NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT No.	877/Phar16/366D
UNDER	the Health Practitioners Competence Assurance Act 2003 (the HPCA Act)
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**THE DIRECTOR OF PROCEEDINGS OF THE HEALTH AND DISABILITY COMMISSIONER'S OFFICE** **Applicant**
AND	**Mr TERRENCE ZELCER** of Christchurch, Pharmacist **Practitioner**

AS AMENDED BY ADDENDUM TO THE DECISION DATED 19 JUNE 2017

HEARING held in Wellington on 5 December 2016

TRIBUNAL:	Mr K Johnston QC (Chair), Mr B Clayton-Smith, Mr K Govind, Ms E Jones and Ms M O'Rourke (Members)
IN ATTENDANCE:	Ms J Kennedy – Stenographer Ms K Davies – Executive Officer
APPEARANCES:	Ms K Eckersley for the Director of Proceedings Ms J Hughson for the Practitioner

Introduction

1. This case concerns the obligations of a pharmacist upon discovering incorrect drugs have been dispensed to a patient.

2. Terrence Stewart Zelcer ("Practitioner") is a registered pharmacist. He qualified for registration with a diploma in pharmacy from the Central Institute of Technology in 1982. He was registered in New Zealand in February 1984 and in the United Kingdom in December 1986. He has practised since being registered, holding appropriate practising certificates as necessary. He has a hitherto unblemished record. As far as the Tribunal is aware, prior to the events which are the subject matter of this decision, he has never been the subject of a professional complaint of any sort. He is thus entitled to be regarded as a qualified, experienced and capable pharmacist, who has no doubt served the communities in which he has worked well.

3. Pursuant to ss91, 100(1)(a) and 100(1)(b) of the Health Practitioners Competency Assurance Act 2003, the Director of Proceedings prefers charges against the Practitioner. The original Notice of Charge was dated 17 August 2016. By Notice of Application dated 17 November 2016, the Director applied to amend aspects of the charges. The Practitioner raised no objection. At the commencement of the hearing the Tribunal amended the charges accordingly. The Amended Notice of Charge particularises the charges in these terms:

***"IN PARTICULAR**:*

1. Between 4 December 2013 and 6 December 2013, knowing that your patient had been dispensed cyclophosphamide 50mg tablets on 15 October 2013 in error (the dispensing error), you failed to take appropriate steps to minimise potential harm to your patient in that you did not:

(i) Advise your patient that the medication dispensed to him in error on 15 October 2013 and labelled cyclosporine 50mg capsules was not cyclosporine 50mg capsules but was cyclophosphamide 50mg tablets; and/or

(ii) Ascertain how many tablets of cyclophosphamide 50mg your patient had taken in error; and/or

(iii) Advise your patient's GP of the dispensing error and/or how many cyclophosphamide 50mg tablets your patient had taken in error; and/or

(iv) Advise the manager of the Pharmacy of the dispensing error.

AND/OR

2. On 4 December 2013, you misled your patient when you told him that he had been dispensed in error on 15 October 2013, a discontinued product, when you omitted to tell him that the medication dispensed in error was not cyclosporine 50mg and/or that he had not been taking cyclosporine 50mg.

The conduct alleged in the above particulars separately and/or cumulative amounts to professional misconduct. The conduct is alleged to amount to malpractice and/or negligence and/or conduct that has brought or was likely to bring discredit to the pharmaceutical profession under s100(10(a) and/or s100(1)(b) of the Act."

4. Subparagraphs (a) and (b) of s100(1) of the Act provide:

> *"1. The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that:*
>
> *(a) The practitioner has been guilty of professional misconduct of any act or omission, that in the judgement of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or*
>
> *(b) The practitioner has been guilty of professional misconduct because of any act of omission, that in the judgment of the Tribunal, has brought or is likely to bring discredit to the profession in that the health practitioner practised at the time that the conduct occurred; ..."*

5. Thus, the Director charges the Practitioner with professional misconduct on the basis that his conduct constituted malpractice or negligence (s100(1)(a)); or brought or was likely to bring discredit to the profession (s100(1)(b)); or both.

Facts

6. The factual background against which this charge is made was comprehensively set out in an Agreed Statement of Facts, dated 17 November 2016 and signed by the Director and the Practitioner. We pick this up from paragraph 2 which follows some introductory material:

> *"2. At all material times Mr Zelcer was employed by Mr E ("the pharmacy manager") who owns and operates the Pharmacy ("the Pharmacy").*
>
> *3. Mr Zelcer began working at the Pharmacy in September 2008 as a Dispensary Manager. Mr Zelcer resigned from his employment at the Pharmacy in December 2013. At all material times he reported to the pharmacy manager. Mr Zelcer's role had key responsibilities including ensuring prescriptions were safe and appropriate for patients and that dispensing and all other pharmacy practice was in accordance with the standard operating procedures ("SOPs"). Mr Zelcer was at all material times aware of the SOPs in place at the Pharmacy.*
>
> *4. Mr Zelcer continues to work as a registered pharmacist as a locum pharmacist at three Christchurch pharmacies working on average 38 hours each week.*
>
> ***Mr R***
>
> *5. At all material times Mr R ("Mr R"), aged [ ] years at the time of these events in late 2013, was a longstanding customer/patient of the Pharmacy and regularly filled his prescriptions there.*
>
> *6. In October 1999 Mr R had a cadaveric renal (kidney) transplant and from that time has taken immunosuppressant medication, including cyclosporine 50mg capsules (brand name neoral)[1] which he is required to take twice daily (50mg in the morning and 50mg in the evening) in conjunction with prednisone 10mg mane[2] to prevent organ rejection.*
>
> *7. Cyclosporine 50mg is a potent immunosuppressive agent which is frequently used in organ transplantation, to prevent graft rejection. At the material times*

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1 Throughout this Agreed Summary of Facts this medication will be referred to as "cyclosporine 50mg".

2 "mane" Latin for "every morning".

cyclosporine 50mg came as white capsules which were foil packed and packaged in a cardboard box containing 60 capsules.

8. *In addition and at the time of these events Mr R was taking eleven other medications which were prescribed to him by the Nephrology Team at Canterbury District Health Board and his GP Dr [ ]:*

- *Prednisone 10mg mane*[3]
- *Frusemide 80mg daily*[4]
- *Quinapril 10mg bid*[5]
- *Diltiazem CD 240mg mane*[6]
- *Terazosin 4mg bid*[7]
- *Allopurinol 200mg at night*[8]
- *Cholecalciferol Strong 1.25mg monthly*[9]
- *Warfarin 2 to 3 mg daily as directed by GP*[10]
- *Ranitidine 150mg daily*[11]
- *Finasteride 5mg daily*[12]
- *Acitertin 10mg daily*[13]

9. *With respect to his Warfarin medication Mr R is required to attend for a Community Pharmacy Anticoagulation Management Service (CPAMS) INR*[14]*blood test once a month. At the time of these events Mr R more often than not had his INR test completed at the Pharmacy and of the four tests completed between September and December 2013, three of those tests were completed by the*

