy gives out a receipt to the person collecting it from the pharmacy if there is money owing for it. In this case the Pharmacy either delivered the 56 tablets of Cytotec dispensed under the prescription for Patient A, directly to [ ], or a staff member from [ ] collected the medication as sometimes occurred. In any event the sticker or receipt ($3.00) issued by the Pharmacy for the prescription referred to and numbered A was later attached to Patient A's faxed Intact HCG Assay results of [ ] held by [ ].

46. Patient A was the final patient of the five or so patients whom she and Dr N saw on the afternoon on [ ]. Dr N believes the consultation was at around 7.00pm.

47. Dr N's consultation with Patient A took place over a period of approximately fifteen minutes. Dr N knew Patient A and she confirmed this to Dr L. Dr N also knew the background events surrounding Nurse W's referral of Patient A to see her that afternoon including her pregnancy and wish for a termination.

48. During the consultation with Dr N Patient A gave a history of [ ]. There was then a discussion about Patient A's low beta HCG level from

earlier that day. Dr N told Patient A that the low level beta HCG indicated either a very early pregnancy as a result of the [ ]

49. *Dr N did not have any discussion with Patient A about options (abortion, adoption, counselling) or other matters such as her social/financial support structures. Further Dr N did not [she] undertake any physical examination or clinical assessments of any kind on Patient A during the consultation; and nor did she suggest to Patient A that she should have an ultrasound scan or any other tests.*

50. *After Patient A told Dr N that she wanted a termination of pregnancy Dr N got up and left the consultation room. She returned with a paracetamol-sized box with a pharmacy sticker on it. Dr N took tablets out of the box and put some tablets in a white bill-sized envelope which she had taken out of her desk. She then wrote down instructions for use on the envelope and then she handed over the envelope to Patient A. Dr N said to Patient A "This will help" and then words like "I think you are having a miscarriage and this will help it along." Dr N told Patient A that the tablets were sometimes used for stomach problems and that they would make her bleed but she did not warn Patient A about excessive bleeding or what she should do if she had excessive bleeding. Nor did Dr N advise Patient A that she should have someone at home with her after she had taken the tablets. There was no safety discussion of any kind. It was clear to Dr L that it was "very understood" by Patient A that she had been given an abortion drug; that Patient A understood she would go home, take the tablets and then come back on the [ ] for another blood test to make sure her beta HCG level was going down. Dr N did not tell Patient A that this was an off-licence use of the drug she had given her.*

51. *Dr N did not write any prescription for Patient A during the consultation and nor did she give Patient A a prescription for anything. Before Dr N and Patient A left the room there was reference to Patient A returning to [ ] on the [ ]. Patient A thanked Dr N and Dr N then took her out of the consultation room.*

52. *After Dr N and Patient A had left the room Dr L went over to the desk and picked up the box of tablets which Dr N had left on the desk. There were still tablets left in the box. The pharmacy label on the box stated misoprostol.*

53. *When Dr N came back into the room Dr L asked her what drug she had given to Patient A and if it was Mifepristone. Dr L was aware Mifepristone is an abortion drug. Dr N told Dr L she had given the patient misoprostol, as only doctors licensed to perform abortions could use the drug Mifepristone, and in a controlled clinic. Dr L had heard of misoprostol before as part of her medical course but she was not familiar with it as she had not done the O&G part of her course at that time.*

54. *Dr N explained to Dr L that misoprostol is a prostaglandin and that it is used in obstetrics and gynaecology to aid abortions. She went on to explain that her use of misoprostol with Patient A was an off-license use of the drug but as Patient A [ ] taking misoprostol would save her a massive ordeal associated with a trip up to [ ] for an abortion. Dr N told Dr L she only gave the drug to certain women in the very early stages of pregnancy. Dr N explained that she considered it was a necessary service and she felt justified in her decision to use it in Patient A's situation. She explained to Dr L that [this] was a strong issue for women and they deserve the right to have this kind of service, not done in H with the sort of pathways that we have in place now or words to that effect. Dr N said that she would defend her decision in this regard in a court of law.*

55. *In the computer notes which Dr N made of her consultation with Patient A on [ ] Dr N recorded "OK for another try at MAP". "MAP" is an abbreviation for the morning after pill (Postinor).*

56. *Dr N did not make any record in Patient A's [ ] notes of the prescription she had written and dated, [ ] for Cytotec (56 tablets dispensed). Nor did she record her dispensing of misoprostol to Patient A during the consultation on [ ], in Patient A's clinical notes.*

57. *There is nothing recorded in Patient A's clinical notes which indicate that she had symptoms of an ectopic pregnancy or possible miscarriage (there is no record of the patient having reported bleeding or cramps). Dr N took no initial steps to exclude the risk of her patient's pregnancy being ectopic by conducting an abdominal examination and a speculum examination.*

58. *The usual practice when a woman presents in the circumstances would have been for Dr N to have requested repeat/serial beta HCG levels for Patient A in two to three days' time before taking any further steps. In a continuing pregnancy the beta HCG levels double about every 48 hours. However if there had been a missed miscarriage this doubling will not usually occur.*

59. *Where there is a diagnosis of a missed miscarriage then misoprostol would be an accepted off label use to expel the contents of the uterus. Usual practice in these circumstances, however, is for the woman to be seen first in a hospital clinic before any misoprostol was dispensed. As at [ ] Dr N was not in a position to have made a diagnosis of a non-viable pregnancy (missed miscarriage) in Patient A. That was because there were no serial beta HCG levels available to Dr N for this patient (as they had not been done) and nor had an ultrasound scan (USS) been done at that time. As at [ ] it would have been too early for an USS to have been done. Beta HCG levels need to be around 2000mIU/L before the pregnancy sac will be seen on a trans-abdominal ultrasound (1500 if trans vaginal).*

60. If the beta HCG levels have been increasing over a period of time and an ultrasound scan shows an ongoing pregnancy then legally the woman would be required to be referred to a licensed abortion clinic for consideration of a termination of pregnancy. If an USS confirmed a non-viable pregnancy (missed miscarriage) then the woman would be given the option of waiting for the pregnancy tissue to be expelled itself or referral to hospital. In hospital she would be given the option of surgical removal or medical management with misoprostol usually administered vaginally.

61. The risks of using misoprostol alone for the purposes of inducing an abortion are that the drug may not in fact have the desired result and a viable pregnancy may continue with a potential risk of fetal abnormality; or that if a miscarriage did occur, it would not be complete. Patient A returned to [ ] on [ ] at which time she consulted with Nurse W. Nurse W noted there had been no bleeding but [ ] Routine ante-natal bloods were also requested (for example rubella serology, HIV etc). Patient A's beta HCG level was reported [ ] which was an increase from the [ ] reported on [ ]. This indicated an ongoing pregnancy (and that the misoprostol prescribed and dispensed by Dr N, if it had been taken, had not worked).

62. Dr N next saw Patient A on [ ] at which time she noted "OBx: TOP referral". As at that date Dr N was aware there was an ongoing pregnancy. Dr N also wrote a referral letter to a gynaecologist. In the referral letter Dr N noted Patient A's rising BHCG level, [ ] However there was no reference to her having prescribed and dispensed misoprostol to this patient a week before. In Patient A's computer notes for [ ] Dr N did however, record her prescriptions for [ ] which she had issued to Patient A that day.

63. Dr L had found the consultation with Patient A to have been a bit unusual and she had an uncertain feeling about it. When she returned to [ ] she was involved in a post GP attachment de-brief about her experiences. Dr L brought up what she had witnessed at Dr N's consultation with Patient A and on [ ] she prepared a file note recording what she had witnessed and her concerns. This letter later formed the basis of the complaint [ ].

64. Patient A's [ ] notes entered by Nurse W on [ ] record that Patient A had telephoned the [ ] that day advising that she had not heard anything about her appointment for a termination, which she had understood was being arranged for her. Nurse W recorded "seems 9/40 today according to date scan on [ ]. Appt made for xx Hosp for [ ] and apt for cert made with Dr N." A note made by Dr N on [ ] recorded [ ]. Will ph them in hope of cancellation 4 earlier. Papers A. [ ]- > med cert". Dr N also recorded her prescription for [ ].

Particular 1 (a)

65. Dr Helen Elizabeth Roberts was requested by the PCC to provide an independent expert opinion on the matters the subject of the charge.

Dr Roberts is an Associate Professor Women's Health in the Department of Obstetrics and Gynaecology at the Faculty of Medicine and Health Sciences, University of Auckland. [ ]. In addition Dr Roberts has worked as a Consultant for the Outpatient Contraceptive Clinic, Auckland District Health Board as well as a Certifying Consultant for the Epsom Day Unit, an abortion clinic of the ADHB in Epsom, Auckland.

66. *In Dr Roberts' opinion Dr N's prescribing and dispensing of Cytotec to Patient A on [ ] was inappropriate, and a serious departure from acceptable professional standards. Further in Dr Roberts' view it was contrary to the best interests of her patient. Dr Roberts considers the prescribing and dispensing to have been inappropriate for the following reasons;*

- *Dr N issued the prescription for an unspecified quantity of Cytotec on [ ] without first having seen Patient A in a consultation;*
- *On the information available the prescription was faxed to the Pharmacy from [ ] when Dr N was not present and before Patient A was seen by Nurse W;*
- *Patient A had had a positive pregnancy test by the time of her visit to Dr N at [ ] on [ ];*
- *There were no serial beta HCG results available on [ ] and therefore Dr N was not in a position to make a diagnosis of a missed miscarriage;*
- *Cytotec was contraindicated in Patient A on [ ];*
- *The Pharmacy was instructed to dispense and did dispense 56 tablets of Cytotec under Dr N's script for Patient A of [ ]. This large amount of Cytotec tablets may be prescribed to a patient for long term duodenal/gastric ulcers yet there were no clinical indications for this in Patient A as at [ ].*
- *There is no evidence that Dr N dispensed all of the Cytotec tablets she had obtained under her prescription for Patient A at the consultation on [ ];*
- *Dr N did not record the prescription or the dispensing (or any clinical justification for it) anywhere in Patient A's clinical records at [ ];*
- *None of the indications specified in the Medsafe Data Sheet for Cytotec were present in Patient A when Dr N saw her on [ ].*

- *Such dispensing was contrary to the legal procedures for termination of pregnancy under the CSA Act 1977. Patient A had not been seen by two certifying consultants.*

- *The prescribing and dispensing was also contrary to [ ] used when a woman presents to a clinic wanting a termination of pregnancy, and in relation to the use of misoprostol (it was not for IUD insertion) and other relevant professional guidelines set out in the Medical Council's Statement on Good Prescribing Practice;*

