Level 6, Axa House, 80 The Terrace, Wellington 6011
PO Box 10509, The Terrace, Wellington 6143, New Zealand
Telephone: 64 4 381 6816 Facsimile: 64 4 802 4831
Email: gfraser@hpdt.org.nz
Website: www.hpdt.org.nz

z

DECISION NO	636/Med14/272P
IN THE MATTER	of s92 the Health Practitioners Competence Assurance Act 2003 ("the Act")
	-AND-
IN THE MATTER	of a charge laid pursuant to Sections 71, 91 and 100(1) of the Act against **Dr T**, of X, Registered Medical Practitioner.

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HEARING held at Dunedin on 8 May 2014

TRIBUNAL: Ms M Dew (Chair)

Dr P Jacobs, Dr J Kimber, Dr P Miller, Ms M Taylor-Cyphers (Members)

Ms G Fraser (Executive Officer)

Ms K O'Brien (Stenographer)

APPEARANCES: Mr S Mount for the Professional Conduct Committee

Mr H Waalkens QC and Ms V Knell for the Practitioner

INTRODUCTION

1. Dr T (to be referred to as "the doctor"), has been a registered medical practitioner for over 10 years, though she has not held a practising certificate since August 2012.

2. The doctor faces a charge of professional misconduct under s100 of the Health Practitioners Competence Assurance Act 2003 ("the Act").

The charge

3. The particulars of the charge are as follows:

> *"Pursuant to section 81(2) of the Act the Committee charges that between on or about [ ], Dr T:*
>
> 1. *Wrote prescriptions for the supply of prescription medicines and controlled drugs otherwise than for the medical treatment of a patient under her care on the 54 occasions listed in the attached schedule, including by the use of fictitious identities the dishonest use of genuine identities, and the use of her own identity without proper medical oversight*[1]*; and*
>
> 2. *Obtained and consumed drugs of dependence, namely codeine phosphate, without proper medical oversight.*
>
> *The conduct alleged in particulars 1 and 2 above either separately and/or cumulatively amount to professional misconduct under s100(1)(a) and/or (b) of the Act."*

The agreed facts

4. The parties provided the Tribunal with an Agreed Summary of Facts dated 23 March 2014. The doctor signed an admission that the facts set out in the agreed summary amounted to professional misconduct under 100(1)(a) and (b) of the Act. The agreed facts are set out below.

---

[1] Schedule 1 attached to the charge contained a table of 54 prescriptions detailing the date, names and addresses of patients and medications prescribed by the doctor.

5. During 2011 and 2012, the doctor was employed as a [ ] District Health Board ("the DHB") in New Zealand. It was during this time that the doctor wrote out the prescriptions for her own use which are the subject of this current charge.

6. In April 2012, the Liaison Pharmacist from the DHB pharmacy notified the Internal Audit Manager at the DHB, about a concern regarding prescriptions issued under the doctor's name. The DHB commenced an internal investigation as a result.

7. In May 2012, the DHB advised the Medical Council of its concerns and a Professional Conduct Committee ("PCC") was established. The DHB also advised the Police about possible fraudulent prescriptions. Following a Police investigation the doctor was charged with a single representative charge of using a document under section 228(b) of the Crimes Act 1961.

8. The doctor applied for police diversion which was subsequently granted on 18 September 2013. This meant that the doctor was not convicted but the charges were withdrawn on the basis that the doctor agreed with the Police to undertake certain conditions. The Tribunal was not advised what the diversion conditions were.

9. Following the outcome of the criminal process the PCC concluded its investigation and the current charge was laid.

The prescriptions

10. The doctor used the names of members of her own family or variations of their names and addresses, when she wrote the false prescriptions. The doctor also wrote two of the prescriptions in her own name. The prescriptions were predominantly for codeine phosphate to which she was addicted, but also included other drugs Ondansetron, Omeprazole, Fluoxetine, Lorazepam, Propranolol and Zopiclone.

11. None of the people named in the prescriptions, the subject of the charge, were patients of the doctor or under her care and they did not receive the prescribed drugs. The two prescriptions written by the doctor for herself were respectively for Omeprazole and Citalopram (180 tablets).

12. The prescriptions were taken by the doctor to numerous pharmacies in and around the city in which she lived at the time. Over the course of the offending she went to 19 different pharmacies to receive the prescriptions. All the prescribed drugs were dispensed directly to the doctor for her own use. She did not provide them to anyone else and there was no direct harm caused to others. The doctor was not under any medical oversight for this medication and did not have a regular general practitioner during the relevant period.

The doctor's response

13. In [ ], the DHB raised its concerns with the doctor about prescriptions. The doctor was, in that same month, admitted to a private psychiatric clinic specialising in addiction. She initially undertook a two week assessment phase followed by eight weeks of addiction treatment. She then elected to continue in treatment with the clinic in its main therapeutic programme, in order to address issues underlining her addiction. The doctor agreed to remain in treatment until discharged and as at the date of hearing remained at the clinic.

