NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

Level 24, AON Building, 1 Willis Street, Wellington 6011
PO Box 10509, The Terrace, Wellington 6143, New Zealand
Telephone: 64 4 381 6816
Website: www.hpdt.org.nz

BEFORE THE HEALTH PRACTIONERS DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

HPDT NO	**1332/Med22/560P**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**A PROFESSIONAL CONDUCT COMMITTEE appointed by the MEDICAL COUNCIL OF NEW ZEALAND** **Applicant**
AND	**Dr S of [location], Registered Medical Practitioner**

HEARING	Held in Auckland on 20 to 22 March 2023
TRIBUNAL	Ms T Baker, Chair Dr A Barrett, Dr A von Biel, Dr K Good, Mr C Nichol (members) Ms D Gainey, Executive Officer Ms K O'Brien, Stenographer
IN ATTENDANCE	Ms Miller and Ms R Mould for the Professional Conduct Committee Mr A Holloway and Ms K Wills for the practitioner

---

TRIBUNAL DECISION

---

[1] A panel of the Health Practitioners Disciplinary Tribunal (**the Tribunal**) convened in Auckland between 20 and 22 March 2023 to hear a charge of professional misconduct laid by a Professional Conduct Committee (**PCC**) of the Medical Council of New Zealand (**the Medical Council**) against the practitioner, [Dr S]. The charge alleged an inappropriate relationship, inappropriate prescribing, alteration of records, and breaches of conditions imposed by the Medical Council as a result of an earlier Tribunal order. A full copy of the charge is found in the **Appendix** to the decision. The particulars of the charge are also set out below within the discussion of the evidence.

[2] On 22 March 2023, having found [Dr S] guilty of professional misconduct, the Tribunal issued an oral decision on penalty.[1] This included cancellation of her registration. Under section 102 of the Health Practitioners Competence Assurance Act 2003 (**the Act**) the Tribunal ordered that she could not apply for re-registration for a period of 12 months. At the request of the parties, a written penalty decision was issued on 7 June 2023.

Facts

[3] The onus of proof is on the PCC and the burden of proof is on the balance of probabilities.

[4] The parties had conferred and filed an Agreed Summary of Facts and Admission of Liability signed by [Dr S]. With the exception of one particular, the practitioner accepted the factual allegations in the charge. She did not agree that any of her prescriptions for [Mr D] had been for medications that were intended for her own use, as alleged in particular 4 of the charge.

[5] The PCC's case also relied on evidence from the following:

(a) Dr Fiona Campbell who was the Convenor of the PCC appointed by the Medical Council to investigate the complaint against [Dr S]. Her evidence was in the form of an affirmation which outlined the investigation and produced a number of documents which were also included in an Agreed Bundle of Documents. She was not required for questioning at the hearing.

[1] PCC v Dr S 994/Med18/417P

(b) [Dr Y] who owns [ ] Health Centre (**The Health Centre**), where [Dr S] had been working under successive long-term locum contracts since June 2017.

(c) Dr Niall Holland, a general practitioner, who was called as an expert witness. In particular, the Tribunal was assisted by his analysis of [Dr S'] prescribing for [Mr D]. There was no dispute as to his expertise to provide this evidence.

[6] Although a brief of evidence had been filed for [Dr S], she did not give evidence at the hearing and so that evidence was not taken into account in the Tribunal's assessment of liability. The Tribunal heard from the following witnesses called on behalf of [Dr S]:

(a) [Dr K], a general practitioner colleague of [Dr S] from [The Health Centre].

(b) Dr Karl Jansen, a consultant psychiatrist who had interviewed [Dr S] in December 2022 and January 2023 for the purposes of providing an opinion on any mitigating issues.

[7] Mr Holloway made submissions about the High Court's dicta that although the burden of proof is on the PCC, there is an expectation that the practitioner must be prepared to answer the charge once a prima facie case has been made out.[2] Mr Holloway reminded the Tribunal that this does not mean simply that a practitioner who fails to give evidence is guilty. The PCC has the evidential burden of establishing a prima facie case and whether or not the practitioner has given evidence is irrelevant to that assessment, as is the practitioner's admission of other particulars. Only where the Tribunal considers there to be a prima facie case on the evidence presented does it have a discretion to draw an adverse inference from a failure to give evidence. The expectation of answering the charge must not be taken so far as to reverse the onus of proof.[3]

[8] The Tribunal accepts Mr Holloway's submissions. The Tribunal's decision of *Vatsyayann,*[4] contained the following summary of relevant law on the expectation that in professional disciplinary hearings, a practitioner answers a charge brought against them:

---

[2] *Cole v PCC* [2017] NHC 1178 at [36]
[3] *Geary v The Psychologists Board* HC Wellington CIV-2005-485-1562
[4] 355Med10/152P,

23.6.1 Re C (A solicitor)[5] where a full Bench of the High Court held that a practitioner against whom a prima facie case was made out must be prepared to answer the charge, and may not simply rely on the submission that the charge has not been proved beyond reasonable doubt.