- *The prescribing and dispensing was contrary to the best interests of Dr N's patient as at the time of the prescribing and/or dispensing, it exposed her to potentially serious adverse effects in the event the misoprostol caused an incomplete abortion (very heavy bleeding) and if the drug did not result in inducing an abortion, risk of fetal abnormalities.*

Particular 2 (a), (b) and (c)

67. *Dr N did not see Patient A on [ ] which is the date of the prescription. Further before dispensing misoprostol tablet to Patient A at her consultation with Patient A on [ ] Dr N did not undertake any clinical assessments or tests to determine if Patient A's pregnancy was a non-viable pregnancy. Although the patient had not presented with any symptoms of an ectopic pregnancy (bleeding and/or abdominal pain) Dr N did not exclude the risk of her patient's pregnancy being ectopic by conducting an abdominal examination and a speculum examination on Patient A when she saw her on [ ] and dispensed misoprostol tablets to her.*

68. *Dr N had no safety discussion with Patient A whereby she sought to ensure her patient had adequate support available to her in the event she took the misoprostol which Dr N prescribed for her on [ ] and dispensed to her at the consultation on [ ].*

69. *Dr Roberts considers that before dispensing misoprostol to Patient A on [ ] Dr N had an obligation to undertake appropriate clinical assessments and/or tests to determine first if Patient A's pregnancy was non-viable. Further, in Dr Roberts' view at the very least Dr N should have ensured that Patient A had adequate support available to her if she took the tablets. With reference to the potentially serious adverse effects of Cytotec on pregnant women recorded in the Medsafe Data Sheet, in Dr Roberts' opinion, it was not in Patient A's best interests or in accordance with acceptable standards of care for Dr N not to have discussed these potential effects and/or safety issues in relation to taking misoprostol when pregnant, with Patient A when she saw her on [ ].*

70. *In Dr Roberts' opinion these failures on Dr N's part were a significant falling short of acceptable standards of care.*

Particular 4 (a)

71. Dr N failed to document in Patient A's clinical notes at [ ], her prescription for Cytotec dated [ ]. Further Dr N failed to document in Patient A's clinical notes her dispensing of misoprostol to Patient A at the consultation on [ ] which was attended by the medical student, Dr L.

72. At her consultation with Nurse W on [ ] the patient is recorded as having had no bleeding but "has had tummy cramps". One possible cause for the cramps could have been the misoprostol, abdominal pain and abnormal uterine contractions being potential adverse effects when misoprostol has been administered to a pregnant woman.

73. Dr Roberts considers that Dr N's failure to record her prescription dated [ ] in Patient A's clinical notes at [ ] was a serious departure from accepted standards for prescribing and note-taking. Dr N issued a prescription before she had seen the patient in a consultation and for a drug which was contraindicated in her patient at the time. In those circumstances Dr Roberts considers that Dr N had an obligation to have written detailed notes in her patient's clinical record at [ ] of the reasons why she had issued this prescription to Patient A, the number of tablets which had been dispensed under the prescription, and the number of tablets which she actually dispensed to the patient during the consultation subsequently. Not recording any of these matters in her patient's clinical notes at any stage (on [ ] and/or seven days later on [ ], in her referral letter to the gynaecologist referred to above) was not in her patient's best interests.

PATIENT B

74. On [ ] a patient identified in the charge as Patient B, presented at [ ] and saw Nurse E who was on duty that day. Dr N was not present at [ ] that day as she was working at her [ ].

75. Patient B told Nurse E that she had taken [ ]. Patient B told Nurse E she wanted a termination of her pregnancy.

76. Nurse E did a urine test and confirmed the pregnancy. Patient B was completely sure she did not want to continue with the pregnancy. Nurse E discussed Patient B's options [ ] Nurse E decided to ring Dr N at her [ ] as she considered the situation with Patient B was complicated. Nurse E hoped that Dr N might be able to see Patient B and/or arrange an urgent scan and help her to make an informed decision about what to do.[ ].

77. Nurse E had several phone conversations with Dr N that day about Patient B. On the first or second phone call Dr N instructed Nurse E to go to the cupboard in her (Dr N's) office, get some misoprostol pills and give them to Patient B. Nurse E told Dr N she was not happy about

giving the patient these pills as it was not [ ] policy to dispense such a drug to pregnant women.[ ]. In the meantime Nurse E sent Patient B off to get a blood test, the results of which showed she had a beta HCG level of [ ].

78. *When Patient B returned to [ ] Nurse E told Patient B the results of the blood tests and then she phoned Dr N with the results hoping that Dr N might arrange a scan or to see the patient. Dr N was angry with Nurse E when she told her that she had not given the patient the misoprostol pills.[ ].*

79. *Dr N told Nurse E that it was unfair not to give the patient these pills; [ ]Patient B; that if Patient B had to wait it would be too late; and that she (Nurse E) would be denying the patient the right to choose if she denied her the pills.*

80. *[ ].*

81. *[ ].*

82. *Dr N was phoned again at which time she instructed Nurse E to write out (handwrite) a prescription for 8 tablets of Cytotec on a [ ] prescription pad for Patient B.[ ].*

83. *The prescription which Nurse E handwrote on Dr N's instructions is dated [ ]. Dr N told Nurse E to tell Patient B to take the prescription to the Pharmacy, which Nurse E did. The pharmacy stamp on the prescription is [ ] which confirms the prescription was dispensed at Pharmacy on that date.*

84. *The prescription was later signed by Dr N.*

85. *Nurse E's clinical notes show that she saw Patient B on [ ]; that Patient B had had [ ]. PT today positive. Talked to Dr N. For Hcg and antenatal bloods today. As above, Nurse E ordered a beta hCG test together with antenatal bloods as confirmed by the blood form in the patient records. These results had confirmed Patient B's pregnancy.*

86. *[ ]*

87. *Patient B returned to [ ] on [ ] and was seen again by Nurse E who ordered another beta HCG test. Nurse E recorded that the patient had passed three large blood clots over the [ ]. The HCG level was reported at [ ] that day and the bleeding was noted to have stopped. At this consultation Patient B reported to Nurse E that she had gone to the [ ] it was too early to have a scan and she had been sent home. On [ ] Patient B's beta HCG level was reported as [ ] (ordered by the X) which was a drop from the result on [ ].*

88. By [ ] the patient's beta HCG level was [ ] at which time Nurse W recorded that she had contacted Dr N to arrange an urgent scan with Mr R for [ ] that day. The typed note of Nurse W on [ ] records that she had phoned Dr N ("O") to organise an urgent scan and that the scan had been organised with Mr R for [ ] that day. The hospital admission note from [ ] indicates Patient B's admission was arranged by Mr R for possible ectopic pregnancy and the notes record that by the time of Mr R's operation Patient B suffered a ruptured ectopic pregnancy and her left fallopian tube was excised that day.

Particular 1 (b)

89. In Dr Roberts' opinion Dr N's conduct in relation to Patient B on [ ] was a significant departure from acceptable professional standards in several respects:

- *Patient B had a positive pregnancy test at [ ] on [ ]. Dr N was informed (by Nurse E over the telephone) of the beta BCG result which confirmed the patient was pregnant. However there were no serial beta hCG results available at that time; Cytotec was therefore contraindicated for Patient B at the time it was prescribed;*

- *None of the indications specified in the Medsafe Data Sheet for Cytotec were present in Patient B when she was seen at [ ] on [ ] and/or when Dr N instructed Nurse E to dispense misoprostol and then to issue a prescription for Cytotec to Patient B.*

- *Such dispensing was contrary to the legal procedures for termination of pregnancy under the CSA Act 1977.*

- *It was also contrary to [ ] Guidelines and other applicable professional guidelines.*

- *Dr N did not record the prescription in her patient's clinical records at any time; and*

- *Dr N's prescribing and/or dispensing at the time it occurred on [ ] was contrary to her patient's best interests in that it exposed Patient B to potentially serious and life-threating adverse effects and in the event the drug did not result in inducing an abortion, risk of fetal abnormalities.*

90. In Dr Roberts' view Dr N's actions in relation to Patient B were inconsistent with acceptable standards of medical practice in that they involved the dispensing of a drug (Cytotec) which;

- *the prescriber was aware was contraindicated in the patient concerned at the time the prescriber ordered it to be dispensed and later prescribed; and*

- *in respect of which there are known risks (risks which Dr N was aware of as a consequence of her involvement in [ ] practice since the 1980's); and*

- *without first having seen the patient.*

Particular 3 (a) (b) and (c)

91. Dr Roberts noted that the accepted practice at [ ] for a woman who presents and is pregnant, and who has had bleeding and or abdominal pain (as Patient B had reported) is for a doctor to do an abdominal examination and a speculum examination. If these examinations suggest an ectopic pregnancy then the patient should be referred to hospital with the referring doctor having contact by phone with the on call registrar and a referral letter. If these examinations do not suggest an ectopic pregnancy and the speculum examination shows a closed cervix then serial Beta hCGs should be arranged every few days to see if the usual doubling of levels occurs. If this level doubling occurs then this would suggest a continuing intrauterine pregnancy which should then be followed up with a USS to check that this is so.

92. Dr N ordered Nurse E first to dispense Cytotec from a supply in her drug cupboard, and then subsequently to prepare a prescription for Cytotec for Patient B on an urgent basis.

93. Dr N issued instructions to Nurse E when she (Dr N) had not seen Patient B in a consultation and/or had not performed any assessments on her of any kind.

94. In Dr Roberts' opinion that was not acceptable practice on the part of any general practitioner especially a medical practitioner working for [].

95. The prescription was dispensed on [ ] as confirmed by the pharmacy sticker on the prescription. The prescription was later signed by Dr N.

96. The patient's notes from X on that day, [ ] confirm Patient B presented to the X with bleeding in the late afternoon (triage time [ ] "has been spotting since yesterday off & on"). The Hospital notes record that Patient B had [ ]. In any event as Patient B was stable at the time of her presentation at X, she was admitted on leave by Dr Y and therefore allowed to go home on the understanding she would have follow up/serial beta hCGs and a USS when her hcg level exceeded 2000.

97. Dr Roberts has observed that if a patient presented with pain/bleeding in pregnancy, as had Patient B then the patient would usually need to see a doctor. Dr N [ ] was not present [ ] when Patient B presented on [ ].