14. In October 2012, the Clinical Director at the DHB interviewed the doctor regarding its investigation of her false prescriptions. At this meeting, she admitted her offending and acknowledged that she had used DHB prescription pads during at least the period [ ]. She also admitted that a considerable number of prescriptions for restricted medications were written in her name and the names of other family members. She confirmed that the prescriptions were for her own use and not for supply and that she had a codeine addiction.

15. The DHB terminated her employment as at [ ]. The doctor has not been employed since and is currently a sickness beneficiary. She does not currently hold a practising certificate.

16. At all times throughout the course of the Police, DHB and PCC investigations, the doctor was co-operative and admitted her offending. Prior to and during her meeting with the PCC, the doctor confirmed the following matters:

    (a) she accepted the complaint that she had self-prescribed large volumes of codeine using fictitious names and addresses of family members;

(b) she had an opiate addiction;

(c) her use of codeine had started in or about 2006 when she brought over the counter Nurofen Plus (codeine) and this use slowly escalated over time.

(d) her addiction has had a devastating effect on her life and her profession as a doctor. She is deeply embarrassed at what she has done. She is confident that there will be no repeat and she wishes to return to medical practice as soon as possible.

Medical Council standards

17. The Medical Council has various statements and guides issued to doctors to set standards for professional conduct. Particularly relevant to this case are the "Good Prescribing Practice"[2] statement and the "Prescribing Drugs of Abuse"[3] statement, both of which were in operation at the relevant time.

18. The "Good Prescribing Practice" includes the following:

"2. The issuing of prescriptions for prescription medicines is legally restricted. In particular, it is noted that:

Under Regulation 39 of the Medicines Regulations 1984, no doctor is permitted to prescribe prescription medicine to an individual unless it is for the treatment of the patient under his or her care;"

and further:

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

[2] Medical Council of New Zealand, Good Prescribing Practice, April 2010, at page 1
[3] Medical Council of New Zealand, Prescribing Drugs of Abuse, April 2010

19. The "Prescribing Drugs of Abuse" statement provides:

> *"The improper prescribing of drugs to drug-seekers is harmful to the individual, society, and the medical profession. It is not solely a pharmacological issue. Appropriate prescribing practice requires that a doctor's customary prescribing conforms to proper patterns established by the doctor's peers in similar practice. Inappropriate prescribing of drugs of abuse is unacceptable, both clinically and ethically."*

and further notes:

> *"5. Section 24 of the Misuse of Drugs Act 1975 prohibits the prescription, administration, or supply of any controlled drug to a person dependent upon that, or any other controlled drug for treatment of dependency unless the prescriber has specific authorisation to do so."*
>
> and
>
> *"7. When you prescribe drugs which have the potential for abuse, you must ensure that the person you are writing the prescription for is not:*
>
> - *Dependent on such drugs;*
> - *Seeking such drugs for supply to other individuals;*
> - *A restricted person."*

20. Codeine is both a prescription medicine and a controlled drug, being a Class C drug under the Misuse of Drugs Act.[4]

THE LAW

21. The practitioner is charged under s100(1)(a) and/or (b) of the Act, which provides as follows:

---

[4] Refer Schedule 3, Part 2 of Misuse of Drugs Act 1975

"100 Grounds on which health practitioner may be disciplined

(1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under s91 against a health practitioner, it makes 1 or more findings that –

(a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time the conduct occurred; or

(b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or is likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred."

Professional Misconduct

22. The Tribunal and the Courts have considered the term "professional misconduct" under s100(1)(a) and (b) of the Act on numerous occasions. The Tribunal draws on the guidance now available in those cases.[5]

23. In *Collie v Nursing Council,* Gendall J states at paragraph [21]:

> *"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."*

24. The Tribunal has also consistently adopted common usage definitions of "malpractice" as being:

---

[5] *PPC v Nuttall,* (8 Med04/03P) , *Collie v Nursing Council of New Zealand,* [2000] NZAR 74, *Aladdin* (12/Den05/04 and 13/Den04/02D) and *Dale* (20/Nur05/09D)

"the immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct" [6]*;* and

"Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer… a criminal or illegal action: common misconduct." [7]

25. It is for the Tribunal to determine whether the conduct has or is likely to bring discredit on the medical profession under s.100(1)(b) of the Act. In *Collie*, Gendall J discussed the meaning of this provision, under the previous legislation, and stated:

"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-standing of the nursing profession was lowered by the behaviour of the nurse concerned."

26. There is a well-established two stage test for determining professional misconduct set out in previous decisions of both this Tribunal and its predecessor.[8] The two key steps involved in assessing what constitutes professional misconduct are:

(a) First, an objective analysis of whether the practitioner's acts or omissions can reasonably be regarded by the Tribunal as constituting malpractice, negligence or otherwise bringing or likely to bring discredit on the profession; and

(b) Secondly, the Tribunal must be satisfied that the practitioner's acts or omissions require a disciplinary sanction for the purposes of protection of the public or maintaining professional standards or punishing the practitioner.