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3 A steroid used, in Mr R's case as an immunosuppressant medication in conjunction with his cyclosporine 50mg to prevent rejection.
4 Used to treat fluid build up due to heart failure, liver scarring or kidney disease. It may also be used for the treatment of high blood pressure.
5 An angiotensin-converting enzyme inhibitor used in the treatment of hypertension and congestive heart failure.
6 A nondilhydropyridines calcium channel blocker used in the treatment of hypertension, angina pectoris and some types of arrhythmia.
7 For treatment of an enlarged prostate. It also acts to lower blood pressure.
8 Used primarily to treat excess uric acid in the blood and its complications, including chronic gout.
9 One of five forms of vitamin D.
10 An anticoagulant medication used for the prevention and treatment of venous thrombosis and pulmonary embolism.
11 Decreases stomach acid production commonly used in treatment of peptic ulcer disease, gastroesophageal reflux disease and Zollinger-Ellison syndrome.
12 For treatment of benign prostatic hyperplasia and male pattern baldness.
13 Second generation retinoid typically used for psoriasis.
14 An INR (International Normalised Ratio) Test is a blood test that is performed to provide a clinical measure of how long it takes the blood to clot.

pharmacy manager. INR tests were undertaken in the pharmacy manager's office which doubles as the INR consultation room.

RELEVANT BACKGROUND – THE DISPENSING ERROR

10. *On 15 October 2013 Mr R presented to the Pharmacy to have a prescription filled for a 7 day course of Flucloxacillin, an antibiotic medication, to treat a skin tear from a piece of wood, on his right lower leg. At this time Mr R also requested a first repeat (second dispensing) of his other twelve regular medications. One of those repeat prescriptions was for 60 capsules of his immunosuppressant medication, cyclosporine 50mg.*

11. *At the time of these events and in accordance with the Pharmacy SOP for "Dispensing a prescription" (which met Medsafe audit requirements) repeat medications were dispensed from the computer record as opposed to from the original prescription.*

12. *A three part label was generated through the computer system with one part of the label going on the medication (and which identifies the medication, strength and directions for the consumer), a second part going on the bag the medication is placed in (and which identifies the patient's name, address and the cost of the medication) and the third part (which identifies the date and prescription details) is initialled by the dispenser and checking pharmacist and is placed into the Pharmacy's daily repeat prescription log book for auditing purposes.*

13. *The supervision (checking) pharmacist, before initialling the third part of the computer generated label, completes an accuracy check of the dispensed medication to ensure the medicine (and strength) that has been dispensed matches the label details. This occurs prior to the medication being issued to the consumer.*

14. *On 15 October 2013 Mr R's antibiotic prescription (and the repeat prescriptions including for cyclosporine 50mg) were made up by pharmacy technician (Mr S) and the accuracy check was made by Mr Zelcer as the supervising pharmacist.*

15. *During the dispensing process the pharmacy technician selected a manufacturer's bottle of 50 cyclophosphamide (brand name cycloblastin)[15] 50mg tablets in error and placed the label for the repeat prescription of 60 cyclosporine 50mg capsules on that bottle of cyclophosphamide 50mg tablets.*

16. *Cyclophoshamide 50mg is a cytotoxic agent predominantly used in combination chemotherapy regimes, for the treatment of several solid tumors and hematologic malignancies. It can also be used as an immunosuppressant for the prevention a d treatment of transplant rejection when the opinion of the physician the benefits to the patient outweigh the risk of treatment with this agent.*

17. *The administration of cyclophosphamide 50mg should be carried out under the supervision of physicians fully trained in the use of cytotoxic drugs. Toxic effects are likely to be related (in frequency and severity) to does and/or frequency of drug administration, however toxicity can occur at all doses and careful monitoring for toxicity is necessary.*

18. *At the time of these events, cyclophosphamide 50mg medication came as small pink tablets inside a bottle containing 50 tablets.*

19. *When checking the "cyclosporine 50mg" dispensed for Mr R, Mr Zelcer read the label which the technician had placed on the bottle, but he did not open the bottle to check the contents of the bottle labelled "cyclosporine 50mg" to ensure the medication inside was in fact cyclosporine 50mg. After completing his accuracy check Mr Zelcer initialled the third part of the computer generated label (as had the pharmacy technician) and issued the medication to Mr R.*

20. *The error was therefore missed during Mr Zelcer's accuracy check of the medication and Mr R was issued 50 cyclophosphamide 50mg tablets in error.*

21. *Mr R maintained an approximate one month buffer of medications at home. He did not start taking the cyclophosphamide 50mg tablets and his other repeat medications which had been dispensed on 15 October 2013 until some time in November 2013. It is estimated that he consumed 35 tablets over an approximate period of two and a half weeks before the error was discovered. During that time*

[15] Throughout this Agreed Summary of Facts this medication will be referred to as "cyclophosphamide 50mg".

Mr R was not taking his prescribed immunosuppressant medication, cyclosporine 50mg. However he continued to take prednisone and his other regular medications.

22. *Mr R presented a further prescription for a 7 day course of flucloxacillin, an antibiotic medication on 18 November 2013, which his GP had prescribed for a new injury on his left leg. At this time Mr R requested and had filled his second (and final) repeats of his 12 regular medications including cyclosporine 50mg (60 capsules). Cyclosporine 50mg was correctly dispensed.*

23. *When some time in November 2013 Mr R began taking the medication he had been dispensed on 15 October 2013, he noticed the difference in the appearance of the medication he had been given on 15 October 2013 (cyclophosphamide 50mg pink tablets) and the cyclosporine 50mg medication he had previously taken (which had been white capsules).*

THE DISCOVERY OF THE DISPENSING ERROR

4 December 2013

24. *On Wednesday, 4 December 2013 Mr R attended the Pharmacy for his monthly CPAMS INR blood test. INR is the International Normalised Ratio test which is a diagnostic procedure used to detect blood clotting rate. When a patient is taking Warfarin medication the INR is a tool used to detect any abnormalities in the clotting process thereby supporting the patient's anti-coagulation management. Mr R was taking Warfarin to control his blood clotting.*

25. *An INR test involves taking a finger prick blood sample from patients, placing the blood on a test strip and in turn placing that in a specialised device and reading the result. Pursuant to the Warfarin Standing Orders for CPAM Services V2.2, the patient is also asked "safety" questions about any signs and symptoms of bleeding or bruising, any new medication including OTC medications and/or other complementary medicines since the previous INR test, their warfarin compliance and whether they have been admitted to hospital since their prior INR test. Online computer support is available to enable the INR accredited pharmacist who performs the test to ascertain the results.*

26. Between September and December 2013 three of Mr R's four INR tests were completed by the pharmacy manager but on 4 December 2013 the pharmacy manager was not in the pharmacy when Mr R attended for his test and therefore Mr Zelcer completed it. Mr Zelcer is an INR accredited pharmacist and was at that time. The blood test and INR consultation was done in the pharmacy manager's office.

27. Mr Zelcer completed the blood test for Mr R. Following the blood test Mr Zelcer asked Mr R the safety questions he was required to ask under the Standing Orders and made observations about his demeanour and general health. In response Mr R indicated that all was "normal".

28. The INR blood measurement was performed at 10.16am by the Coagucheck machine in the pharmacy manager's office, with the results of the test logged in the INR online system at 10.18am. The results of the INR blood test were slightly below the expected range (1.9 with the target normal range being 2 – 3) but no change to Mr Rs Warfarin dose was required. The INR blood result indicated that Mr R's platelet count had not decreased.