98. In Dr Roberts' view there was insufficient information available at the time Dr N ordered Nurse E to issue a prescription for Cytotec for

Patient B, to enable her to determine if Patient B's pregnancy was non-viable and to exclude the possibility of an ectopic pregnancy. It is Dr Roberts' opinion that in all of the circumstances as they were on [ ] the prescribing on that date would be regarded by a reasonable medical practitioner as falling short of acceptable professional standards, particularly as it had the potential to cause serious adverse effects in a pregnant patient, and a risk of fetal abnormalities. Further, it potentially compromised Patient B's on-going right to quality of care and continuity of service and was not in the patient's best interests.

Particular 4 (b)

99. Dr N failed to document in Patient B's clinical notes at [ ] the prescription she instructed Nurse E to prepare for Cytotec for Patient B on [ ] (8 tabs) (which Dr N later signed).

100. In Dr Roberts' opinion Dr N had a professional obligation to note the prescription and the details thereof in Patient B's clinical notes. Dr N prescribed a drug to a patient she had not seen in a consultation but whom she had been told by a Nurse had had a positive pregnancy test; and she (Dr N) had been given the beta hCG result which confirmed the pregnancy. Further Dr N ordered the issue of a prescription for a drug which at the time was contraindicated in Patient B and which had known adverse effects when taken in pregnancy. In Dr Roberts' opinion these circumstances imposed an obligation on Dr N to justify her prescription and the clinical decision-making around it, in her patient's notes.

101. Dr Roberts considers that Dr N should have made an appropriate clinical note herself including details of the prescription, at her next opportunity, which at the latest would have been when she next attended [ ].

102. In Dr Roberts' view Dr N's failure to record this prescription, given the circumstances surrounding it, fell short of accepted standards for these reasons.

103. Further, in Dr Roberts' opinion the prescription was relevant information pertaining to Patient B's clinical picture which should have been recorded in Patient B's records at [ ], for future reference by other health professionals, including clinic nurses, as and when necessary.

PATIENT C

Particular 1(c)

104. Patient C's medical records from the XY contain a note of one consultation only which occurred on [ ]. The front sheet of the notes records that Patient C had been referred by "Nurse W (nurse from GP)". Nurse W acknowledges having made this referral to Dr N [ ], in her capacity [ ]. Patient C had had a positive pregnancy test and wanted a termination. Nurse W referred Patient C to the XY because

she was aware Dr N would not be attending doctor [ ] and she (Ms W) considered this patient (Patient C) should be seen more urgently by Dr N given her expressed[ ] wish for a termination of her pregnancy.

105. On [ ] Dr N issued a handwritten prescription for Cytotec on a pre-printed [ ] prescription form to a patient identified as Patient C in the charge (Cytotec 2 bd -16 tabs). Dr N's stamp and signature appears on the prescription.

106. The [ ] notes which Dr N made for the consultation she had with Patient C on [ ] record only that " [ ] prefers TOP →. [ ].

107. Dr N failed to record the prescription or the clinical reasons for the prescription in the patient's clinical notes which she made for the consultation on [ ].

108. Patient C's XY records contain swab results [ ] and antenatal bloods results [ ]. These are all dated [ ]. The Intact HCG Assay result sent to the XY/Dr N records a level of [ ] IU/mL. These results confirm the patient was pregnant on [ ].

109. In Dr Roberts' opinion, as Dr N would have been aware as at [ ] that Patient C was pregnant, her prescription for Cytotec (16 tabs) for Patient C was inappropriate. That is particularly as no serial beta HCG levels had been obtained as at that date to enable her to diagnose a missed miscarriage.

110. This was not a case where there was to be an IUD insertion and nor was it a case of a confirmed missed miscarriage. Further none of the other indications for Cytotec specified in the Medsafe Data Sheet were present in relation to Patient C as at [ ].

111. Dr N's prescription for misoprostol was issued to Patient C in a manner which was contrary to the procedures for termination of pregnancy specified in the CSA Act 1977. Dr Roberts has noted that the conduct was therefore inappropriate and (as with Patient's A and B) the woman had not [been seen by] two certifying consultants as is required under the CSA Act.

112. Further in Dr Roberts' opinion Dr N's conduct was not in Patient C's best interests. If Patient C took the Cytotec which Dr N had prescribed for her and it did not have the effect of inducing an abortion of Patient C's pregnancy then there was a significant risk of fetal abnormalities caused by the ingestion of the drug. Further, there was a risk of Patient C suffering one or more of the adverse effects specified in the Medsafe Data Sheet.

113. There is no information available about the outcome for Patient C. Patient C's clinical notes from the XY contain no letter of referral to xx Hospital. However as at the date of the prescription, [ ], Dr Roberts

considers that Dr N ought to have had regard to the risks for Patient C when prescribing Cytotec for her.

Particular 4 (c)

114. There is no record of the [ ] prescription for Cytotec (16 tabs) in Patient C's clinical notes from the Y. Dr N failed to document in Patient C's clinical notes her prescribing of misoprostol to Patient C on [ ].

115. As Dr N was issuing a prescription for a drug which was contraindicated in this patient because she was five weeks pregnant in Dr Roberts' opinion there was an obligation on Dr N to record the fact of the prescription in the patient's clinical records and in addition the reasoning behind the clinical decision-making for the issuing of the prescription in these circumstances.

116. As with her failure to record the other prescriptions referred to in the charge, Dr Roberts considers Dr N's failure to note her prescription for Patient C to fall short of acceptable standards. Dr Roberts observed that by not recording the prescription in the patient's clinical notes on [ ], this had the potential to affect the patient's continuity of care particularly if the Cytotec did not have the effect desired by the patient. Patient C's clinical notes from the XY contain no record of Dr N having reported back to the referring GP and/or to Nurse W as referring GP practice nurse about her consultation with Patient [C] on [ ], nor any advice back to the GP that she had prescribed Cytotec to Patient C. Therefore, there is no record in any of Patient C's clinical notes of any prescription for Cytotec.

PATIENT D

Particular 4(d)

117. On [ ] Dr N handwrote on pre-printed [ ] prescription form, a prescription for Cytotec (2 tabs) and Diclofenac (2 tabs) to be taken "before appointment" to a patient identified as Patient D in the charge.

118. The handwritten clinical notes for this patient record that the patient was interested in having an IUD inserted. The typed clinical notes of Dr N's record as the reason for the patient's visit "Wants Iucd" (now more commonly abbreviated as IUD).

119. The misoprostol which Dr N prescribed to Patient D was in the correct dosage for a difficult IUD insertion and would in Dr Roberts' opinion be acceptable practice [ ].

120. There is a pharmacy sticker on the prescription showing it was dispensed on [ ].

121. There is no information available which confirms whether Patient [D] took the misoprostol prescribed for her by Dr N on [ ] or whether she

ever had an IUD inserted. The typed clinical notes for this patient state at the bottom in handwriting "Nothing else" being a reference to the fact there are no further notes for this patient held [ ]. Dr N failed to record the prescription for Cytotec and Diclofenac which she issued on [ ], in Patient D's clinical notes.

122. In Dr Roberts' opinion Dr N's failure to document her prescription for Cyotec for Patient D on [ ] fell short of accepted standards for note-taking."

22. Submissions were made by Counsel for the PCC as to liability. She outlined relevant legal principles (as set out above) and in summary submitted that each of the particulars when considered separately constituted negligence, malpractice and otherwise met the standard of having brought or being likely to bring discredit to the medical profession; and that the seriousness of the admitted facts in each instance was such as to warrant discipline for the purposes of protecting the public, maintaining professional standards and punishing Dr N. The same conclusion should be reached when the particulars were considered cumulatively. In support of these conclusions, emphasis was placed on the opinions expressed by Dr Roberts.

23. Counsel for Dr N stated that as Dr N accepted there was professional misconduct, there was no need to advance submissions on that topic.

Applicable standards:

24. In the course of assessing the individual particulars, the Tribunal had regard to:

24.1. The legal requirements of the CSA Act. In that regard, consideration was given to:

24.1.1. Section 18, which provides that subject to the provisions of the Act, no abortion shall be performed elsewhere than in an institution licensed for the purposes of the Act.

24.1.2. Section 29, which provides that abortions shall not be performed unless and until it is authorised by two certifying consultants.

24.1.3. Section 30, which establishes the regime by which the supervisory committee is to set up and maintain a list of certifying consultants.

24.1.4. Section 32, which stipulates the procedure where a woman seeks an abortion. In particular, every medical practitioner who is consulted by or in respect of a female who wishes to have an abortion shall, if requested to do so by or on behalf of that female, arrange for the case to be considered and dealt with in accordance with the provisions of the Act. Where such a request is made, and it appears that the case may be one to which section 187A of the Crimes Act 1961 applies, the certifying procedure is to be undertaken.

24.1.5. Section 35, which provides that when certifying consultants have made a decision in any case, they shall (in consultation, where practicable, with the woman's own doctor) advise her of her right to seek counselling from any appropriate person or agency.

24.1.6. Section 45, which provides that every medical practitioner who performs an abortion, or any other medical or surgical procedure that could lead to effect a subsequent unnatural miscarriage, shall make a record thereof and of the reasons therefore, and shall within one month after performing that abortion or procedure, forward a copy of the record to the supervisory committee.

24.2. The provisions of the MCNZ Guide, "Good Prescribing Practice". The document emphasises that a medical practitioner:

24.2.1. Should only prescribe medicines or treatment when the practitioner has adequately assessed the patient's condition.

24.2.2. The practitioner must be familiar with the indications, side effects,

contra indications, major drug interactions, appropriate dosages, effectiveness and cost effectiveness of the medicines prescribed.

24.2.3. The practitioner should take an adequate drug history of the patient including any previous adverse reactions to medicines, and current medical conditions.

24.2.4. The practitioner should consider whether a prescription is warranted given the nature of the patient's complaint and presentation.

24.2.5. The practitioner should ensure the patient is fully informed and consents to the proposed treatment in a way the patient can understand as to the options available, including an assessment of the expected risks, side effects, and benefits and costs of each option. The practitioner also has an obligation to satisfy himself or herself that the patient understands how to take any medicine prescribed, and is able to take it.

24.2.6. There should not be indiscriminate excessive or reckless prescribing.

24.2.7. Prescribing should take place in accordance with accepted practice in any best practice guidelines.

24.2.8. The practitioner should keep a clear and accurate patient record containing all relevant clinical findings, decisions made, information given to the patient and the medicines and any other treatment prescribed.

24.2.9. For a patient to be under a practitioner's care, the doctor must have had a face to face consultation with the patient, or have discussed that specific patient's treatment with another New Zealand registered health practitioner who can verify physical data and identify it.

24.3. The MCNZ Guide, "The Maintenance and Retention of Patient Records" emphasises the importance of maintaining clear and accurate patient records that report:

24.3.1. relevant clinical findings;

24.3.2. decisions made;

24.3.3. information given to patients;

24.3.4. any drugs or other treatment prescribed.