Onus and standard of proof

27. The burden of proof in the present case is on the PCC. This means that it is for the PCC to establish that the practitioner is guilty of professional misconduct. It is for it to produce the evidence that establishes the facts on which the charge is based to the appropriate standard of proof.

---

[6] Collins English Dictionary, 2nd Edition.
[7] The New Shorter Oxford Dictionary, 1993 Edition.
[8] *McKenzie v MPDT* [2004] NZAR 47 at [71] and *PCC v Nuttall* (8Med04/03P)

28. The standard of proof is the civil standard of proof, that is proof which satisfies the Tribunal that on the balance of probabilities the particulars of charge are more likely than not. The Tribunal must apply a degree of flexibility to the balance of probabilities taking into account the seriousness of the allegation, and the gravity of the consequences flowing from a particular finding.[9]

29. The Tribunal is also required to consider each particular independently and then cumulatively, in the context of determining whether the overall charge is established.[10]

IS THE CHARGE ESTABLISHED?

30. The doctor does not dispute the charge. Nevertheless, the Tribunal must still satisfy itself as to the elements of the charge.

31. The Tribunal is satisfied that the PCC has discharged the burden of proof. The agreed facts upon which the charge of professional misconduct is based clearly establish conduct by the doctor that is regarded by the Tribunal as constituting malpractice, negligence and conduct that has or is likely to bring discredit to the practitioner's profession.

Particular 1 – Unauthorised Prescriptions

32. The evidence presented to the Tribunal has established that on 54 occasions the doctor wrote prescriptions for the supply of medicines and controlled drugs that were not for the medical treatment of any patient under her care. She dishonestly used genuine family members' identities on 52 occasions, as evidenced in the prescriptions she wrote that were presented to the Tribunal. The doctor wrote a further two prescriptions using her own identity without proper medical oversight.

33. The writing of false prescriptions for supply of medicines and controlled drugs that are not for the medical treatment of any patient under the doctor's care is clearly contrary to the Good Prescribing Practice and Prescribing Drugs of Abuse statements issued by the Medical Council as referred to already in this decision.

---

[9] *Z v Complaints Assessment Committee* [2009] NZLR 1 and followed by this Tribunal in *PCC v Karagiannis* 181/Phar08/91P.

[10] *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513, CA 75/85

Particular 2 – Codeine use

34. The obtaining and consuming of codeine phosphate, a drug of dependence, without proper medical oversight is also established. This particular is established based on the agreed statement of facts and the doctors admission that she obtained and consumed the codeine recorded in all but two of the 54 prescriptions she wrote. She did so self-prescribing the codeine for her own use and without any proper medical oversight.

Is a disciplinary sanction required?

35. The Tribunal is also satisfied that the conduct established in both particulars above, does require a disciplinary sanction in order to meet the primary objectives of the Act; namely to protect the public and maintain appropriate professional standards for the medical profession. The doctor's conduct was a significant departure from acceptable professional standards. The facts as established amount to extremely serious matters of misconduct for any doctor.

36. The prescribing of medicines, in particular controlled drugs, is subject to legislation and regulations. The Misuse of Drugs Act 1975, s24 makes it an offence to prescribe, administer or supply a controlled drug to any person whom the practitioner has reason to believe is dependent on that controlled drug. While the Police elected not to proceed to seek a conviction against the doctor, the Tribunal must still act to take disciplinary action.

37. It is an essential feature of the trust that is placed in doctors that they carry out their duties in a way that does not breach the legal, ethical and clinical boundaries set for the profession. It is a serious abuse of the power and privilege that doctors are given to write prescriptions if they are not for the proper care of patients. It is also clearly a matter of community expectation that such conduct amounts to malpractice, negligence and is a serious matter of discredit to the profession.

38. The charge is established. Particulars 1 and 2 of the charge, do separately and cumulatively amount to professional misconduct under both s100(1)(a) and (b) of the Act.

PENALTY

39. The Tribunal, once satisfied the charge is established, must go on to consider whether it is appropriate to order any penalty under s101 of the Act. The penalties may include:

    (a) Cancellation of registration;

    (b) Suspension of registration for a period not exceeding 3 years;

    (c) An order that the practitioner may only practise in accordance with any conditions as to employment, supervision or otherwise, such conditions not to be imposed for more than 3 years;

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

    (e) A fine not exceeding $30,000;

    (f) An order that the practitioner pay part of all of the costs of the Tribunal and/or the PCC.

40. The Tribunal adopts the sentencing principles as contained in *Roberts v Professional Conduct Committee*[11] in which Collins J identified the following eight factors as relevant whenever the Tribunal is determining an appropriate penalty. In particular, the Tribunal is bound to consider what penalty:

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

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

    (c) punishes the practitioner;

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

    (e) promotes consistency with penalties in similar cases;

    (f) reflects the seriousness of the misconduct;

---

[11] [2012] NZHC 3354 at [44]-[51]

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

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

The doctor's evidence

41. The doctor gave evidence to the Tribunal in relation to penalty. She explained how her use of "over the counter" Nurofen Plus (codeine) had started with a toothache and had continued over some years when she had used it to help her sleep. This developed into a dependence and by May 2011 she admits she started to write the false prescriptions.