23.6.2 *Auckland District Law Society v Leary*[6] to the same effect.

23.6.3 Webbs' "Legal Ethics"[7] where the learned author stated:

> "Lawyers do not have a right to silence in the context of disciplinary proceedings, they cannot simply rely on their silence and claim that allegations have not been proved satisfactorily."

23.6.4 Mr Upton[8] said that these comments apply generally in the disciplinary field. He stated that the practitioner was particularly at risk of an adverse inference in due course if the Tribunal was satisfied that a prima facie case had been established.

[9] The Tribunal notes:

(a) Although the summary of law on the expectation of a practitioner to give evidence was set out in *Vatsyayann*, as reproduced above, the Tribunal did not make any further comment in that case on how Dr Vatsyayann's decision not to give evidence affected their findings. Similarly, although *Leary*[9] was quoted in *Cole*,[10] there was no suggestion that the nurse in *Cole* did not answer the charge. Therefore, the ramifications for the practitioner of not giving evidence in a charge brought before a professional disciplinary tribunal are not settled.

(b) The onus of proof remains with the PCC.

(c) There may be situations where a practitioner's decision not to give evidence gives rise to an adverse comment.

(d) The Tribunal may nonetheless draw adverse inferences from the evidence before the Tribunal, which may include prior inconsistent statements.

---

[5] [1963] NZLR 259
[6] Auckland Registry, M1471/84, 12 November 1985, Hardie-Boys J
[7] 2nd Edition, 2006 at p153.
[8] Mr Upton QC was appointed as a technical advisor to the Tribunal.
[9] Above, note 6.
[10] Above, note 2.

(e) In assessing the evidence, the sworn or affirmed and tested evidence of a witness carries more weight than the statements that have not been sworn or affirmed, or given orally before the Tribunal, and been subject to cross-examination. In the present case, the Tribunal has not had an opportunity to seek clarification from [Dr S] on some matters.

Background

[10] It was agreed that on 6 June 2017 [Dr S] started working at [The Health Centre] on a series of locum contracts. In April 2018 the patient, [Mr D] had an appointment with [Dr S].

[11] On 26 October 2018 [Dr S] appeared before the Tribunal on a charge of professional misconduct. A copy of the Tribunal's decision dated 28 November 2018 was produced by Dr Campbell. The established conduct included self-prescribing sumatriptan,[11] and prescribing multiple medications in the name of five different family members. It was accepted that the prescribing for four of the five people was intended for [Dr S'] own use. The penalty imposed included a condition for three years that she not self-prescribe or prescribe for or treat her family members or any other partner that she may have at that time. That condition expired on 27 November 2021.

[12] From June 2019 [Dr S] was [Mr D's] regular GP, and in the same month a close personal relationship between them started, developing into a sexual relationship in October 2019.

[13] In November 2019 [Dr S] told [Dr Y] that [Mr D] had transferred to another practice.

[14] In June 2020 [Dr S] entered into a lease with [Mr D] for her granny flat.

[15] On 7 October 2020 Dr Joel Jackson, a consultant psychiatrist with Community Alcohol and Drug Service (**CADS**) Waitemata DHB notified the Medical Council that it was suspected that [Dr S] was in a relationship with a patient. Relevant documents from CADS recorded that during [Mr D's] interactions with the duty counsellor at CADS, he had introduced his partner as [Dr S] and had advised that he and [Dr S] had met when she was his GP. He said that they had ended the doctor/patient relationship when their personal relationship began.

[11] Sumatriptan is one of a group of medicines known as triptans, used to treat symptoms of migraine headaches .

[16] [Dr Y] provided [Mr D's] medical records to the PCC. She told the Tribunal she understood that [Mr D] had left [The Health Centre] in December 2019. [Dr S] had told [Dr Y] that it was because of the cost compared with a "Very Low Cost Access" practice next door. [Dr Y] told [Mr D] that they would be able to subsidise his visits, but he said he had already left.