Such records should be made at the same time as the events that are recorded or as soon as possible afterwards.

Particular 1: prescribing and/or dispensing misoprostol (Cytotec) in a manner contrary to the CSA Act, and otherwise inappropriately, in respect of Patient A, Patient B and Patient C:

25. Dr Roberts provided expert opinion evidence in relation to the circumstances faced by each of the three patients. It is convenient to reproduce her evidence, as set out in the Agreed Summary:

25.1. In respect of Patient A:

> "*Dr Roberts considers the prescribing and dispensing to have been inappropriate for the following reasons;*
>
> - *Dr N issued the prescription for an unspecified quantity of Cytotec on [ ] without first having seen Patient A in a consultation;*
> - *On the information available the prescription was faxed to the Pharmacy from [ ]when Dr N was not present and before Patient A was seen by Nurse W;*
> - *Patient A had had a positive pregnancy test by the time of her visit to Dr N at [ ] on [ ];*
> - *There were no serial beta HCG results available on [ ] and therefore Dr N was not in a position to make a diagnosis of a missed miscarriage;*
> - *Cytotec was contraindicated in Patient A on [ ];*

- *The Pharmacy was instructed to dispense and did dispense 56 tablets of Cytotec under Dr N's script for Patient A of [ ]. This large amount of Cytotec tablets may be prescribed to a patient for long term duodenal/gastric ulcers yet there were no clinical indications for this in Patient A as at [ ]*

- *There is no evidence that Dr N dispensed all of the Cytotec tablets she had obtained under her prescription for Patient A at the consultation on [ ];*

- *Dr N did not record the prescription or the dispensing (or any clinical justification for it) anywhere in Patient A's clinical records at [ ];*

- *None of the indications specified in the Medsafe Data Sheet for Cytotec were present in Patient A when Dr N saw her on [ ]*

- *Such dispensing was contrary to the legal procedures for termination of pregnancy under the CSA Act 1977. Patient A had not been seen by two certifying consultants.*

- *The prescribing and dispensing was also contrary to [ ] Guidelines used when a woman presents to a clinic wanting a termination of pregnancy, and in relation to the use of misoprostol (it was not for IUD insertion) and other relevant professional guidelines set out in the Medical Council's Statement on Good Prescribing Practice;*

- *The prescribing and dispensing was contrary to the best interests of Dr N's patient as at the time of the prescribing and/or dispensing, it exposed her to potentially serious adverse effects in the event the misoprostol caused an incomplete abortion (very heavy bleeding) and if the drug did not result in inducing an abortion, risk of fetal abnormalities.*"

25.2. In respect of Patient B:

> "*In Dr Roberts' opinion Dr N's conduct in relation to Patient B on [ ] was a significant departure from acceptable professional standards in several respects:*
>
> - *Patient B had a positive pregnancy test at [ ] on [ ]. Dr N was informed (by Nurse E over the telephone) of the beta BCG result which confirmed the patient was pregnant. However there were no serial beta hCG results available at that time; Cytotec was therefore contraindicated for Patient B at the time it was prescribed;*
>
> - *None of the indications specified in the Medsafe Data Sheet for Cytotec were present in Patient B when she was seen [ ] on [ ]*

and/or when Dr N instructed Nurse E to dispense misoprostol and then to issue a prescription for Cytotec to Patient B.

- *Such dispensing was contrary to the legal procedures for termination of pregnancy under the CSA Act 1977.*
- *It was also contrary to [ ] Guidelines and other applicable professional guidelines.*
- *Dr N did not record the prescription in her patient's clinical records at any time; and*
- *Dr N's prescribing and/or dispensing at the time it occurred on [ ] was contrary to her patient's best interests in that it exposed Patient B to potentially serious and life-threating adverse effects and in the event the drug did not result in inducing an abortion, risk of fetal abnormalities.*"

25.3. In respect of Patient C:

> "*In Dr Roberts' opinion, as Dr N would have been aware as at [ ] that Patient C was pregnant, her prescription for Cytotec (16 tabs) for Patient C was inappropriate. That is particularly as no serial beta hCG levels had been obtained as at that date to enable her to diagnose a missed miscarriage.*
>
> *This was not a case where there was to be an IUD insertion and nor was it a case of a confirmed missed miscarriage. Further none of the other indications for Cytotec specified in the Medsafe Data Sheet were present in relation to Patient C as at [ ].*
>
> *Dr N's prescription for misoprostol was issued to Patient C in a manner which was contrary to the procedures for termination of pregnancy specified in the CSA Act 1977. Dr Roberts has noted that the conduct was therefore inappropriate and (as with Patient's A and B) the woman had not [been seen by] two certifying consultants as is required under the CSA Act.*
>
> *Further in Dr Roberts' opinion Dr N's conduct was not in Patient C's best interests. If Patient C took the Cytotec which Dr N had prescribed for her and it did not have the effect of inducing an abortion of Patient C's pregnancy then there was a significant risk of fetal abnormalities caused by the ingestion of the drug. Further, there was a risk of Patient C suffering one or more of the adverse effects specified in the Medsafe Data Sheet."*

25.4. Save for the evidence given by Dr Roberts as to an alleged failure to exclude the risk of an ectopic pregnancy in respect of Patient A and Patient B, which is

dealt with more fully below, the Tribunal accepts Dr Roberts' opinions.

26. In short, in respect of each patient:

26.1. Illegality: Misoprostol was prescribed or dispensed in a manner contrary to the legal pregnancy termination procedures specified in the CSA Act. That is, there was no attempt to refer the patient in each instance for counselling and to another certifying consultant; the misoprostol was not given on licensed premises; and proper records were not kept.

26.2. Acted inappropriately: underpinning the inappropriate care described by Dr Roberts was a complete failure to provide each patient with an opportunity to consider expected risks, side effects, benefits and costs of all options. Dr N acted unilaterally and in a manner which could not be said to be in each patient's best interests.

27. Accordingly, the elements of Particular 1 are established. The Tribunal is satisfied that this pattern of illegal and inappropriate care constitutes serious negligence, malpractice and brings discredit to the medical profession. Dr N was acting contrary to all relevant guidelines especially as to safe prescribing, and discipline is therefore warranted in respect of Particular 1.

Particular 2: before prescribing/dispensing Misoprostol to Patient A, failed to undertake appropriate clinical assessment/tests, exclude the risk of ectopic pregnancy, ensure Patient A had adequate support:

28. Dr Roberts' opinion as to these breaches is as follows:

> "*Dr Roberts considers that before dispensing misoprostol to Patient A on [ ] Dr N had an obligation to undertake appropriate clinical assessments and/or tests to determine first if Patient A's pregnancy was non-viable. Further, in Dr Roberts' view at the very least Dr N should have ensured that Patient A had adequate support available to her if she took the tablets. With reference to the potentially serious adverse effects of Cytotec on pregnant women recorded in the Medsafe Data Sheet, in Dr Roberts' opinion, it was not in Patient A's best interests or in accordance with acceptable standards of care for Dr N not to have discussed these potential effects and/or safety issues in relation to taking misoprostol when pregnant, with Patient A when she saw her on [ ].*

> *In Dr Roberts' opinion these failures on Dr N's part were a significant falling short of acceptable standards of care.*"

29. The Tribunal does not accept that, at four weeks from conception, Dr N could positively have excluded an ectopic pregnancy. Normally, an ectopic pregnancy would not declare itself until one or two weeks later. Whilst, in fact, Dr N failed to exclude the risk of Patient A's pregnancy being ectopic (as alleged in the subparticular), it would not have been feasible to do so. Consequently, it is not appropriate to include this allegation as an aspect of a disciplinary charge.

30. The Tribunal accepts, on the basis of Dr Roberts' evidence, that subparticulars (a) and (c) are established. To that extent, Particular 1 is established. The Tribunal is satisfied that this conduct constitutes negligence, malpractice, and brings discredit to the medical profession. Dr N was acting contrary to all relevant guidelines especially as to safe prescribing, and discipline is therefore warranted in respect of Particular 2.

Particular 3: prescribing/instructing a nurse by telephone to dispense misoprostol/cytotec without seeing patient, undertaking appropriate clinical assessments and/or tests as to non-viability, or excluding risk of the patient's pregnancy being ectopic:

31. Dr Roberts' opinion as to these breaches is as follows:

> "*Dr N ordered Nurse E first to dispense Cytotec from a supply in her drug cupboard, and then subsequently to prepare a prescription for Cytotec for Patient B on an urgent basis.*
>
> *Dr N issued instructions to Nurse E when she (Dr N) had not seen Patient B in a consultation and/or had not performed any assessments on her of any kind.*
>
> *In Dr Roberts' opinion that was not acceptable practice on the part of any general practitioner especially a medical practitioner working for a [ ].*
>
> *The prescription was dispensed on [ ] as confirmed by the pharmacy sticker on the prescription. The prescription was later signed by Dr N.*
>
> *The patient's notes from X on that day, [ ] confirm Patient B presented to the X with bleeding in the late afternoon. The Hospital notes record that Patient B had [ ]. In any event as Patient B was stable at the time of her presentation at X, she was admitted on leave by Dr Y and therefore allowed to go home on the understanding she would have follow up/serial beta hCGs and a USS when her hcg level exceeded 2000.*

> *Dr Roberts has observed that if a patient presented with pain/bleeding in pregnancy, as had Patient B then the patient would usually need to see a doctor. Dr N [ ] was not present [ ] when Patient B presented on [ ].*
>
> *In Dr Roberts' view there was insufficient information available at the time Dr N ordered Nurse E to issue a prescription for Cytotec for Patient B, to enable her to determine if Patient B's pregnancy was non-viable and to exclude the possibility of an ectopic pregnancy. It is Dr Roberts' opinion that in all of the circumstances as they were on [ ] the prescribing on that date would be regarded by a reasonable medical practitioner as falling short of acceptable professional standards, particularly as it had the potential to cause serious adverse effects in a pregnant patient, and a risk of fetal abnormalities. Further, it potentially compromised Patient B's on-going right to quality of care and continuity of service and was not in the patient's best interests.*"

32. This patient presented at approximately five weeks following conception. It cannot be concluded with certainty that an abdominal examination and speculum examination would be capable of establishing or excluding an ectopic pregnancy. Subparticular (c) is therefore not appropriate for discipline.

33. The Tribunal accepts Dr Roberts' opinion, however, with regard to subparticulars (a) and (b).

34. It was a fundamental breach for Dr N not to have seen Patient B at all; this led to her not undertaking appropriate clinical assessments and/or tests to ensure that the pregnancy was non-viable.