42. The doctor also gave evidence that in May 2012 she admitted herself to a private psychiatric clinic specialising in addiction and undertook an addiction programme. She then decided that she would remain in treatment at the clinic to undertake the main therapeutic programme to address her depression and issues underlying her addiction. She has now been in treatment at the clinic for some two years. The doctor currently remains voluntarily at the private clinic on a full time basis but has had short periods where she has stayed with family or been out on day visits.

43. She accepts that she has had an opiate addiction and is ashamed and embarrassed by what she has done and deeply regrets her actions. Her evidence was that she has been devastated by the loss of her role with the DHB and by letting down her family and profession.

44. The doctor explained that she is already in contact with the Health Committee of the Medical Council. She wishes to return to practice as soon as possible and hoped to be in a position to do so in mid 2014. She has agreed to provide the Committee with a discharge report and then undertake an assessment with an independent dual diagnosis assessor. The dual diagnosis will be in relation to both addiction and depression. Following the report there will be ongoing monitoring and conditions to be set by the Health Committee. The doctor is confident that she will not relapse given the steps she has taken to address her addiction and the fact that she has not had any drug relapse in the two years since entering treatment.

45. The Tribunal was also provided with a report dated 14 April 2014, written by Dr I, Consultant Psychiatrist at the clinic. This was addressed to the Tribunal. The report

confirms the doctor's treatment while at the clinic and states that she has made good use of the addiction and therapeutic programmes. It also notes that the doctor's opioid dependence has been in full and sustained remission since May 2012. The report confirms that during the course of treatment the doctor did develop a [ ] is currently in full remission.

46. The doctor's evidence was that the partial relapse of her [ ] disorder in early 2014 was due to facing the PCC investigation and the disciplinary charges which she has found stressful.

47. The Tribunal also received a letter dated 20 March 2014 from [The Clinical Lead] at the DHB that employed the doctor when the misconduct was discovered. This letter was also addressed to the Tribunal.

48. [The Clincal Lead] writes that he worked with the doctor for some 17 months. He made a number of positive comments about her, both personally and professionally, which are set out below.

> *"I always found Dr T to be a hard-working, reliable, knowledgeable and dedicated doctor. She was well liked and respected by all the [ ] staff, both medical and non-medical. She was polite, courteous, caring and empathetic with all patients. She had medical knowledge consistent with her level of training and experience, had a good skill set and exercised good clinical judgement including understanding the limitations of her capabilities. She managed medical crises well. She was well organised and was thorough and reliable regarding record keeping, discharge planning and other administrative activities.*
>
> *I received no complaints regarding her clinical acumen and application, and she was progressing well in her development towards training in [ ] Medicine.*
>
> *I am obviously aware of why Dr T is before the Tribunal. Although I was concerned about her during the time in question, I was surprised and deeply saddened when provided with the evidence of her drug dependency. As I say, I always found Dr T to be a hard-working, reliable, knowledgeable and dedicated doctor so it was a surprise to me that this was going on in the background.*

To the best of my knowledge Dr T has progressed well in rehabilitation from her drug dependency and I wish her all the best for the future. I have every confidence that with the right choice of specialty medical career path, and appropriate support, Dr T will continue to make a meaningful contribution to the health and well-being of New Zealanders."

49. During cross examination by Mr Mount for the PCC, the doctor acknowledged that she had become socially isolated during the period of her addiction but that she now has a greater understanding of the need for social support and regular engagement with her general practitioner.

50. The doctor indicated that she wished to return to practice in a role in either radiology or pathology. She accepted that there would likely be some conditions on her ability to prescribe medications and that some form of drug testing would be imposed if she returned to work. The doctor also accepted as reasonable, conditions that she not be permitted to work in sole practice for the next three years and that she would need to advise future employers of her misconduct. She generally accepted as reasonable the conditions on practice as sought by the PCC when these were put to her by Mr Mount.

51. The doctor gave details of her financial circumstances and provided the Tribunal with a declaration of financial means. She has limited means as she has been unemployed since October 2012. She has an older model car, a few household chattels and a modest amount in savings of some $11,000. She hopes to use her savings to support herself when she leaves the clinic which she expects to do in the next few months.

PCC submissions on penalty

52. The PCC has asked the Tribunal to impose penalties on the doctor as follows:

(a) A fine;

(b) A censure; and

(c) A number of conditions to be imposed upon the doctor after recommencing practice for a period of three years, including:

i. a prohibition from prescribing controlled drugs;

ii. not being permitted to work in sole practice;

iii. accepting professional supervision, drug testing and any other requirements set by the Medical Council Health Committee;

iv. to register with and maintain appropriate contact with a General Practitioner; and

v. being required to advise future employers of the Tribunal decision.

(d) A contribution to costs.