29. At the conclusion of the INR consultation Mr Zelcer asked Mr R if there was anything else he could assist with at which point Mr R showed Mr Zelcer a bottle of tablets dispensed to him on 15 October 2013 and which had a label on the bottle identifying the medication as "cyclosporine 50mg". Mr R asked Mr Zelcer about the difference in appearance between the tablets in the bottle labelled "cyclosporine 50mg" and the other cyclosporine 50mg he had been dispensed by the Pharmacy previously (including in September 2013 and November 2013).

30. Mr Zelcer saw that whilst the level on the bottle said cyclosporine 50mg, when he peeled back the label he identified that the label had been placed on a bottle which actually contained the cycloblastin brand of cyclophosphamide 50mg tablets. Mr Zelcer immediately realised that a dispensing error had occurred and Mr R had been dispensed cyclophosphamide 50mg tablets instead of his prescribed cyclosporine 50mg capsules. Mr Zelcer was not aware who had made the error or how it had occurred.

31. Mr Zelcer asked Mr R why the bottle still contained a lot of tablets in it given it had been dispensed almost two months ago. Mr R advised that he was still taking the tablets from this bottle. Whilst seated together Mr Zelcer checked Mr R's dispensing history on the computer and noted that he had been dispensed a follow-up month's supply of cyclosporine 50mg on 18 November 2013. Mr Zelcer asked Mr R if he had taken any of the cyclosporine 50mg which had been dispensed on 18 November 2013. Mr R explained that he had accumulated a surplus of his medicines and was now taking the medicine dispensed in October 2013 (the cyclophosphamide 50mg). Mr R told Mr Zelcer that he had not yet started the medicine dispensed on 18 November 2013 but that he puts his medication in his personal dosset box at home and noticed he had gone from his usual capsule to a tablet and back to a capsule again with his 18 November dispensing (where cyclosporine 50mg had been correctly dispensed).

32. Mr Zelcer did not tell Mr R he had been dispensed cyclophosphamide 50mg instead of his prescribed cyclosporine 50mg.

33. Mr Zelcer told Mr R he had been dispensed a "discontinued product" and he apologised for the error. At the time Mr Zelcer did not know that the cycloblastin brand of cyclophosphamide 50mg had been discontinued.[16] Mr Zelcer did not tell Mr R that the medication dispensed in error was not cyclosporine 50mg or that Mr R had not been taking his prescribed cyclosporine 50mg.

34. Mr Zelcer advised Mr R to stop taking the tablets in the bottle and Mr R said he would. Mr Zelcer advised Mr R that he should immediately start taking the cyclosporine 50mg medication he had been dispensed on 18 November 2013 (the white capsules). Mr R then handed the bottle of tablets to Mr Zelcer and departed the Pharmacy.

35. Mr Zelcer accepts he should have told Mr R that the medication dispensed in error was cyclophosphamide 50mg (rather than misleading him by telling him that the product was a discontinued product and not telling him that he had not been

[16] The cyclophosphamide 50mg Mr R received as Pfizer Australia's cycloblastin which was discontinued by Pfizer Australia from 1 October 2013 and was de-registered from the New Zealand Pharmaceutical Schedule on 1 April 2014. This was notified to the pharmacy by Pharmac via its monthly updates.

dispensed and had not been taking his prescribed cyclosporine 50mg), and that this was a serious lapse of judgement.

36. *Mr Zelcer did not ask Mr R how many of the cyclophosphamide 50mg tablets he had taken or on which date in November 2013 he had started taking them.*

37. *Mr Zelcer did not count how many cyclophosphamide 50mg tablets remained in the bottle given to him by Mr R.*

38. *Mr Zelcer accepts he should have ascertained how many tablets of cyclophosphamide 50mg Mr R had taken in error. Mr Zelcer also accepts that asking Mr R how many tablets he had taken and counting how many tablets remained in the bottle were steps he should have taken.*

39. *Mr Zelcer accepts he should have taken immediate steps to advise Mr R's GP of the dispensing error and he accepts that once he was aware of the error he could not rely on the results of Mr R's INR test to safely establish his well-being.*

40. *After Mr R left the Pharmacy Mr Zelcer placed the bottle of cyclophosphamide 50mg tablets into the pharmacy's yellow returned medicines bag outside the pharmacy manager's office.*

41. *Mr Zelcer then checked the Pharmacy's daily repeat prescription log book to see who had dispensed the incorrect medication. He saw that it had been prepared by the pharmacy technician (Mr S) and that he (Mr Zelcer) had completed the accuracy check. As a first step in the incident handling process Mr Zelcer circled the relevant label in the log book which was situated in its usual place at the end of the dispensary bench.*

42. *After he had attended to checking some prescriptions for waiting customers, Mr Zelcer went and checked to see whether the dispensing error may have occurred because the cyclophosphamide was in the wrong place on the shelf. To do this Mr Zelcer checked the Pharmacy's physical medication stocks to see if cyclosporine 50mg and cyclophosphamide 50mg were next to each other on the shelf in the dispensary (at the pharmacy medication was arranged on the shelf in alphabetical order generically not by brand name). Mr Zelcer saw there was no stock of cyclophosphamide 50mg tablets on the shelf and also that there were two*

cyclosporine 50mg in stock. Knowing therefore that more stock of cyclophosphamide 50mg was needed in case a customer came in with a prescription for this medicine, Mr Zelcer took steps to ensure it was replaced.

43. To do this Mr Zelcer entered his password on the Toniq stock control system in the computer at 10.24:09 am. Mr Zelcer entered the medicine maintenance are of Toniq Dispensary and first adjusted the stock record for Neoral (cyclosporine) 50mg capsules from 0 to 2P at 10.24:15 am. The stock control system showed there was 1 unit of cycloblastin (cyclophosphamide) 50mg in stock. Knowing that was not correct having just physically checked the stock, Mr Zelcer then adjusted the electronic stock record for cycloblastin 50mg from 1P to 0, at 10.24:52am. These adjustments to the electronic stock records triggered the stock ordering process through which the Pharmacy is notified of the stock to be ordered. These adjustments ensured that the Pharmacy's stock records were accurate.

44. Mr Zelcer had already sent off the Pharmacy's morning stock order at 10.09am (shortly before seeing Mr R) as he knew the pharmacy manager would not be arriving in the Pharmacy until later that morning, after the cut-off for morning stock orders had passed. Mr Zelcer corrected the stock 9 as above) after the morning order had been sent so this would show up when the second order was placed for the day (the cut-off for afternoon orders was 2.30pm). The pharmacy manager usually placed the stock orders.

45. Mr Zelcer did not take any steps to complete an incident report. He accepts that he was required to do so under SOP 38 (Dispensing Incidents) and in accordance with the standards of care expected of the pharmacy profession and that he should have done this as a means of informing the pharmacy manager (and other staff involved) of the dispensing error.

46. CCTV footage from the Pharmacy shows that the pharmacy manager returned to the Pharmacy and was present in the dispensary at 10.37am. However the time-stamp on the CCTV camera was out on that date by approximately 5-10 minute meaning that the actual time was approximately 10.42-10.47am. Mr R had departed the pharmacy at 10.13am (approximately 10.1 – 10.23am) and therefore

the pharmacy manager had returned to the pharmacy within 30 minutes of Mr R's departure.