35. Since subparticulars (a) and (b) are made out and Particular 3 is established. The Tribunal is satisfied that this conduct constitutes negligence, malpractice and brings discredit to the medical profession. Dr N was acting contrary to all relevant guidelines especially as to safe prescribing. Discipline is therefore warranted in respect of Particular 3.

Particular 4: failed to document in her patients' clinical notes the prescribing and/or dispensing of misoprostol (cytotec) in respect of four patients:

36. Dr Roberts stated:

    36.1. In respect of Patient A:

"Dr Roberts considers that Dr N's failure to record her prescription dated [ ] in Patient A's clinical notes at [ ] was a serious departure from accepted standards for prescribing and note-taking. Dr N issued a prescription before she had seen the patient in a consultation and for a drug which was contraindicated in her patient at the time. In those circumstances Dr Roberts considers that Dr N had an obligation to have written detailed notes in her patient's clinical record at [ ] of the reasons why she had issued this prescription to Patient A, the number of tablets which had been dispensed under the prescription, and the number of tablets which she actually dispensed to the patient during the consultation subsequently. Not recording any of these matters in her patient's clinical notes at any stage (on [ ] and/or seven days later on [ ], in her referral letter to the gynaecologist referred to above) was not in her patient's best interests."

36.2. In respect of Patient B:

In Dr Roberts' opinion Dr N had a professional obligation to note the prescription and the details thereof in Patient B's clinical notes. Dr N prescribed a drug to a patient she had not seen in a consultation but whom she had been told by a Nurse had had a positive pregnancy test; and she (Dr N) had been given the beta HCG result which confirmed the pregnancy. Further Dr N ordered the issue of a prescription for a drug which at the time was contraindicated in Patient B and which had known adverse effects when taken in pregnancy. In Dr Roberts' opinion these circumstances imposed an obligation on Dr N to justify her prescription and the clinical decision-making around it, in her patient's notes.

Dr Roberts considers that Dr N should have made an appropriate clinical note herself including details of the prescription, at her next opportunity, which at the latest would have been when she next attended [ ]

In Dr Roberts' view Dr N's failure to record this prescription, given the circumstances surrounding it, fell short of accepted standards for these reasons.

Further, in Dr Roberts' opinion the prescription was relevant information pertaining to Patient B's clinical picture which should have been recorded in Patient B's records at [ ], for future reference by other health professionals, including [] nurses, as and when necessary.

36.3. In respect of Patient C:

"As Dr N was issuing a prescription for a drug which was contraindicated in this patient because she was five weeks pregnant in Dr Roberts' opinion there was an obligation on Dr N to record the fact of the prescription in the patient's clinical records and in addition the reasoning behind the clinical decision-making for the issuing of the prescription in these circumstances.

> *As with her failure to record the other prescriptions referred to in the charge, Dr Roberts considers Dr N's failure to note her prescription for Patient C to fall short of acceptable standards. Dr Roberts observed that by not recording the prescription in the patient's clinical notes on [ ], this had the potential to affect the patient's continuity of care particularly if the Cytotec did not have the effect desired by the patient. Patient C's clinical notes from the XY contain no record of Dr N having reported back to the referring GP and/or to Nurse W as referring GP practice nurse about her consultation with Patient [C] on [ ], nor any advice back to the GP that she had prescribed Cytotec to Patient C. Therefore, there is no record in any of Patient C's clinical notes of any prescription for Cytotec.*"

36.4. In respect of Patient D:

> "*There is no information available which confirms whether Patient [D]took the misoprostol prescribed for her by Dr N on [ ] or whether she ever had an IUD inserted. The typed clinical notes for this patient state at the bottom in handwriting "Nothing else" being a reference to the fact there are no further notes for this patient held at [ ]. Dr N failed to record the prescription for Cytotec and Diclofenac which she issued on [ ], in Patient D's clinical notes.*
>
> *In Dr Roberts' opinion Dr N's failure to document her prescription for Cytotec for Patient D on [ ] fell short of accepted standards for note-taking.*"

37. The four subparticulars are established. The Tribunal is satisfied that a pattern of failures to document the prescribing of misoprostol (cytotec) on four occasions between 2009 and 2011 constitutes negligence, malpractice, and brings discredit to the profession; and is sufficiently serious as to warrant discipline.

Cumulative effect of four established particulars:

38. The charge also requires the Tribunal to consider whether the conduct established in the four particulars cumulatively amounts to professional misconduct.

39. Since each individual particular constitutes professional misconduct, the cumulative effect of the four established particulars must also amount to professional misconduct.

Penalty:

40. The Tribunal announced the above decision at the hearing and then received information/submissions from the parties.

41. Counsel for the PCC submitted:

41.1. The Tribunal should have regard to sentencing principles as outlined in the relevant case law; this is summarised below.

41.2. There were many significant aggravating features, as described in the agreed summary of facts.

41.3. There could be no trust in Dr N's practice as a general practice or [ ], especially as a prescriber of misoprostol.

41.4. Dr N had acted unprofessionally and with complete disregard for the law relating to abortion in New Zealand, and contrary to her patients' best interests. This was of significant concern especially as she was a certifying consultant under the CSA Act at the time. The views expressed to Dr L on [ ] were incompatible with her role as a certifying consult.

41.5. Failure to record suggested Dr N's primary focus was not on protecting the need for her patients' care and continuity of care, but on protecting her own position in circumstances where she must have been aware she was conducting herself illegally and/or inappropriately.

41.6. Dr N breached the fundamental ethical principle of "*do no harm*" in respect of all patients.

41.7. She had acted in a manner which placed nursing colleagues at risk professionally.

41.8. There was no evidence Dr N had any insight into the seriousness of her

offending. She had acted "*highly unprofessionally*" and had brought the profession into disrepute. Mitigating factors were the admission of the charge and facts; and that to the best of Counsel's knowledge Dr N had not previously appeared before the Tribunal.

41.9. In view of the aggravating factors, it would be reasonable and proportionate to cancel Dr N's registration; cancellation could properly be regarded as inevitable in this case.

41.10. The nature and gravity of the offending indicated she was unfit in the wider sense to practise medicine.

41.11. Cancellation was the only outcome which would send a sufficiently strong message to Dr N and to the medical profession that the established conduct was completely unacceptable, and to maintain high standards.

41.12. Given Dr N's fundamental beliefs about the rights of women in relation to pregnancy/termination, and that she had been prepared to conduct herself contrary to the law and to acceptable standards of professional practice, a sentence short of cancellation would not be appropriate. For example, while conditions could be directed to isolated issues (for example note taking and prescribing practice) these would not address what appeared to be an underlying problem relating to fitness to practise.

41.13. The potential for harm arising from Dr N's conduct in relation to Patients A, B and C could not be understated.

41.14. Should the Tribunal consider that an order for cancellation was not a proportionate response, suspension should be considered for a period of at least 24 months.

41.15. Further, conditions should be imposed.

41.16. The Tribunal should also recommend to the Medical Council that the Council take immediate steps to notify the Abortion Supervisory Committee of the Tribunal's findings, with a recommendation that her certifying consultant status be revoked.

41.17. A fine in the order of $10,000.00 would not be unreasonable.

41.18. Submissions as to costs and name suppression were also made, and these are considered below.

42. Dr N made a statement to the Tribunal; she elected not to give evidence or to be cross examined or questioned by the Tribunal, it being stated that this was on advice from Counsel. In her statement she referred to the following matters:

42.1. She described the nature of her practice and the extent of her professional commitments.

42.2. She said that until mid 2012 she had a very busy work schedule, which came about as a result of significant financial hardships which were explained.

42.3. With the benefit of hindsight she realises now she was working too hard, and had been stressed and allowed herself to become overwhelmed by the need to help those desperately seeking her help.

42.4. [ ]; Dr N was contending with significant stressors at the time. This included another doctor leaving the area [ ]. She felt she was under extreme stress.

42.5. [ ] was over this period very busy; and xx had been closed [ ]. H Hospital was struggling to maintain abortion services over the period.

42.6. She gave details of the circumstances of two of the patients.

42.7. In 32 years of practice this is the only complaint made against her.

42.8. She said she finds it *"difficult to terminate a consultation particularly where a patient has not got what they came for, or what they believe is appropriate."*

She accepted that this was an area where her practice could be improved, and that she had investigated several relevant courses. She was intending to approach the RNZCGP about attending their courses: to date she had received no reply.

42.9. She had taken steps to reduce her workload, and was no longer working at the Emergency Department. She had resigned from [ ], and only then appreciated how demanding and stressful that work had been. She no longer works as a certifying consultant; and does not intend to involve herself in referring pregnant women for abortions in the future, except for general practice patients. She planned to arrange a mentor with whom she could discuss and/or refer patients.

42.10. She has a locum who now works in her practice every [ ]; the various steps taken meant that her workload was far more manageable than it had been up to [ ].

42.11. She described contributions she had made to the community which she said she was rightly proud of.

42.12. She had been very committed to [ ] which she regarded as an important contribution to the community and important service for girls and women in the region.

42.13. She was concerned that if she was struck off or suspended the community that she served would be significantly prejudiced.

42.14. Similarly she believed publication of her name and details of the charge would be very upsetting for patients, particularly as the charge relates to a specialised part of her practice, not connected with her main practice.

43. Counsel for Dr N submitted:

43.1. Reference should be made to the standard sentencing principles, which are set out below.

43.2. Reference was made to the facts; three of the four patients were in the very early stages of pregnancy, and a striking feature of three cases was that Dr N's actions were conducted openly in front of or witnessed by others. That was not offered as an excuse or justification; Dr N accepted they were inappropriate and contrary to the provisions of the CSA Act.

43.3. The penalty to be imposed must only relate to the events particularised in the charge.

43.4. Reference was made to Dr N's positive record, and to references submitted from medical colleagues.

43.5. As it was not being submitted that Dr N was not fit to practise, the Tribunal should focus on the protection of the public and the rehabilitation of Dr N; removal or suspension were not appropriate.

43.6. It was not in the public interest for Dr N's career to be terminated and she should be allowed to rehabilitate herself.

43.7. Removal or suspension are remedies of the last resort and before imposing such, the Tribunal had to be satisfied that there were no penalties short of those outcomes which would protect the public, maintain standards, operate as a deterrent, or rehabilitate.

43.8. Dr N had resigned from [ ], and no longer worked as a certifying consultant. She proposed to arrange a mentor. She was agreeable to there being a

condition on her practice that she not be able to prescribe misoprostol or similar drugs.

43.9. Accordingly, she did not pose a risk to the public; in the 22 months since the matter had been brought to the attention of the Medical Council she had practised without restriction, conditions or difficulty.