53. The PCC does not seek cancellation or suspension of the doctor's registration in this case. However, the PCC submits that the case would have warranted a period of suspension if the practitioner had not already voluntarily removed herself from practice for the last two years. The PCC invited the Tribunal to give some indication in this decision as to the period of suspension that might otherwise have applied. However, the Tribunal declines to do so in this case. In our view, it is not an exercise it should attempt. It is better confined to cases where the Tribunal is able to make an immediate assessment of the appropriate period of suspension based on the facts and personal circumstances of the practitioner as they exist at the time a suspension is under serious consideration.

54. The PCC submits that in considering the appropriate penalty, the following aggravating features are particularly relevant:

(a) The sustained nature of the misconduct over an 11 month period and involving 54 prescriptions. The PCC says this was not a matter of a "one off" mistake or poor judgment.

(b) The offending did involve premeditated and determined conduct, using the names of family members and variations of their names, addresses and visiting 17 pharmacies to avoid detection.

(c) This was a significant and fundamental breach of the doctor's legal and ethical obligations to prescribe medications strictly in accordance with the law, medical practice and ethics.

(d) This was a serious breach of the employer's trust in misusing the DHB's prescription pads to fraudulently self-prescribe and this inevitably risks harm to her employer's reputation.

(e) The offending posed a potential risk to patient and public harm. A doctor addicted to a controlled drug while remaining at work must pose a serious risk. However, it was accepted that no complaints were received from the public or otherwise about the doctor's clinical practice.

(f) The doctor failed to disclose her addiction prior to being confronted by her employer. Every doctor has a duty to disclose any health concerns including addictions, to the Medical Council. The doctor in this case failed to disclose her addiction for some years.

55. The PCC did acknowledge some mitigating features in this case, including;

(a) The doctor made no attempt to hide her misconduct once uncovered by her employer;

(b) She has co-operated fully with her employer, the PCC and in relation to this Tribunal hearing;

(c) There is no evidence that the doctor was providing the controlled drugs or medication for supply to others; and

(d) The doctor has taken serious steps to address her addiction and depression and as a result has not practised since the offending was discovered in May 2012.

56. The PCC also acknowledge that the doctor has limited means to pay a fine but submitted that a fine was appropriate to mark the seriousness of the conduct and that she would be in a position to repay the fine over time once she returns to practice.

57. The PCC advised the Tribunal that its investigation and legal costs had been in the region of $26,550. It sought a contribution of 30% of its costs to be paid by the doctor.

Penalty submissions for the doctor

58. Mr Waalkens made submissions as to penalty on behalf of the doctor. In summary, Mr Waalkens submits:

(a) That the chronology of events shows that once the doctor's misconduct and addiction was uncovered, she did everything she could to comply and co-operate with her employer, the Police and the Medical Council. It is submitted that this case, unlike other dishonesty or addiction relapse cases, does not involve a doctor lying or covering up her behaviour once discovered.

(b) While the doctor completely accepts her behaviour was wrong, her case does not have many other aggravating features;

(c) Her misconduct was entirely a product of her addiction and she immediately took steps to admit herself for addiction treatment once her misconduct was discovered;

(d) The doctor has suffered from a major depressive illness. She has had some associated suicide risks since her addiction was uncovered and she lost her employment. The medical reports produced do show that the depression and suicide risk has reemerged in January 2014 and that this coincided with the disciplinary charges laid before this Tribunal in January 2014. The orders made by this Tribunal should support her rehabilitation rather than put it at risk. Her case does not require a harsh penalty to set standards when her addiction illness is so central to her offending. This is properly a case for the focus to be on rehabilitation as this doctor is highly amendable to rehabilitation.

(e) That in all the circumstances a censure is the most appropriate penalty.

(f) That it would be wrong for the Tribunal to impose conditions on her return to practice. The Tribunal should instead provide recommendations for the Medical Council to consider so that it can determine how best to rehabilitate the doctor. Mr Waalkens urges that the Health Committee is best placed to monitor the doctor's fitness to re-enter the profession.

(g) The strong written reference provided by her former Clinical Lead at the DHB is notable particularly given the DHB dismissed her and reported her misconduct to the Medical Council; and

(h) The doctor has never been the subject of any previous disciplinary action or sanctions.

59. In relation to any fine, Mr Waalkens submits that the doctor has already suffered significant financial consequences. She has already lost her employment and income over a period of two years and that the imposition of a fine would be unduly harsh in the circumstances.

60. As to costs, Mr Waalkens submits that the PCC costs at $26,000 appeared high given that the doctor had admitted the misconduct and co-operated in the investigation. He opposed any order for costs submitting that the doctor's financial circumstances mean this would be excessively harsh and given her ill health caused the misconduct it would be unfair to impose costs.

Comparative cases on penalty

61. The Tribunal was referred to a number of previous penalty cases in both the Tribunal and Court. Counsel for the parties acknowledged that there is no case substantially similar. However there are a range of cases in which health practitioners have been disciplined for professional misconduct relating to their misuse of prescription drugs.

62. The cases considered included;

(a) *PCC v Brocksmith*[12] – Dr Brocksmith had allowed himself to be pressured by a patient who had a drug addiction history. The doctor was found guilty of professional misconduct as a result of prescribing controlled drugs to a restricted person on at least two occasions and writing false prescriptions for a false patient to enable the restricted person to obtain these drugs. The doctor was censured and ordered to pay a fine of $7,000 together with 30% of the costs of hearing. There were also significant conditions imposed on his ability to prescribe and supply controlled drugs and monthly peer review meetings and training conditions imposed.