47. *At approximately 2pm the pharmacy manger generated an electronic stock reorder and saw that cycloblastin (cyclophosphamide) 50mg was included in the stock re-order list. In the course of placing the order and due to the legislative change relating to this drug the pharmacy manager asked the dispensary staff, including Mr Zelcer, if cyclophosphamide 50mg had been dispensed because if so, he would need to supply a patient name and prescribing doctor if more stock was required. Mr Zelcer responded that he had observed there was no cyclophosphamide 50mg on the shelf and had therefore "zeroed" the stock. Mr Zelcer did not tell the pharmacy manager about his conversation with Mr R approximately three and a half hours earlier, or the fact that Mr R had been dispensed cyclophosphamide 50mg in error.*

48. *Mr Zelcer accepts that he should at that time have advised the pharmacy manager of the error. He also accepts that by not disclosing the error he did not follow SOP 38 (Dispensing Incident) or the standards of care expected of the pharmacy profession which required him to notify the pharmacy manager.*

49. *The pharmacy manager sent off the afternoon stock order at 2.20pm to CDC Pharmaceuticals (invoice number 36373715). No cyclophosphamide of any brand appears on the invoice.*

50. *Mr Zelcer accepts that at no time on 4 December 2013 did he take appropriate steps to minimise the potential harm to Mr R including:*

    a. *Advising the pharmacy manager about the dispensing error; and*

    b. *Contacting Mr R's GP to tell him that Mr R had not been taking his prescribed cyclosporine 50mg but instead had been taking cyclophosphamide 50mg which had been dispensed to him in error.*

5 December 2013

51. *On 5 December 2013 Mr Zelcer was working in the dispensary. The pharmacy manager was also present in the Pharmacy.*

52. *Mr Zelcer accepts that on 5 December 2013 he did not take any steps to address the dispensing error that he had discovered the day prior In particular he did not take the following steps to minimise potential harm to Mr R, in that he did not:*

    a. *Contact Mr R to tell him that the medication he had been dispensed in error on 15 October 2013 was cyclophosphamide 50mg and that he had not been dispensed and therefore had not been taking his prescribed cyclosporine 50mg.*

    b. *Contact Mr R to ask him if he knew how many of the cyclophosphamide 50mg tablets he had taken.*

    c. *Count the number of cyclophosphamide 50mg tablets left in the bottle that Mr R had given to him the day prior in order to ascertain how many tablets he had taken in error. Mr Zelcer accepts he could have and should have retrieved the bottle from the returned medicines bag and counted the tablets as on 5 December 2013 he knew the bag had not been emptied since he had placed the bottle in the bag.*

    d. *Tell the pharmacy manager about the dispensing error or his conversation with Mr R the day prior. He also accepts that he did not complete an incident report. He accepts that by not doing so he did not follow SOPs 38 and 38a (Procedure for Dispensing Incidents/Procedure for Dispensing Incidents – handling the error) or follow the standards of care expected of the profession.*

    e. *Contact Mr R's GP to tell him that Mr R had not been taking his prescribed cyclosporine 50mg but had been taking cyclophosphamide 50mg which had been dispensed to him in error.*

6 December 2013

53. On Friday, 6 December 2013, Mr R returned to the Pharmacy and asked to speak to the pharmacy manager in private. This was at approximately 10.30am. Mr R and the pharmacy manager went into the pharmacy manager's office.

54. When in the pharmacy manager's office, Mr R gave the pharmacy manage a small bag containing 6 pink tablets and asked him if he knew what they were. The pharmacy manager said he could not be sure just by looking at them. Mr R told the pharmacy manger that he had asked Mr Zelcer about them on Wednesday (4 December 2013) and that he had given Mr Zelcer the original bottle. Mr R told the pharmacy manager that Mr Zelcer had admitted the tablets had been dispensed in error and had apologised, and that Mr Zelcer had said they were a discontinued product.

55. The pharmacy manager told Mr R that he could not be certain about what the tablets were but that he would speak to Mr Zelcer. He confirmed with Mr R that he would phone him later that day.

56. After Mr R left the pharmacy the pharmacy manager went into the dispensary and asked Mr Zelcer about the pink tablets that Mr R had given him. Mr Zelcer admitted to the pharmacy manager at that time that Mr R had been dispensed cyclophosphamide 50 mg tablets instead of cyclosporine 50mg capsules in error on 15 October 2013. Mr Zelcer said "Sorry [ ], we inadvertently gave Mr R cyclophosphamide". The pharmacy manager exclaimed "Bloody hell Terry, how many has he had?" Mr Zelcer said he did not know but he had told Mr R to stop taking the pink tablets and to start taking the cyclosporine 50mg dispensed to him on 18 November 2013.

57. Mr Zelcer showed the pharmacy technician, Mr S in Mr E's presence the repeat prescriptions dispensing log book where he had highlighted by circling, the third part of the computer generated label which related to Mr R's 15 October 2013 dispensing of "cyclosporine 50mg".

58. Mr Zelcer advised the pharmacy manger that he had put the returned bottle of cyclophosphamide 50mg tablets into the yellow (returned medicines) bag outside his office. An intern pharmacist and Mr Zelcer then went to search for the bottle which was found, without the pharmacy label from 15 October 2013 on it, lying under a plastic shopping bag's worth of other returned medicines in the yellow bag. The tablets inside were counted. There were 9 tablets remaining in the bottle and Mr R had given 6 tablets from his personal dosset box, to the pharmacy manager.

59. It was determined by the pharmacy manger that Mr R had likely consumed 45 cyclophosphamide 50mg tablets in error and that this equated to approximately 3 weeks where Mr R had not been taking his prescribed immunosuppressant medication (cyclosporine 50 mg capsules) and instead had been taking, cyclophosphamide 50mg tablets. In fact Mr R had consumed 35 tablets equating to a 2.5 week period where he was not taking his prescribed medication.[17]

60. Mr Zelcer offered to phone Mr R's GP however the pharmacy manager indicated that as Mr Zelcer was involved he needed to take a step back. The pharmacy manager contacted Mr R's GP, Dr T at approximately 11.00am and explained what had occurred. Mr R's GP then phone the Nephrology Department at Canterbury District Health Board (Dr Nick Cross, who prescribes Mr R's cyclosporine 50mg) and was told that Mr R would need an urgent blood count and kidney function test.

61. The blood count was required because cyclophosphamide 50mg is a drug that can lead to a decrease in the white blood count (due to bone marrow suppression) and if this occurs it can lead to an increased risk of serious infection. The kidney function test was required because although Mr R had continued to take his prednisone, he had not been taking his prescribed immunosuppressant medication, cyclosporine 50mg, for approximately two and a half weeks. Therefore there remained a risk of transplant (kidney) rejection because he had not been taking his prescribed cyclosporine 50mg.

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[17] The pharmacy manager assumed at this time that 60 cyclophosphamide tablets had been dispensed on the basis the prescription was for "60 cyclosporine 50mg". However, the label for "60 cyclosporine 50mg capsules" was placed on a manufacturer's bottle of cycloblastin (cyclophosphamide 50mg) which contains 50 tablets.