43.10. Over the period to which the charge related she had a very heavy workload and was working under considerable stress and pressure; she had taken steps to alleviate these factors.

43.11. She had demonstrated considerable insight, evidenced by the admission of the charge, and changes to practice. She was also willing to submit to conditions. She had identified the shortcomings in her practice which in part led her to act in the way that she did.

43.12. If she was no longer able to practise, her patients and the community would be hugely disadvantaged. Given the XZ's waiting list it was self evident that it would be the community that would ultimately suffer if she was not able to continue to practise.

43.13. She had made a huge contribution to her particular community over 32 years, and there was no reason to doubt that would not continue.

43.14. The principles and objectives of sentencing could be achieved without striking off or suspending Dr N; professional standards could be maintained without such outcomes; nor should she be punished in the circumstances. Her ability to achieve full rehabilitation could not be disputed. The impact of cancellation or suspension would be overwhelming and would far outweigh any public interest there might be from preventing her from practising.

43.15. It was submitted that conditions should be imposed that would achieve rehabilitation and enable continuity of service in the community.

43.16. Submissions as to costs and name suppression were also made, and are considered below.

Penalty – legal principles:

44. A convenient summary as to relevant sentencing principles was recently provided by Williams J in *Katamat v Professional Conduct Committee*.[6] The decision draws on the case of *Roberts* mentioned by Counsel for the PCC, as well as other decisions. The Court stated:

> "*[49] In Roberts v Professional Conduct Committee, Collins J identified the following eight factors as being relevant whenever the Tribunal is determining an appropriate penalty. They are which penalty:*
>
> *(1) most appropriately protects the public and deters others;*
>
> *(2) facilitates the Tribunal's "important" role in setting professional standards;*
>
> *(3) punishes the practitioner;*
>
> *(4) allows for the rehabilitation of the health practitioner;*
>
> *(5) promotes consistency with penalties in similar cases;*
>
> *(6) reflects the seriousness of the misconduct;*
>
> *(7) is the least restrictive penalty appropriate in the circumstances; and*
>
> *(8) looked at overall, is the penalty which is "fair, reasonable and proportionate in the circumstances".*
>
> *[50] In Patel v Dentists Disciplinary Tribunal, regarding the decision to de-register the practitioner specifically, Randerson J held that:*
>
> > *… the task of the Tribunal is to balance the nature and gravity of the offences and their bearing on the dentist's fitness to practise against the need for removal and its consequences to the individual: Dad v General Dental Council at 1543. As the*

[6] [2012] NZHC 1633, 21 December 2012

Privy Council further observed: [in Dad]

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

[51] Similarly in A v Professional Conduct Committee, Keane J derives the following five principles from the Privy Council speeches in Taylor v General Medical Council:

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

[52] Keane J continued, affirming the importance of considerations of rehabilitation:

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

[53] In summary, the case law reveals that several factors will be relevant to assessing what penalty is appropriate in the circumstances. Some factors, such as the need to protect the public and to maintain professional standards, are more intuitive in their application. Others, such as the seriousness of offending and consistency with past cases, are more concrete and capable of precise evaluation. Of all the factors discussed, the primary factor will be what penalty is required to protect the public and deter similar conduct. The need to punish the practitioner can be considered, but is of secondary importance. The objective seriousness of the misconduct, the need for consistency with past cases, the likelihood of rehabilitation and the need to impose the

> *least restrictive penalty that is appropriate will all be relevant to the inquiry. It bears repeating, however, that the overall decision is ultimately one involving an exercise of discretion.*"

45. In exercising its discretion the Tribunal is required to consider aggravating and mitigating factors, and then give a proportionate response.

46. These principles have all been carefully reviewed for the application in this case.

Penalty – discussion:

47. The Tribunal considers there are the following aggravating factors:

47.1. A pattern of offending that involved, over a period of two years, illegal conduct and inappropriate prescribing.

47.2. The statement made by Dr N to the medical student who observed the consultation with Patient A, to the effect that she was justified in her decision to administer the misoprostol on an off licence basis because women deserve the right to have this kind of service; and that this was a strong issue for women. As explained by the Tribunal earlier, such an approach was not in the best interests of the women and demonstrated a significant lack of insight.

47.3. Lack of respect for guidelines, especially given that Dr N was at the time a certifying consultant. She failed to maintain proper standards which she must have been aware of, for no obvious reason other than she felt it was desirable for women not to have to go through the formal process of complying with the requirements of the CSA Act.

47.4. Also relevant is the potential harm arising from the failures to document, for instance if there were subsequent complications and it was necessary to refer to patient notes.

47.5. The drug was contra-indicated in three instances, because the women were pregnant. Dr N knew they were pregnant at the time of prescribing and/or dispensing.

47.6. Of particular concern is the failure to carry out clinical examination or tests before prescribing and/or dispensing misoprostol; and in one case not even seeing the patient.

47.7. A nursing colleague was placed in a very difficult position where she was potentially required to act outside her scope of practice.

47.8. The short point is that the prescribing was illegal; it is obvious that no practitioner should place themselves in a situation of illegality.

48. There are the following mitigating factors:

48.1. 32 years of committed practice.

48.2. A guilty plea.

48.3. Dr N has resigned from [ ] and has undertaken some constructive steps to address some of the issues that arose in the present case; and is committed to further constructive steps which will enhance her rehabilitation.

48.4. She was in a situation of stress, professionally and personally.

48.5. There is some evidence of remorse and insight. This went as far as admitting the facts and pleading guilty to the charge; but the insight did not extend as far as telling the Tribunal in the statement she read to it that she understood why the conduct was unprofessional and inappropriate, or expressing any regret that it occurred.

48.6. The offending was restricted to one area of practice only.

48.7. There was no evidence that she had not practised safely over the two years since the matter came to light; and no evidence of any other unsafe areas of practice.

48.8. She was motivated by good (although misguided) intent. She did not seek personal gain.

49. The Tribunal considers that there were underlying problems of isolation, stress, and a tendency to act unilaterally in respect of an issue where she held strong views. Notably, one of her referees confirmed that Dr N [ ], particularly in the area of unplanned pregnancies and contraception. In the Tribunal's view her commitments to these objectives overcame her better judgment.

50. The Tribunal carefully considered all options placed before it by Counsel, which ranged from conditions only to cancellation of registration.

51. It considers that a strong message needs to be sent to Dr N and to other medical practitioners that breaches of the kind which occurred here will be dealt with very firmly by the Tribunal. It must denounce and deter conduct of the kind which arose here. However, it also considers that in other respects Dr N is competent and well regarded.

52. Assessing all factors, the Tribunal is able to proceed by imposing outcomes which reflect public interest objectives, standard setting objectives and rehabilitation objectives.

53. It has concluded that the seriousness of the matters is such that a period of suspension does have to be imposed, for a period of six months. It deferred the commencement of the suspension for one month, until 27 May 2013, to allow Dr N to order her affairs.

54. Rehabilitation considerations require the imposition of conditions on practice. Those were largely agreed and are set out in full below.

55. Given the period of suspension which may cause financial difficulty the Tribunal did not consider it necessary also to impose a fine.

56. It considers an order of censure is appropriate.

Non-publication issues:

57. The chronology with regard to non-publication issues is as follows:

57.1. An interim order was made in respect of Dr N on 9 November 2012.[7]

57.2. Interim orders were made in respect of Nurse E, X, and the XY on 9 November 2012.[8]

57.3. A permanent order was made in respect of Dr L, on 8 January 2013.[9]

57.4. An interim order was made in respect of [ ] on 5 March 2013.[10] Following a formal application, a permanent order was made at the first hearing.[11]

57.5. On 2 April 2013, a formal application for a permanent order was made on behalf of the XZ, X and XY. By Minute dated 12 April 2013,[12] the interim order was confirmed, it being stated that the possibility of a permanent order would be considered at the resumed hearing.

57.6. At the commencement of the hearing on 4 April 2013, interim orders were made in respect of the XXX and Ms V, both referred to in the Summary of Facts.

57.7. An interim order was made in respect of Nurse W at the hearing on 11 March 2013; a formal application for a permanent order was made on 24 April 2013.

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7 489/Med12/224P
8 489/Med12/224P
9 505/Med12/224P
10 513/Med12/224P
11 Transcript for hearing of 11 March 2013, pp4 & 19
12 526/Med12/224P

57.8. A permanent order of non-publication of name and all identifying details of patients, including their NHI numbers, was made at the commencement of the hearing on 29 April 2013,[13] there being no indication from the patients after they had been spoken to by medical practitioners that they wish to be heard on the issue, or had a contrary view. Both parties agreed such an order should be made.

Name suppression – legal principles:

58. Section 95 of the Act governs issues of non-publication of name. It relevantly provides:

> "*1. Section 95(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 their parties or on its own initiative) make any one or more of the following orders:*
>
> *(a) An order that the whole or any part of a hearing must be held in private:*
>
> *(b) An order prohibiting the publication of any report or account of any part of a hearing, whether held in public or in private:*
>
> *(c) An order prohibiting the publication of the whole or any part of any books, papers, or documents produced at a hearing.*
>
> *(d) An order prohibiting the publication of the name, or any particulars of the affairs, of any person.*"

59. In many previous decisions,[14] the Tribunal has evaluated the following public interest factors:

59.1. Openness and transparency of disciplinary proceedings.[15]

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[13] Transcript 29 March 2013 p5

[14] Eg, 51/Nur06/35P, and 65/Nur06/40P

[15] *M v Police* (1991) CRNZ 14; *R v Liddell* [1995] 1 NZLR 538; *Lewis v Wilson & Horton Ltd* [2003] 3 NZLR 546; *Director of Proceedings v I* [2004] NZAR 635

59.2. Accountability of the disciplinary process.[16]

59.3. Public interest in knowing the identity of a health practitioner charged with a disciplinary offence.[17]

59.4. Importance of freedom of speech and the right enshrined in section 14, New Zealand Bill of Rights Act 1990.[18]

59.5. Unfairly impugning other health practitioners.[19]

60. Also relevant is the statement made by Pankhurst J in *T v Director of Proceedings***:**

> "*[F]ollowing an adverse disciplinary finding more weighty factors are necessary before permanent suppression will be desirable. This, I think, follows from the protective nature of the jurisdiction. Once an adverse finding has been made, the probability must be that public interest considerations will require that the name of the practitioner be published in a preponderance of cases. Thus, the statutory test of what is "desirable" is necessarily flexible. Prior to the substantive hearing of the charges the balance in terms of what is desirable may incline in favour of the private interests of the practitioner. After the hearing, by which time the evidence is out and findings have been made, what is desirable may well be different, the more so where professional misconduct has been established.*"[20]

61. In *B v B*, supra, the Court held: at pg 99

> "*In normal course where a professional person appears before the disciplinary tribunal and is found guilty of an offence, that person should expect that an order preventing publication of his or her name will not be made. That will especially be so where the offence found to be proved, or admitted, is sufficiently serious to justify striking off or suspension from practice. But where the orders made by a disciplinary tribunal in relation to future practice of the defendant directed towards that person's rehabilitation and there is no striking off or suspension but rather, as here, a decision that practice may continue, there is much to be said for the view that publication of the defendant's name is contrary to the spirit of the decision and counterproductive. It may simply cause damage which makes rehabilitation impossible or very much harder to achieve.*"

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16 *Director of Proceedings v Nursing Council* [1999] 3 NZLR 360

17 *Director Proceedings v Nursing Council,* supra; *F v Medical Practitioners Disciplinary Tribunal* (Laurenson J, 5 December 2001, HC Auckland AP21-SW01)

18 *R v Liddell,* supra and *Lewis v Wilson & Horton Ltd*, supra; *Gravatt v Coroners Court* [2013] NZHC 390, [38] & [39]

19 This point has been emphasised on numerous occasions in the criminal Courts where Judges have declined name suppression to avoid suspicion falling on other members of a profession.