(b) *PCC v Gilgen*[13] – Dr Gilgen was found guilty of professional misconduct relating to one charge of forging a fellow doctor's signature on three

[12] 16/Med05/18P
[13] 149/Med07/60 and 07/61P

prescriptions for anabolic steroids. There was a second charge established of practising while suspended, by writing four prescriptions again for anabolic steroids. Dr Gilgen had denied the charges before the Tribunal claiming that the signatures were not his but the evidence established both his forgeries and his practising while suspended. The Tribunal seemed to have little difficulty cancelling his registration. Previous conditions imposed on his practice had been unsuccessful. He was also ordered to pay $10,000 towards the costs of hearing.

(c) *PCC v Aitcheson*[14] – The doctor was charged with prescribing pethidine for clinical operations in doses not consistent with standard medical practice and for his own use. He admitted having used patient prescribed pethidine for his own use and administering saline to the patients. While there was no direct harm caused to most patients, one patient had undergone an unnecessary procedure which had caused inherent harm. Dr Aitcheson was addicted to pethidine and had relapsed three times over the course of his career, but the Tribunal considered that he was worthy of one final chance of rehabilitation.

He was suspended from practice for 12 months and significant conditions were imposed on his return. He was also censured, fined $10,000 and ordered to pay 40% of the costs of hearing. The suspension and frequency of the drug testing were both overturned on appeal.[15] The High Court held that to suspend the doctor two years after his offence, given all that had been achieved, would be disproportionate and would cut across the Tribunal's intent to give the doctor one final chance to rehabilitate.

There are two further cases which are also useful when considering comparative cases as referred to in the High Court decision of *A v Professional Conduct Committee*[16].

[14] 154/Med07/80P
[15] *A v Professional Conduct Committee* HC AK CIV 2008 – 404- 2927, 5 September 2008
[16] Supra, at [128] and [129]

(d) *Complaints Assessment Committee v DR K*[17] - in which the medical practitioner had been opioid dependent in 1992 and relapsed in 2003. He wrote prescriptions for pethidine by forging the signature of a colleague. He was censured, made subject to conditions of practice for three years and ordered to pay costs. He was not fined or suspended.

(e) *PCC v Dr M Keshvara*[18] - The practitioners opioid and alcohol dependence had become evident in 1987 when he was suspended for four months. In 1999, he suffered a six month relapse and obtained morphine and pethidine using the prescription pad of another practitioner. He was convicted by the Court of two related offences under the Misuse of Drugs Act. The Tribunal then censured him and conditions were imposed on his practice for three years, together with an order to pay costs. In 2004, he relapsed again and on this third relapse he was suspended for 12 months, made subject to further conditions for three years and ordered to pay one third of total costs.

Tribunal consideration of penalty

63. The Tribunal accepts each of the aggravating factors outlined on behalf of the PCC. The Tribunal has no doubt that the offending involved a sustained and premeditated level of dishonesty by the practitioner. It also involved serious breaches of trust and breaches of legal and ethical obligations.

64. However, the Tribunal equally accepts as relevant the number of mitigating factors that have been acknowledged by the PCC and presented by Mr Waalkens for the practitioner.

65. The doctor has otherwise had an unblemished medical career for seven years prior to the offending. She had gained the respect of her Clinical Lead who oversaw her work at the DHB, despite her working at the time with the impairment of her addiction.

66. It does appear to the Tribunal that the doctor's offending was very much a product of her addiction and while this does not excuse the misconduct, it does allow the Tribunal

[17] MPDT decision 321/05/128C
[18] HPDT decision 53/Med/06/29P

to understand the root of the offending and the path available for rehabilitation in this case.

67. The Tribunal has taken into account all of the aggravating and mitigating factors. It has also assessed, the sentencing principles and previous cases referred to by both counsel.

68. The Tribunal has determined that it is necessary to impose the following penalties which together are the proportionate penalty overall, while still allowing for the rehabilitation of the practitioner. The Tribunal orders:

(a) a censure;

(b) conditions to be imposed on the doctor's return to work which will be aimed primarily at the protection of the public and the rehabilitation of the doctor. These conditions are set out in full on the final pages of this decision under "Orders of the Tribunal"; and

(c) a contribution towards costs to be paid by the doctor.

69. The Tribunal's costs and disbursements incurred up to and including the date of hearing were estimated at $18,000. The PCC costs and disbursements claimed amounted to $26,550.

70. There was some discussion raised by Mr Waalkens as to the level of costs incurred by the PCC, given that the doctor had admitted the charges from the outset. However, the Tribunal is satisfied with the explanation provided by Mr Mount for the PCC, that wider investigation costs were incurred given that the PCC sought to ensure it had properly investigated and determined the extent of the misconduct.