62. The pharmacy manager then phoned Mr R, explained what had occurred and apologised for the error and the way it was handled. He provided information to Mr R about cyclophosphamide 50mg (what it is used for and potential side effects) and confirmed that the medical tests were being organised for Mr R by his GP.

63. Mr R underwent blood tests (a complete blood count) and a Renal Function Panel that afternoon. The Renal Function Panel returned results unchanged from testing completed earlier in the year. The total white blood cell count was reported within the normal range of 5.1 x 10e9/L but minor lymphopenia was present (a low lymphocyte count where lymphocytes are one type of white blood cell which make up 30% of the total white blood cell count).[18] Mr R's neutrophil count was normal. Mr R's GP recorded in his medical notes on 6 December 2013 that the minor lymphopenia would be the effects of the cyclophosphamide, however no action was required.

64. At the pharmacy manager's request Mr Zelcer completed a PDA Incident Notification Form on Saturday, 7 December 2013 after work at his home. On Monday, 9 December 2013 Mr Zelcer wrote and faxed a letter to the PDA explaining the incorrect dates in the PDA Incident Notification Form which he had completed on the Saturday.

RISK OF HARM

65. The dispensing error placed Mr R at risk of harm, because of the risk of medication toxicity (and therefore infection) from the cyclophosphamide. Further there was a risk of organ rejection by not taking his prescribed immunosuppressant medication, cyclosporine 50mg despite his continuing to take his prescribed prednisone. Mr R's GP confirmed the effect was mitigated somewhat by the continued taking of prednisone.

66. Mr R's GP has confirmed that had the dispensing error not been picked up Mr R would have been at serious risk of infection.

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[18] The Laboratory result records: "Lymphopenia present. This is usually diagnostically unhelpful but may be associated viral infections, drug therapy and autoimmune disorders".

67. At the time it was also not known to Mr Zelcer exactly what sort of interaction cyclophosphamide 50mg may have had with Mr R's other eleven medications which he is required to take on a regular basis. Mr Zelcer accepts this meant that he should have taken immediate steps to contact Mr R's GP on 4 December 2013.

68. On the morning of Monday, 9 December 2013 Mr Zelcer telephoned Dr T to apologise to him for the dispensing error not having been reported to him earlier than it was. Dr T reassured Mr Zelcer that Mr R's health was not showing any adverse effects from taking the wrongly dispensed medication. Mr Zelcer assured Dr T that he was double-checking his accuracy checking from now on.

EXPERT EVIDENCE

69. Mr Glenn Mills, registered pharmacist of Auckland, has provided expert advice to the Director of Proceedings in relation to the care provided to Mr R by Mr Zelcer between 4 and 6 December 2013 which is the subject of the charge.

70. Mr Mills' concluded that Mr Zelcer's actions, upon discovering the dispensing error on 4 December 2013, were in his opinion a serious and concerning departure from acceptable practice. He stated:

> *On discovering the error, I do not believe Mr Zelcer appropriately considered the clinical implications of the situation, including the potential for harm to Mr R, and the appropriate clinical steps and referral required to appropriately minimise this harm. Mr Zelcer's demonstrable lapse of judgment in not honestly and transparently disclosing the nature of the error to the patient … deviates significantly from the level of care Mr R should reasonably have expected to receive. Further, Mr Zelcer's failure to disclose the error to his employer … failure to abide by the Pharmacy's SOP's and failure to [complete an incident report] of the incident in a timely and appropriate manner, further compounds what I believe my peers would view as a serious departure from an acceptable standard of practice.*

71. In particular Mr Mills opinion:

a) Mr Zelcer's failure to bring the dispensing error to the attention of the pharmacy manager is concerning and unacceptable. Further, his explanation

for not bringing the dispensing error to the attention of the pharmacy manager that "it was at the back of my mind" was not reasonable or acceptable. Mr Zelcer had an obligation to disclose the error to the pharmacy manager in accordance with the Pharmacy's SOP's. Likewise, Mr Zelcer's explanation for not starting an incident report, that he was "distracted" (by high volume checking and dispensing of prescriptions and medico-packs), is unacceptable as a serious error/incident of this nature would remain top of mind for a pharmacist.

b) *The consideration from most pharmacists faced with this situation, other than the potential acute toxicity and/or harm from a non-prescribed cytotoxic/immunosuppressant medication would be the risk of transplant rejection.*

c) *Mr Zelcer's failure to advise Mr R's GP at the time of the discovery of the dispensing error was not an acceptable discharge of his professional obligations to his patient and is the most concerning and serious aspect of this case. This demonstrates a serious and significant lack of professional and clinical judgment both with respect to not immediately advising the patient's GP so that relevant diagnostic tests and monitoring could be performed thereby minimising potential harm to the patient, but also procedurally with respect to failing to follow the Pharmacy SOP's.*

d) *It was not within Mr Zelcer's scope of practice as a pharmacist to safely establish Mr R's wellbeing without having a discussion with and seeking advice from Mr R's GP. Although Mr Mills is not an INR accredited pharmacist, in his opinion, the information which Mr Zelcer obtained during the INR consultation could not safely establish Mr R's well-being (because it is the white blood cell count that may have been compromised which is not measured in an INR test) and Mr Zelcer should not have directed Mr R to commence his cyclosporine without first advising the GP of the dispensing error and obtaining his instructions.*

72. *Mr Zelcer accepts that between 4 December 2013 and 6 December 2013, he did not fully follow the processes set out in the Pharmacy's SOPs which applied at the time being SOPs 38 Procedure for Dispensing Incidents and 38a Procedure for Dispensing Incidents – handling the error, nor did he meet the standards of care expected of the pharmacy profession.*

73. *Further Mr Zelcer accepts that in this time period he acted contrary to the Pharmacy Council's Code of Ethics 2011 and contrary to the Pharmacy Council's Competence Standards for the Pharmacy Profession (January 2011), which at all material times he was aware of.*

74. *Mr Zelcer accepts full responsibility for his conduct as particularised in the charge. He accepts without reservation that he handled the matter inappropriately and that he did not fulfil his professional and ethical obligations.*

PROFESSIONAL MISCONDUCT

75. *I, Terrence Stuart Zelcer, registered pharmacist of Christchurch hereby admit that this Agreed Summary of Facts is true and correct, admit the disciplinary charge (as amended by consent) that has been brought against me, and admit the conduct as described in the Agreed Summary of Facts and that it amounts to professional misconduct under s. 100 of the Health Practitioners Competence Assurance Act 2003.*

76. *I will not oppose any application which may be made for an order suppressing the names of the consumer, Mr R, and the complainant, Mr T*

"Terrence Stuart Zelcer"

Terrence Stuart Zelcer

"Nicola Wills"
Nicola Wills
Director of Proceedings

17.11.16"

7. The parties also lodged with the Tribunal an Agreed Bundle of Documents. This extended to nearly 150 pages, and included documentation covering the Practitioner's registration details; correspondence between the Pharmacy Council of New Zealand and the Practitioner including a letter of apology from the Practitioner; documentation kept by the pharmacy where the Practitioner worked at the relevant time drawn upon in the Agreed Statement of Facts; the patient's medical notes; technical information in relation to the various drugs involved; and documentation published by the Pharmacy Council and the pharmacy at which the Practitioner worked relating to the standards expected of pharmacists.