20 Para 42, 21 February 2006, CIV-2005-409-002244

62. In *Anderson v PCC* (High Court, Wellington CIV-2008-485-1646, 14 November 2008) Gendall J stated:

> "*[36] Private interests will include the health interests of a practitioner, matters that may affect a family and their wellbeing, and rehabilitation. Correspondingly, interest 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 knowing the identity of a 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 and advance the public interest by ensuring that it is informed of the disciplinary process and of practitioners who may be guilty of malpractice or professional misconduct. It reflects also the principles of openness of such proceedings, and freedom to receive and impart information.*"

63. It is also necessary to have regard to the proportionality principle referred to by Baragwanath J in *J v Director of Proceedings* (17 October 2006, CIV-2006-404-2188, paragraph [71]).

64. Turning to the position of persons other than a practitioner, the following points may be made:

64.1. In *M v Complaints Assessment Committee* (22 April 1999, Judge Ongley, DC Wellington MA106/99) the District Court held that the starting point in respect of complainants who are patients is that their information is private and confidential. The Judge said:

> *"In my view, the consideration of the complainant's interests must begin from the standpoint that aspects of her medical treatment are private and confidential and the subject of privilege against disclosure at law. The complainant waives privilege to the extent that it is necessary to deal with the complaint but seeks that the disclosure of her personal medical treatment should be confined to the extent necessary for the Tribunal to deal with the complaint. She possesses a general right of privacy in relation to the subject matter of her treatment and it may be said that it is of a sufficiently intimate nature that her sensitivity to its*

> *disclosure and the adverse consequences of publicity may be assumed without requiring evidence.*
>
> …
>
> *Allied with the privacy issue is the practical consideration that publication of details of health treatment is bound to be a deterrent to the laying of a complaint by persons who might otherwise have a justifiable grievance. If resort to the Tribunal is likely to carry with it the embarrassment of public disclosure of private and intimate information the consequences will surely dissuade complainants to have a need of access to the Tribunal. It is possible that practitioners may be embarrassed on occasions by publication of allegations against them which turn out to unfounded. The balance between the competing considerations cannot be resolved fairly by adopting the same consequence of publication for both the complainant and the practitioner.*"[21]

64.2. It follows from the general principles summarised above that where the person/entity involved is not a complainant or patient, but a third party whose privacy and/or reputation may be affected if identified, it may on occasions be appropriate to conclude that those interests outweigh the principles of open justice. Examples in that regard include *P v Medical Practitioners Disciplinary Tribunal* (AP2490/97, 17 June 1997) and *W v The Complaints Assessment Committee* (MA122/98, 9 July 1998).

The position of all persons/entities other than the Respondent:

65. In the particular circumstances of this matter, the sensitive and intensely private information of patients was such that unless a patient expressly stated she wished to be identified, then her privacy interests significantly outweighed the principles of open justice; it was appropriate for a permanent order to be made. This was recognised by the parties who ensured that the information placed before the Tribunal was completely anonymised and agreed orders in favour of the patients should be made.

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[21] pp4 & 6.; see also *Director of Proceedings and the Health and Disability Commissioner v The Nursing Council of New Zealand* [1999] 3 NZLR 360; *ZX v Medical Practitioners Disciplinary Tribunal* (1997) DCR 638 and *Director of Proceedings v MPDT and M* (15 March 2002, MA53/02 Wellington, Tuohy DCJ)

For those reasons, a permanent order was made in respect of the patients on 29 April 2013.

66. Affidavit evidence was placed before the Tribunal in respect of the persons/entities described at paragraphs 57.2, 57.4, 57.5 and 57.7; and an oral application was made in respect of the person and entity named at paragraph 57.6. That evidence satisfied the Tribunal that there were very compelling factors of privacy and confidentiality in respect of those persons/entities (whose conduct was not at issue in this proceeding), such that it was appropriate to make permanent orders. The parties also submitted this was appropriate.

Non-publication of name: Dr N:

67. For Dr N, it was submitted that a permanent order of non-publication of name should be made. The following submissions were made in support of that application:

    67.1. Dr N has worked at [ ] since [ ] and was regarded as [ ]. If she were to be named it would be invariably lead to the identification of not only [ ] but also its staff. It was submitted that naming Dr N would quite likely compromise or render nugatory each of the permanent suppression orders made in the case.

    67.2. There is a very real risk that if Dr N was identified it may lead to the identification of one or more of the patients. Certainly within the close circle of their family/friends. Given the issues that are the subject of the charge this could have serious ramifications for the patients in their private lives. This was so, particularly given the fact that at no stage throughout the investigation were the patients advised by the PCC that they and their private and intensely personal health information were the subject of investigation.

67.3. Dr N practises in a small rural community and is very concerned that if her name is published it would have a negative impact on her patients (many of whom are elderly) and her practice.

67.4. Dr N's partner suffers health issues, and she was concerned about the impact the publication could have therefore.

67.5. Dr N has an elderly family member, and he would be devastated if her name was published.

67.6. Publication of Dr N's name would have a serious impact on her rehabilitation, and it was noted that this was a matter addressed by Blanchard J in *B v B* (supra).

67.7. In *Anderson v PCC* (supra) Gendall J emphasised that private interests under the Act would include the health interests of the practitioner or "*matters that may affect a family and their wellbeing, and rehabilitation …*".

67.8. It was also necessary to have regard to the proportionality principle referred to by Baragwanath J in *J v Director of Proceedings* (supra).

67.9. Dr N no longer works in [ ]. There was no public benefit in publishing her name, but rather a potential for serious harm, as had been outlined in Nurse W's affidavit; this raised an issue where Dr N felt she had fears for her safety.

68. The PCC submitted:

68.1. Given the grave nature of Dr N's "*unprofessionalism*" and the principle of transparency, the public had a right to see that the profession upholds its standards. Members of the public, including local practitioners, have the right to know that Dr N had been called to account for her practice and/or to avoid suspicion falling on them.

68.2. There was now no risk of any of the four patients referred to in the charge being identified if Dr N's name was published. The Tribunal had considered anonymised information only in relation to those patients. They were aware of the matters and the charge so there was no issue that publication of Dr N's name in connection with these proceedings might cause them to identify themselves as being the patients concerned.

68.3. Dr N had worked in at [ ] clinics over the relevant time. There were appropriate suppression orders in relation to the institutions involved. The risk of those institutions being identified as clinics where Dr N engaged in the offending was not sufficiently significant so as to displace what was described as the presumption in favour of the publication of Dr N's name, now that the charge had been upheld.

68.4. If the Tribunal was concerned that publication of Dr N's name might lead to identification of the clinics named in the charge, then it was submitted the Tribunal might consider suppressing the name of the drug concerned, and the reference to the CSA Act and/or such other details as may lead a member of the public to speculate that the offending might have occurred at one or other of the named clinics.

68.5. Whilst Dr N may well hold concerns about her safety if her name was published in connection with these proceedings, it was submitted that this personal factor (or other personal factors raised) did not displace the "… *strong presumption in favour of openness*".

68.6. It was noted that Dr N had admitted in relation to Patient A she considered she was justified in dispensing misoprostol as it was a "*necessary service*". It was a "*strong issue for women*" and "*they deserved to have this kind of service, not*

done in H" and further that "*she would defend her decision in this regard in a Court of law*". It was submitted that if Dr N seriously considered that her offending was justified and/or that there was a wider need for lobbying for improved access to health services for women, then she should have no objection to her name being published.

68.7. In short, it was submitted that in all the circumstances it would be contrary to the public interest that Dr N's name and details were to remain suppressed.

Decision as to application for permanent order:

69. The Tribunal considers there are the following factors which point to publication of name:

69.1. The open justice factors which have been identified above at paragraph 59; the Tribunal regards factors such as the openness and transparency of disciplinary proceedings are strong indicators in favour of the making of an order; as is the right of the public to know the identity of a health practitioner particularly when a serious charge is established. Pankhurst J in *A v Director of Proceedings* emphasised that once an adverse finding has been made, the probability is that public interest considerations will require the name of the practitioner to be published in the preponderance of cases; and in *B v B* Blanchard J emphasised that this would be so particularly where the offence is sufficiently serious such as to justify striking off or suspension from practice. That is the case here.

69.2. A further factor which points to publication of name is the necessity of avoiding the unfair impugning of other practitioners, particularly when the matters at issue are serious charges amounting to illegality and inappropriate conduct.

69.3. These factors are entitled to considerable weight.

70. A range of factors was identified by Counsel for Dr N which it was submitted should satisfy the Tribunal that it was desirable to make a permanent order of non-publication of name. These have been carefully considered. The Tribunal's conclusions with regard to those factors are:

70.1. A strong submission was made that publication of Dr N's name would effectively render nugatory the extensive orders it made in respect of other persons and/or entities. In some circumstances it is necessary to suppress a practitioner's name so as to preserve the integrity of other orders made. Here, the evidence before the Tribunal is that Dr N worked [ ] clinics over the relevant period. Whilst there may be patients who consulted with Dr N at [ ], and there is accordingly a risk of some members of the public speculating as to which premises the consultations may have occurred, the Tribunal does not consider this factor is so strong as to outweigh the various factors which point towards publication of name. The Tribunal assesses this risk as modest, which can be mitigated by an order suppressing the place of the offending was in x. It is a point which is entitled to some weight but it is far from being determinative.