71. In relation to costs, the Tribunal records that it has used as a starting point that a health practitioner will generally be expected to contribute 50% of the actual and reasonable costs of the Tribunal and PCC.[19] However, in the present case the Tribunal has determined that a further discount is appropriate to reflect the doctor's co-operation and financial circumstances. The doctor should nevertheless properly contribute to the costs arising from her misconduct.

---

[19] ` *Coorey v PCC*, AP 23/94, 14 September 1995, Doogue J

72. The Tribunal considers the proper contribution to costs in this case should be 15% of the total costs of both the Tribunal and PCC. The Tribunal makes this order as to costs noting the doctor's early co-operation and that she does not appear to have any substantial assets, has not earned any income for the past 18 months and currently remains unemployed. However, the doctor intends to return to practice and will in due course be able to pay the costs ordered.

NAME SUPPRESSION APPLICATION

73. The doctor was granted interim name suppression pending the Tribunal hearing. The doctor has sought permanent name suppression under s95 of the Act. Interim name suppression is not to be taken as any indication of the final order. As is usual, this matter must be reconsidered once the charge is established.

74. Every hearing of this Tribunal must be held in public unless the Tribunal orders otherwise. Section 95 of the Act deals with the Tribunal's powers in this regard as follows:

> ***95 Hearings to be public unless Tribunal orders otherwise***
>
> *(1) Every hearing of the Tribunal must be held in public unless the Tribunal orders otherwise under this section or unless section 97 applies.*
>
> *(2) If, after having regard to the interests of any person (including without limitation, the privacy of the complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on the application of any of the parties or on its own initiative) make any 1 or more of the following orders:* …[including private hearing orders or suppression of publication orders].

75. The Tribunal must take into account the important presumption of openness in judicial proceedings as set out in s95. The discretion given to the Tribunal under s95 to order non publication must only be used in accordance with the guidance given under that section and in the case law.

76. When the Tribunal is considering an application to suppress the name of any person appearing before it, or whether parts of a hearing will be in private, it must consider whether it "*is satisfied that it is desirable*" to make such an order taking into account

the following:

(a) The interests of any person; and

(b) The public interest.

77. The interests of any person will include any complainant, the applicant and any third parties.

78. The public interest will include an evaluation of the relative strength of the public interest factors namely:

(a) There is a public interest in knowing the name of a doctor accused of a disciplinary offence;

(b) Accountability and transparency of the disciplinary process which is subject to a statutory presumption that hearings will be in public unless ordered otherwise;

(c) The importance of freedom of speech and the right enshrined in s14 New Zealand Bill of Rights Act 1990.

79. A useful summary of these interests has been provided by the Court in *Anderson v PCC*, in which Gendall J states:

"[36] Private interests will include the health interests of a practitioner, matters that may affect a family and their wellbeing, and rehabilitation. Correspondingly, interests such as protection of the public, maintenance of professional standards, both openness and 'transparency' and accountability of the disciplinary process, the basic value of freedom to receive and impart information, the public interest in knowing the identity of 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."

80. The Tribunal also recognises that once the practitioner has been found guilty of professional misconduct, the onus is on the applicant to satisfy the Tribunal on the balance of probabilities that the presumption of open justice should be departed from.[20] However that onus is not to the higher criminal standard but only that suppression orders are "desirable" as set out in s95(2) of the Act.

The doctor's application for name suppression

81. The doctor seeks name suppression and suppression of any identifying features including the name of her treatment clinic, her treatment doctor and family members. The grounds for the application are:

    (a) that there is a real risk of harm to the doctor's rehabilitation;

    (b) there is no strong question of public interest in knowing the name of the doctor as she has not practised for two years and will not be able to do so until cleared by the Medical Council;

    (c) the nature of the offending is at the lower end of the scale and is directly related to her addiction.

82. Mr Waalkens referred to the doctor's earlier affidavit dated 17 February 2014, in support of her application for interim name suppression. In particular, the concern that the prospect of publicity would have a direct and detrimental impact on her therapy and recovery. The doctor was also concerned about the impact on members of her family including her grandfather and brother who is studying at medical school in New Zealand.

83. Mr Waalkens submitted that the doctor is in a very sensitive and vulnerable state and publicity could well set back her recovery. It was submitted that support for this risk is evident in the depression setback the doctor suffered in early January 2014, related to the start of the PCC and disciplinary process. The timing of this setback in her

[20] *Director of Proceedings v I* [2004] NZAR 635

recovery is also reported in the consultant psychiatrist report dated 14 April 2014.

84. It was submitted that if conditions were imposed then those members of the public that need to know will be informed in particular her employers and the Medical Council Health Committee who will be monitoring her return to practice.

The PCC position

85. The PCC does not oppose suppression of any personal details relating to the doctor's medical conditions. It submits this should be sufficient and opposes any name suppression for the doctor.

86. Mr Mount, submitted that there are no sufficient grounds to override the presumption of openness and transparency. In particular;

    (a) The PCC says there is no independent medical evidence to determine what would be the impact of publicity on the doctor.

    (b) There is no evidence that publicity would significantly impact on her recovery or rehabilitation and there is no evidence of the risk of any self-harm.