Liability

8. The Director's charge that the Practitioner's conduct constituted professional misconduct was not defended. Nevertheless, the Tribunal is obliged to reach its own conclusion in relation to liability.

9. Having said that, we record that the Tribunal has had little difficulty in reaching the same conclusion as the parties. On any view, having identified the dispensing error on 4 December 2013, the Practitioner not only kept this from the patient but failed to take all necessary steps immediately to mitigate the situation for the patient by for example informing his general practitioner. It is unnecessary to go further than that to conclude that the Practitioner's behaviour constituted malpractice or negligence, and conduct that has brought or was likely to bring discredit to the profession. Accordingly, the Tribunal is quite satisfied that the Director has made out the allegation of professional misconduct against the Practitioner.

10. The real issue in this case concerns the appropriate penalty.

Penalty

Approach

11. Counsel made extensive submissions in relation to penalty.

12. For the Director, Ms Eckersley began by submitting that the pivotal issue was whether the Practitioner had attempted to *"cover up"* the dispensing error, or whether his actions after having identified the error were a series of misjudgements on his part. Her submission was that if the Tribunal were to reach the former conclusion, then it would

be appropriate to consider the suspension or cancellation of the Practitioner's registration, but that, if it reached the latter conclusion, then the appropriate outcome would be a censure, a fine and the imposition of conditions on the Practitioner.

13. The Tribunal regards that as a fair way of approaching the case, and we say now, without further analysis, that we do not accept that there is an evidential foundation upon which we could conclude on the balance of probabilities that the Practitioner was intending to cover up the dispensing error and had no intention ultimately of addressing it appropriately. That of course narrows the scope of the debate as to the appropriate penalty in this case. Ms Hughson for the Practitioner accepted the appropriateness of a suite of penalties along the lines sought on the Director's behalf by Ms Eckersley in the event of our concluding that the Practitioner was not engaged in covering up the dispensing error.

14. In the result, then, given the Tribunal's determination as to the Practitioner's intention, the parties are effectively in agreement as to the nature of the appropriate penalty, if not the precise details.

15. It is appropriate at this point to address the evidence and submissions going to the issue of the Practitioner's intentions.

16. Ms Eckersley's submission was that it was unlikely that the Practitioner *"... was ever going to disclose the dispensing error..."* and in support of this submission she referred us to the following aspects of the evidence:

> *"• In Mr Zelcer's own words, Mr R "appeared well" and this was "not a situation where a customer presented with the wrong meds and feeling unwell". Mr Zelcer was seemingly so assured by his assessment of Mr R's health that the dispensing error went to "the back of [his] mind" and he was only "reminded of" the error when Mr R returned to the pharmacy and spoke with Mr E. These statements are inconsistent with Mr Zelcer having had an intention to disclose the error (to anyone) because he had forgotten about it. He was content he had assessed Mr R's health as fine, he had directed him back onto the cyclosporine 50mg he had been correctly dispensed in November 2013 and he was therefore satisfied that no further action was required to address the effects of the dispensing error.*

- *Mr Zelcer gave to his patient what he thought at the time was false information. In addition, he omitted the truth from his patient. In the 48 hours that followed Mr Zelcer took no steps to contact his patient to reveal the truth of the error.*

- *Mr Zelcer disposed of the returned bottle of medication in the yellow returned medicines bag where it was later found with the label removed, underneath a shopping bag's worth of other returned medications. Mr Zelcer did not take any steps towards ascertaining how many tablets Mr R had taken in error, because he did not need that information, he was never going to report the incident.*

- *Mr Zelcer altered the electronic stock records and when he was asked about those alterations and had the opportunity to report the dispensing error, he kept silent and omitted the truth from his manager.*

- *Mr Zelcer took no steps to report the incident to his manager. The pharmacy manager returned to the pharmacy within 30 minutes of the error being discovered on 4 December 2013 but Mr Zelcer said nothing. Mr Zelcer and the pharmacy manager were in the pharmacy together on 5 December 2013 but Mr Zelcer said nothing. Mr Zelcer only revealed the error when he had no other choice.*

- *Mr Zelcer took no steps to complete (or even start) an incident report."*

(We have excluded references from the above quotation).

17. If, as Ms Eckersley submits, those are the strongest points indicating that the Practitioner was engaged in a "*cover up*", then the Tribunal does not accept that they are sufficient to establish such a serious allegation. All of those aspects of the evidence are equally consistent with the view of the case pressed on us on behalf of the Practitioner by Ms Hughson, which is essentially that the Practitioner mishandled the situation and in the course of doing so acted in a way which constituted professional misconduct, but that "*...he always intended to bring the matter to the attention of the pharmacy manager (he advised the Pharmacy Council in February 2014 that he fully intended to notify the patient's doctor and the pharmacy manager and fill out an*

incident report [ab: 9]. Of course the evidence is that the patient came in before [the Practitioner] had taken these steps."

18. Take for example Ms Eckersley's first and perhaps strongest point. The Practitioner admits to having made his own judgment that the patient *"... appeared well..."* and that this was *"...not a situation where a customer presented with the wrong meds and feeling unwell..."*. Ms Eckersley contends that the Practitioner, having made his own judgment about the patient's state of health, and re-established an appropriate pharmaceutical regime, was satisfied that no further action was required. For his part, the Practitioner says that, all he meant by his admission was that the matter did not appear to him to be urgent, and that is why he concluded that it was unnecessary to take immediate steps, but that he fully intended to take those steps in due course. Both parties therefore accept that the Practitioner made a grave error of judgement, but they ask the Tribunal to draw different inferences – the Director asks us to conclude that the Practitioner was seeking to bury the incident, whereas the Practitioner asks us to accept that it was his intention to report the matter and address it appropriately and that his error of judgement was in concluding that there was no immediate urgency about this.

19. In the Tribunal's assessment both explanations are plausible.

20. It is relevant in this context to have regard to the fact that the Tribunal is dealing with a highly experienced Practitioner of some 30 years standing with a hitherto unblemished record who has been able to put before the Tribunal an extensive portfolio of references which speak very highly of him.

21. Against that background, the Tribunal is unable to accept that the Director has established this component of the charge, even on the balance of probabilities.

Principles

22. Both Counsel made detailed submissions in relation to the principles which must guide the Tribunal in identifying the appropriate penalty. The Tribunal expresses its gratitude for their assistance. However, we regard it as unnecessary to go further than to restate the summary of these principles contained in the Tribunal's recent decision in *Allen HPDT* 871/Phar16/367P. At page 6 of that decision the Tribunal said:

"• *In approaching penalty the Tribunal must consider all available options;*

- *Before imposing any particular penalty or combination of penalties, the Tribunal must satisfy itself that any less severe penalty or combination of penalties will not meet the case;*

- *The primary purposes of professional disciplinary proceedings, and the purposes which the Tribunal must therefore bring to its consideration in any given case, are the protection of the public and the maintenance of professional standards;*

- *Professional disciplinary proceedings are not primarily concerned with punishment, so that whilst the imposition of any penalty will be punitive, punishment is not to be an objective;*

- *The Tribunal is obliged to have regard to the prospects of a practitioner's rehabilitation;*

- *Consistency is important, and the Tribunal must therefore have regard to penalties imposed in comparable cases in the past. This principle is not to operate as a straight-jacket. Times change, and societal attitudes with them. The Tribunal must be free to change its approach. However, it must do so expressly, and on a principled basis;*

- *The Tribunal's responsibility is to identify the least punitive outcome which meets the seriousness of the practitioner's conduct;"*

23. On the basis of the Tribunal's conclusion that the Director is not able to make out the allegation that the Practitioner was engaged in a *"cover up"*, the parties' submissions as to the appropriate penalty in this case are very similar indeed. Both submit that that penalty should involve a censure and a fine. The Director submits that it should also include the imposition of conditions. The Practitioner's submission is that imposition of conditions is unnecessary, but he does not object to them.