70.2. As regards the question of whether patients may be identified the Tribunal considers that the extensive permanent orders which have been made will ensure that there is practically no possibility of patients being identified, even by family members or close friends. No names, addresses, dates of birth or other identifying information have been placed before the Tribunal and will not be published; neither will dates and locations be published. No particular concerns were conveyed to the Tribunal by the patients involved with regard to

this factor; such concerns would have been made known to the Tribunal if they existed. Furthermore, the extent of Dr N's involvement in the work which is the subject of this proceeding over the years means that she will have seen a very significant number of patients over time; and that fact reinforces the conclusion that there is no real risk of patients being identified through Dr N's name being published. This factor is not compelling.

70.3. It was submitted that because Dr N practises in a [ ], that there could be a negative impact on her patients and her practice. The Tribunal considers there is no real prospect of patients of her general practice being adversely affected by Dr N's name being published. Furthermore, the Tribunal has made an order of suspension and patients have a right to know this has happened, and that for a time alternative arrangements may have to be made in respect of their medical care. It is correct that there may be some harm to Dr N's reputation, but that is an inevitable consequence of any positive disciplinary findings. These factors are not entitled to weight.

70.4. Having regard to the information placed before the Tribunal as to family circumstances, it recognises the force of the submission that family members will be distressed by the Tribunal's findings. Again, that is often an unfortunate and inevitable consequence of a positive disciplinary finding. The particular nature of the findings in this case may well be upsetting to family members. This factor is entitled to weight, but it is not a factor in the Tribunal's view that outweighs the factors which support publication of name. Further, the Tribunal is of the view that any such harm could be mitigated by an opportunity being provided for Dr N to inform family of the outcome of this

proceeding; thus a window of seven days for that to happen was considered appropriate.

70.5. Submissions were made that publication of name would compromise rehabilitation prospects. Although Blanchard J did refer in *B v B* to the fact that name suppression might be appropriate where rehabilitation was directed, he specifically stated that this would not be the case where there were striking off or suspension orders. Whilst there is a rehabilitative element to the Tribunal's orders, the penalty of suspension has been imposed for the protection of the public and the maintenance of professional standards. As Gendall J stated in *Anderson v PCC* these factors point to the openness, "*transparency*" and accountability of the disciplinary process.

70.6. Reference was made to fears for safety, given the nature of the issues which arise in this case. While the Tribunal accepts that abortion is a contentious issue in New Zealand and one that can engender strong reactions in some people, there is no evidence that doctors providing illegal abortions are at greater risk than those providing legal abortions in New Zealand. Dr N has obviously seen herself as providing what she described in evidence as a "*necessary service*"; but it was an illegal one, and it did not have regard to appropriate prescribing standards. Criticism is a likely consequence of the professional misconduct which has occurred. But the Tribunal has no evidence that there is indeed an actual risk of safety being compromised. It is a factor which in the particular circumstances is entitled to some weight, but it is not an overwhelming factor.

71. Standing back, the Tribunal must also consider the total of penalty outcomes, and decide what a proportionate response is in all the circumstances. The Tribunal has

suspended Dr N so as to protect the public and maintain standards; and it has also imposed rehabilitative outcomes in the form of conditions. But it has not acceded to the PCC's submission that Dr N's registration should be cancelled. Given the range of penalty outcomes it has imposed, it considers that publication of name is appropriate even although that may be seen as having a punitive consequence. In the Tribunal's view that is appropriate having regard to the seriousness of the matters that are before it.

72. The Tribunal is not satisfied that it is desirable to make a permanent order, after a careful evaluation of all the factors that it has been required to consider.

73. Accordingly, at the conclusion of the substantive hearing, the Tribunal announced that the interim order made in favour of Dr N would be discharged on 6 May 2013, so as to provide Dr N with an opportunity to inform family members; however, there would be an order of non-publication of the fact that the offending took place in X.

Costs:

74. Counsel for the parties agreed that issues of costs would be dealt with in writing following the announcement of penalty outcomes on 29 March 2013, and according to a timetable which was established for filing.

75. The PCC has applied for costs in respect of the PCC investigation and attendances at the hearing, which total $101,450.00, excluding GST; and in respect of the Tribunal, which total $51,219.98, excluding GST.

76. For the PCC it was submitted, in summary:

76.1. The investigation by the PCC was thorough and involved interviewing multiple witnesses and obtaining an expert opinion, as well as considering difficult ethical issues which arose.

76.2. Part of the costs includes inhouse Counsel who were actively involved either at the PCC stage, or as Junior Counsel at the hearing.

76.3. The PCC costs associated with the adjournment of the hearing were estimated to be $4,950.00 excluding GST; as to the merits of the adjournment of the initial fixture (11 March 2013) it was submitted that the PCC had taken a considered view on the issue of whether patients needed to be notified. Although the Tribunal reached a different view which resulted in an adjournment so due process could be undertaken with regard to patients, the PCC had taken legal advice on this issue previously, and had acted in good faith.

77. For Dr N it was submitted in summary:

77.1. Under the High Court Rules there were cases which indicated costs would be awarded for work carried out by inhouse Counsel. Accordingly, for the purposes of this hearing only, it was accepted in principle that the Tribunal does have the power to make an order as to costs which includes those reasonably incurred by inhouse Counsel.

77.2. Dr N's involvement in the prehearing processes was appropriate.

77.3. By any measure the costs of the PCC investigation seemed high and that had to be taken into account when assessing what were reasonable costs.

77.4. As regards the adjournment, whilst the PCC had taken a particular ethical view as to notification of patients that was not the view which had been upheld by the Tribunal, and accordingly Dr N should not carry any potential liability in the assessment of costs with regard to that adjournment.

77.5. Dr N could not be criticised for not having suggested to the PCC or the Tribunal that patients should be notified. It was submitted that Dr N was

unaware the PCC had formed a firm view on legal advice that patients should not be notified. Nor was it her place to notify the patients herself, given a confidential investigation process and the fact that it would have been inappropriate for her to do so in the circumstances where she was the subject of a charge.

77.6. Accordingly all costs of the PCC and the Tribunal relating to the adjournment on 11 March (both prior to and subsequently) should be excluded from the costs which she is ordered to contribute.

77.7. Otherwise it was submitted that an appropriate contribution to costs should be in the range of 20% to 30% of reasonable costs.

78. In *Vatsyayann v Professional Conduct Committee* [2012] NZHC 1138, Priestley J stated:

> "*[34] So far as the costs orders were concerned, the Tribunal correctly addressed a number of authorities and principles. These included that professional groups should not be expected to bear all the costs of a disciplinary regime and that members of the profession who appeared on disciplinary charges should make a proper contributions towards the costs of the inquiry and a hearing; that costs are not punitive; that the practitioner's means, if known, are to be considered; that a practitioner has a right to defend himself and should not be deterred by the risk of a costs order; and that in a general way 50% of reasonable costs is a guide to an appropriate costs order subject to a discretion to adjust upwards or downwards. The Authority went on to consider High Court judgments where that standard had been applied subsequently, and where adjustments were made when GST had been wrongly added to costs orders.*" [22]

79. As regards the adjournment, the view of the PCC that it did not need to contact patients to inform them that their information would be considered in this proceeding was not upheld by the Tribunal. The Tribunal accordingly considers that a portion of

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[22] Footnotes omitted

the cost relating to the fixture originally set down for 11 March 2013 should follow that event.

80. The PCC costs in that regard are said to be a little under $5,000.00; the costs of the Tribunal for the first fixture were approximately $32,000.00. However, a proportion of its costs related to the fact that a three day fixture had been scheduled because it had been advised the charge would be defended. It was only shortly before the fixture itself that an agreed way forward was found so that only one day would be needed. However the costs relating to the possibility of a three day fixture could not at that stage be avoided. Accordingly, the Tribunal considers that the PCC costs should be reduced by $4,900.00, and the Tribunal's costs should be reduced by $20,000.00 as being costs reasonably attributable to the adjournment.

81. Having regard to all the circumstances, which includes a consideration of the complexity of the matters before the Tribunal on the one hand, and the cooperation that Dr N demonstrated at the two hearings (although recognising that a change of plea was not able to be given until fairly late in the process), the Tribunal considers that a fair proportion of costs for Dr N to bear is:

81.1. 30% of the PCC's costs of $96,560.00 which is $28,950.00.

81.2. 30% of the Tribunal's costs which is $31,200.00 which is $9,360.00.

Conclusion:

82. The charge of professional misconduct is established.

83. Dr N is suspended for a period of six months; the commencement of the period of suspension is deferred until 27 May 2013, to allow Dr N to order her affairs.

84. Conditions on practice will apply from the resumption of practice, and for a period of three years thereafter. They are:

84.1. That Dr N attend regular peer group meetings and disclose the fact of the charge to her peer review group for the period to which the condition will apply, that is three years from the resumption of practice.

84.2. That Dr N attend appropriate courses stipulated by the Medical Council to focus on clinical note taking, prescribing practices and informed consent.

84.3. That Dr N disclose the fact of the charge in her disciplinary history to all current and future employers, this being a condition that will apply for three years from the resumption of practice.

84.4. That Dr N is to have mentoring from a mentor approved by the Medical Council, for example a clinical psychologist, for the purpose of managing the stresses and challenges of clinical practice. Dr N is to meet the mentor monthly for three years from the resumption of practice, and this is to be at Dr N's expense.

85. It is recommended to the Medical Council that it recommends to the Minister of Health that Dr N be prohibited from prescribing or supplying misoprostol for the maximum period of three years (from the resumption of practice), and that consideration be given to an appropriate Gazette Notice being published to this effect.

86. The Tribunal imposes an order of censure in order to formally mark its disapproval of the conduct it has been required to consider.

87. With regard to name suppression, the interim order in respect of Dr N was discharged with effect from 6 May 2013, save for the fact that the offending took place in X which shall remain a matter that is the subject of a non-publication order. The interim orders in respect of all other persons and entities are now permanent.

88. Dr N is to pay costs as follows:

88.1. $28,950.00 in respect of the PCC's costs. This figure does not include GST which is not payable.

88.2. $9,360.00 in respect of the Tribunal's costs. This figure does not include GST which is not payable.

89. The Tribunal directs that the Executive Officer publish a copy of this decision and a summary on the Tribunal's website. It further directs the Executive Officer to publish a notice stating the effect of the Tribunal's decision in the New Zealand Medical Journal.

DATED at Wellington this 31st day of May 2013

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B A Corkill QC
Chairperson
Health Practitioners Disciplinary Tribunal