    (c) The impact on family members is not a relevant ground in this case as it is an inevitable consequence of any disciplinary finding that there will be distress and embarrassment for family members and this in itself does not make name suppression desirable.

Tribunal decision on name suppression

87. The Tribunal considers that the application for non-publication of the doctor's name and any identifying features should be granted.

88. In making this decision, the Tribunal has been very mindful of the fact that the principle of open justice is key in any effective disciplinary regime. It has been Parliament's clear intention, expressed in s95 of the Act, that professional disciplinary hearings should generally be held in public. This is the presumption of openness that the application has had to overcome.

89. However, the Tribunal considers that this is one of the relatively rare cases in which permanent name suppression can properly be granted to the practitioner. There is a compelling interest in rehabilitation of the practitioner on this occasion and against this compelling interest there are not sufficiently strong public interest considerations that require publication of the name of the doctor in this case.

90. The Tribunal has been mindful of the guidance provided by Frater J in *Director of Proceedings v I* [21] when at paragraph 50 she says:

"In the normal course where a professional person appears before a 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 be 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 are 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."

91. The Tribunal also notes that open justice will be limited only to the extent that the decision will anonymise the name of the doctor and related parties involved.[22] The decision otherwise gives a full account of what has occurred, what the misconduct was and the penalty imposed.

---

[21] [2004] NZAR 635

[22] Refer *N v Professional Conduct Committee of Medical Council of New Zealand* CIV 2013-485-718 [2013] NZHC 3405, at [68], where Mallon J. noted in relation to an appeal against a decision of this Tribunal declining name suppression, that in unusual cases where permanent name suppression is granted, that *"In reaching that view, I note that open justice will be limited only to the extent that the decision will anonymise the entities and persons involved."*

92. The usually strong public interest in knowing the identity of the practitioner concerned is substantially reduced in this case given the following matters:

(a) The lack of any patient harm or substantial patient safety concerns arising in this case; and

(b) The fact that the doctor has been willing to take such extensive rehabilitation steps herself to resolve her addiction and voluntarily remove herself from practice for the past two years.

93. Further the Tribunal has imposed substantial conditions on the doctor's return to practice. As a result, the persons who need to know of this decision will be informed including any future employer and the Medical Council Health Committee. These conditions will provide a very substantial safeguard in relation to public and patient safety. The Tribunal therefore does not consider that there is any overriding need for the public to know the name of this practitioner.

94. In making this decision to grant name suppression, the Tribunal has not taken into account the doctor's concerns raised about the impact on family members. Those matters raised are not sufficient to justify name suppression in this case. The Tribunal also notes that in the absence of any independent medical evidence about the likely impact of publicity on the doctor, the Tribunal has not sought to determine the application for suppression on the basis that there is a real risk of harm to the doctor.

Orders of the Tribunal

95. The Orders of the Tribunal are as follows:

(a) The charge laid against the doctor under s100(1)(a) and (b) of the Health Practitioners Competence Assurance Act is established;

(b) The doctor is censured to mark the Tribunal's disapproval of her conduct the subject of the charge.

(c) The doctor will on her return to registered medical practice only practise in accordance with the following conditions for a period of **two years** after her return to practice:

i. That the Medical Council of New Zealand recommend to the Minister of Health that the doctor be prohibited from prescribing or supplying to any person all controlled drugs including Class A, B and C drugs as defined under the Misuse of Drugs Act 1975;

ii. The doctor will not be permitted to work in sole practice as a registered medical professional;

(d) The doctor will on her return to registered medical practice only practise in accordance with the following further conditions for a period of **three years** after her return to practice:

i. The doctor is required to register with and maintain an appropriate level of regular contact with her general practitioner at her own expense;

ii. The doctor is required to immediately advise any future employers of this decision and the orders made by the Tribunal;

iii. The doctor will accept professional supervision, a regime of regular drug testing and any other requirements as is determined necessary by the Medical Council's Health Committee. This condition will apply for such period as the Medical Council Health Committee considers necessary, but in any event not to be more than three years. The costs of the Health Committee conditions will be met by the doctor;

(e) The doctor is further ordered to pay 15% of the total costs of the PCC and the Tribunal, ($44,550) , which amounts to $6,600 to be paid as follows:

i. $3,300 in respect of the costs and disbursements of the Tribunal; and

ii. $3,300 in respect of the costs and disbursements of the PCC;

(f) Permanent suppression orders are made prohibiting the publication of the name of the doctor, Dr T, and any particulars that might identify her including but not limited to the name of xx and Dr I, Consultant Psychiatrist at xx. There will also be non-publication orders made in relation to the names of the family members named in the prescriptions the subject of the charges.

(g) The Tribunal directs the Executive Officer publish a copy of this decision on the Tribunal's website, together with a summary. It further directs that the Executive Officer publish a notice stating the effect of the Tribunal's decision in the New Zealand Medical Journal.

DATED at Auckland this 30th day of June 2014

....

MJ Dew, Chairperson
Health Practitioners Disciplinary Tribunal