24. Notwithstanding the similarity of the parties' positions, it is nevertheless appropriate to summarise – briefly – the arguments advanced by Ms Eckersley and Ms Hughson.

25. For the Director, Ms Eckersley emphasised the fact that the Practitioner is a Practitioner with 30 years of experience and well aware of his professional obligations. She submitted that the patient in question was a *"... a particularly vulnerable consumer..."*. This vulnerability, Ms Eckersley submitted, arose from three factors – the fact that the patient was [ ] years of age; the fact that the patient had multiple health issues; and the power imbalance between the parties. The Tribunal does not accept the fact that the patient was [ ] necessarily renders him vulnerable in any way. That said there can be no doubt that his seriously compromised health rendered him vulnerable, and that the relative positions of the parties certainly created a knowledge imbalance which added to his vulnerability. Ms Eckersley emphasised that the Practitioner's conduct involved a breach of trust and that seems uncontestable. She suggested that the Practitioner's taking it upon himself to make an assessment of the patient's health showed a severe lack of judgment. The Tribunal agrees. That judgement took the Practitioner well outside his area of professional competence. Ms Eckersley then developed her argument in relation to the Practitioner's intention, with which we have already dealt. The final point made by her on the Director's behalf was that the Practitioner's conduct came to light when the patient returned to the pharmacy on 6 December 2013 and spoke to the owner – rather than as a result of any actions of the Practitioner. That we must regard as a mere happenstance, given our conclusion as to the Practitioner's intentions.

26. Ms Eckersley acknowledged that there were also mitigating features of this case including the Practitioner's record and that the Pharmacy Council considered this case for the purposes of determining whether the Practitioner's competence needed to be reviewed and determined that his general competence did not require review.

27. She then referred us to a number of comparable cases.[19] Given the similarity of the submissions made on behalf of both parties, it is unnecessary for us to review these cases in detail. We simply observe that the outcomes are similar to the outcome contended for by the parties here.

28. For the Practitioner, Ms Hughson took us through a detailed summary of the background of the case and its aftermath, and the Practitioner's circumstances.

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[19] Morrison HPDT 118/Phar07/66D; Cruzada HPDT 34/Nur05/17D; Draper HPDT 534/Nur12/227D

29. She then submitted that the Practitioner is held in high regard by his colleagues and referred us to the character references provided by his current employers and professional colleagues. We do not need to focus on these in detail. But it is fair to say that it is obvious from these references that the Practitioner is held in the highest regard. He is entitled to substantial credit for that. We record that the references from his current employers and professional colleagues which he has been able to supply have been a major consideration for us in reaching the conclusion we have in relation to his intentions. As Ms Hughson submitted, this evidence is testament to the Practitioner's *"... skill and dedication as a pharmacist. They demonstrate that he is a respected pharmacist and that he has high standards of professional practice and he discharges his professional responsibilities to a high standard. They also demonstrate his high personal qualities and attributes including his strong moral character."*

30. Ms Hughson then submitted that the Practitioner had been forthcoming in accepting his professional misconduct, to his then employer; to the Pharmacy Council that looked into the matter; to the Director; and in the course of this professional disciplinary proceeding. She went on to submit that the Practitioner has shown considerable insight into his conduct. She reminded us that the Practitioner has written a formal letter of apology to the patient acknowledging that he let him down, and more recently consulted a psychologist to obtain assistance with *"... processing the enormity for him of his misconduct and to deal with the stress which inevitably arises for practitioners who appear before the Tribunal, and also in practice."* We have in evidence an affidavit from the psychologist which reports in favourable terms on his treatment of the Practitioner.

31. Ms Hughson submitted that the Practitioner *"...has suffered immeasurably as a consequence of his actions, emotionally. The matter has had a profound affect and has left a deep impression on him. Over the past three years he has reflected deeply on his actions, including the clinical implications of the dispensing error and the possible consequences for the patient of him having handled it the way he did. This is evidenced by the clinical psychologist's affidavit. He is deeply regretful for his actions. He is sincerely sorry for what he describes as "this dreadful situation and for the distress and any inconvenience his actions have caused [the patient] and his family". The ongoing investigation processes over the past three years (as well as other stressful situations in his life including earthquake recovery and the poor health of his parents-*

in-law having referred to in his [evidence] have taken a significant toll on his [the practitioner] and his wife and the charge has had a significant salutary effect on him." She concluded this aspect of her submission by saying that the Practitioner is confident that there will be no repetition of this conduct. The Tribunal shares this confidence.

32. Like Ms Eckersley, Ms Hughson referred us to a number of cases.[20] Once again, all we need to say about these cases is that the facts and outcomes are comparable to those being urged upon us here.

33. As the Tribunal informed the parties at the conclusion of the hearing, we have reached the conclusion that the appropriate penalty in this case is a censure, a fine of $5,000 and the imposition of conditions on the Practitioner's practising certificate which are intended to ensure that there is no repetition of this conduct. In our judgment, that outcome is the least punitive penalty we can impose consistent with our obligations to the public and the profession, consistent with the comparable cases, and is fair, proportionate and reasonable.

Costs

34. In professional disciplinary proceedings costs are always difficult. The issue of course is the proportion of the costs involved which should be borne by a practitioner found to have conducted himself or herself inappropriately, and the proportion which should be left to be borne by the profession as a whole. The difficulties involved are amply reflected in the contrasting approaches adopted by different disciplinary bodies. Some approach costs from the starting point that a practitioner who has transgressed should pay 100% of the costs involved unless there are good reasons for ordering otherwise. Other professional disciplinary bodies – including this Tribunal – start from the basis that a practitioner should bear 50% of the costs, but leave open the possibility of increased or decreased costs, depending on the circumstances.

35. In this case, the Tribunal's costs total $17,868.95, and those of the Director total $34,166.00. There was less focus on costs in this case than there is in others. The Tribunal has not been provided with any evidence for example as to the Practitioner's financial position. In those circumstances, the Tribunal proposes to order that the Practitioner pay half of the Tribunal's costs. We would have made a similar order in

[20] Chiew HPDT 180/Phar08/95P; Morrison; May HPDT 222/Phar08/99P; Winefield HPDT 60/Phar06/30P

relation to the Director's costs, but for the fact that the Director applies only for an order that the Practitioner pay 30%. That, then, is the order we will make in relation to the Director's costs.

Suppression

36. By Notice of Application dated 5 December 2016 and lodged with the Tribunal during the course of the hearing, the Practitioner applies for an order permanently suppressing his name and other details of the matter which might identify him. Although the application does not say this in straight-forward terms, in fact this application relates not only to the Practitioner's name but the names of the pharmacy which employed him at the relevant time, and the pharmacies which currently engage him. To the extent that the application seeks the suppression of the names of these concerns, it is advanced on the basis that to identify them would be to identify the Practitioner. Yet amongst the grounds articulated in the application are the protection of the commercial interests of these concerns.

37. The Tribunal makes the observation – for future reference as much as anything else – that there is no necessary entitlement on the part of entities – individuals or businesses – to name suppression, however *"innocent"* they may be in connection with the proceeding.

38. There is a fundamental principle which permeates the common law's approach to the administration of justice at all levels, which is that it is administered openly. Whilst entities peripherally involved in litigation may indeed suffer reputational damage, by and large, that is the price that we all pay for an open and transparent justice system.

39. For her part, the Director applies for an order suppressing the name of the patient and his relatives, essentially so as to protect his privacy.

40. The Director opposes the Practitioner's application for an order suppressing his name, but consents to the other orders sought – that is to say those relating to the names of the concerns for which the Practitioner worked at the relevant time and is currently working, and anyone associated with them.

41. The Practitioner consents to the Director's application for the suppression of the name of the patient and his relatives.

42. Section 95(1) provides that Tribunal hearings are to be in public. The default position is therefore one of openness, consistent with the common law principle to which we have already referred. Section 95(2) confers on the Tribunal jurisdiction to prohibit the publication of various things such as the name of any person, including the Practitioner involved, if the Tribunal concludes that it is desirable to do so having regard to the public interest and the interests of any person.

43. As Ms Eckersley submitted, in *T v The Director of Proceedings* CIV-2005-409-2244 Pankhurst J observed that:

> *"[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 some of the probability must be that the public interest considerations will require that the name of the Practitioner be published in the preponderance of cases."*

44. It seems to the Tribunal that the force of Pankhurst J's observations are that generally it will be wise to accede to an application for the suppression of a practitioner's name prior to the disposal of the case by the Tribunal – essentially because it is difficult to tell in advance how matters might develop – but that those considerations do not apply following a hearing and an adverse finding, and that in the event of such a finding the onus is very much on the practitioner to establish grounds for contending that the default position should not prevail. With great respect, it is difficult to see how it helps to suggest that the *"preponderance of cases"* should be decided one way or another.

45. Ms Eckersley also referred us to other cases which re-enforce that the onus is on a practitioner seeking name suppression to establish grounds for it.

46. For the Practitioner, Ms Hughson did not advance a detailed argument in favour of the order sought by him. She accepted that publication of the Practitioner's name usually follows an adverse disciplinary finding for the public policy reasons we have traversed. But she submitted that there are private interests involved in this case that would support the order sought in relation to the Practitioner's name. These included the stress which this proceeding had already engendered for the Practitioner, and the apparently fragile health of his father-in-law. Ms Hughson also referred to the potential for adverse

commercial consequences for the pharmacy by which the Practitioner was employed at the time of the events and the pharmacies by which he is currently engaged. She spoke also about the Practitioner's future and we take from what she told us that the submission is that the publication of his name might have an adverse impact on his employment prospects in the future. She concluded in these terms:

> *"So, in my submission the combination of those private interests, and in the interests of [the Practitioner], the interests of his elderly parents-in-law and family, including his wife it must be said, and of his current employers, outweigh the public interest in knowing the [Practitioner's] name and connection with the case and with the Tribunal's finding the public is entitled to know a finding has been made in respect of this misconduct, can still be met without [the Practitioner's] name being published."*

47. For the Director, Ms Eckersley submitted that the grounds put forward in support of the Practitioner's application fell *"... woefully short of supporting an order for permanent suppression."* Whilst this may be putting the position in extravagant terms, and whilst the Tribunal has taken great care to consider what limited information it has available to it in relation to the Practitioner's father-in-law, we are not satisfied that the Practitioner has put enough before us to enable us to make the order he seeks departing from the default position of publication. Of course this matter has been stressful for the Practitioner and his family. But, without wishing to put too fine a point on it, that is a stress which he has brought upon himself by his conduct. We accept that publication of his name may have an adverse impact on him and his family. But once again, that is simply a natural consequence of the Practitioner's conduct. In short, we are not prepared to grant the Practitioner's application for suppression of his name. We will however make a temporary order for suppression of his name for one calendar month from the date of this written decision in order to enable him to take advice and consider taking the matter up elsewhere.

48. Though such parties as the pharmacy which engaged the Practitioner at the relevant time, the pharmacies, which currently engage him, and any individuals associated with those pharmacies do not in our view have especially strong cases for name suppression, given that the applications relating to them are not opposed, we will make orders suppressing their names and identifying details (other than the Practitioner's name).

49. Given that s95(2) talks specifically about the protection of privacy, the Tribunal's view is that the application made by the Director on behalf of the patient and his family for suppression of their name is well made. And of course it is not opposed. The Tribunal will make an order suppressing the name of the patient and his family.

Conclusion

50. The Tribunal's formal orders are as follows:

50.1 Pursuant to s 101(1)(d) of the Health Practitioners Competence Assurance Act 2003, the Tribunal censures the Practitioner;

50.2 Pursuant to s 101(1)(e), the Tribunal fines the Practitioner the sum of $5,000;

50.3 Pursuant to s 101(1)(c), the Tribunal orders that, for a period of 12 months from the date of this decision the Practitioner shall practise only in accordance with the following conditions:

50.3.1 From the date of this decision, and for a 12 month period thereafter, Mr Zelcer must, at his own cost, practise under the mentorship of a Council approved Senior Pharmacist and record details of interaction with this mentor to be reported to the Pharmacy Council of New Zealand every three months;

50.3.2 Mr Zelcer must, at his own cost, attend a course approved by the Pharmacy Council of New Zealand which relates to dealing with stressful and difficult situations.

50.4 Pursuant to s 101(1)(f) the Tribunal orders the Practitioner to pay the sum of $8,934.47 by way of a contribution to the Tribunal's costs, and the sum of $10,249.80 by way of a contribution to the Director's costs;

50.5 Pursuant to s95(2), the Tribunal makes orders permanently suppressing:

50.5.1 The names and any other identifying details of the patient and his family;

50.5.2 The names and any other identifying details of the pharmacy which employed the Practitioner at the time of the events which are the subject of this decision, and the pharmacies which currently engage him, and the owners and others associated with those pharmacies;

50.6 Also pursuant to s95(2) the Tribunal makes an order suppressing Mr Zelcer's name and any other identifying details, this order to subsist for one month from the date hereof and then expire;

50.7 Pursuant to s 157, subject to the orders made in 50.5 and 50.6 above, the Tribunal directs the Executive Officer to publish a copy of this decision, and a summary, on the Tribunal's website. The Tribunal further directs the Executive Officer to request the Pharmacy Council of New Zealand either to publish the summary of, or a reference to, the Tribunal's decision in its professional publications to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

Dated at Wellington this 10th day of February 2017.

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Kenneth Johnston QC
Chair
Health Practitioners Disciplinary Tribunal