[17] [Dr Y] gave evidence of the unravelling of the true story of [Dr S'] relationship with [Mr D] once the complaint had been made to the Medical Council. Initially [Dr S] told [Dr Y] that she and [Mr D] had art in common and that they had met up outside the practice at an art event in November 2019 and become friends. After December 2019 [Dr Y] was not aware of any further interaction between [Dr S] and [Mr D].

[18] [Dr S] told [Dr Y] that she went to [Mr D's] CADS appointment as his support person because he is dyslexic and anxious about this socially. [Dr S] said that she had helped [Mr D] set up his website for his carvings so that he could try to sell some of his work and that their relationship was misconstrued when they were really more like business partners.

[19] On the basis of her understanding of the relationship, [Dr Y] wrote a letter of support to the Medical Council on 5 November 2020. It was not until she was auditing [Mr D's] clinical notes in April 2021 that she became aware that [Dr S] was still prescribing for him.

[20] On Saturday 10 December 2022, having read all of the PCC evidence, including Facebook posts of [Mr D's], [Dr Y] realised that [Dr S] was in a relationship with [Mr D] and she rang [Dr S]. They spoke for an hour, after which [Dr Y] sent a lengthy email to counsel for both parties setting out her concerns that [Dr S'] situation with [Mr D] was harmful to [Dr S] and she could not extricate herself from this. She said that [Dr S] had given [Mr D] her credit card and had paid for his dental work. [Dr Y] felt that her colleague was being preyed on by a streetwise person.

[21] [Dr Y's] evidence was that two days later on Monday 12 December 2022, [Dr S] said to [Dr Y] that she had caught her at a weak moment and [Dr S] should not have said those things.

[22] At the time of the hearing in March 2023, [Dr Y] understood that the relationship had ended and [Mr D] was out of [Dr S'] life.

[23] [Dr Y] considered [Dr S] was an excellent doctor and that she had made a big error of judgment in her personal life.

Particulars 1 and 2: Inappropriate relationship with a patient and lease

[24] The PCC alleged that in June 2019 [Dr S] entered into a close personal relationship with [Mr D] and, in October 2019, [Dr S] entered into a sexual relationship with [Mr D] in circumstances where:

(a) [Mr D] was a patient of [Dr S]; and/or

(b) [Dr S] knew or ought to have known that [Mr D] had been diagnosed with depression and/or anxiety and/or PTSD.

[25] [Dr S] accepted that between June 2019 and October 2020 she provided GP services to [Mr D]. These included prescribing medications, completing certificates and ACC claims, providing advice on his neck injury and referrals to other treatment providers. On 23 December 2019 [Mr D] consulted a GP at another practice as a casual patient, but otherwise [Dr S] was [Mr D's] sole GP until 21 October 2021. She was aware that he had historic diagnoses of anxiety states, depression and PTSD. A close personal relationship arose from June 2019 and became a sexual relationship from October 2019. Particular 1 is established.

[26] Particular 2 alleges that on or about 24 June 2020, [Dr S] entered into a lease with [Mr D] to provide him with accommodation at her home, in circumstances where he was her patient and she had recently prescribed medication for him or in his name.

[27] [Dr S] agreed that in June 2020 she had offered the granny flat on her property to [Mr D] for rent and he had agreed and moved in. She also accepted that between 5 June 2019 and 24 September 2020 she had prescribed medications for him as set out in an appendix to the charge. This included prescriptions on 18 April 2020 for ciprofloxacin,[12] omeprazole[13] and diclofenac sodium,[14] on 19 May 2020 for sumatriptan tablets and injectables and rizatriptan,[15] and 29 May 2020 for omeprazole and celecoxib.[16] Particular 2 is established.

[12] An antibiotic
[13] To reduce stomach acid
[14] A non-steroidal anti-inflammatory
[15] To ease symptoms of migraine headaches
[16] A non-steroidal anti-inflammatory

Particular 3: inappropriate prescribing for Mr D

[28] Particular 3 alleges that [Dr S] prescribed medications to [Mr D] when she was in a sexual relationship and/or close personal relationship and was providing accommodation to him and that the medicines included oxycodone and tramadol, both opioids that are controlled drugs or have a risk of addiction, and that the triptans and fluticasone[17] were in excess of the recommended therapeutic dose for one person.

[29] [Dr S] accepted that between 5 June 2019 and 24 September 2020, she prescribed medications for [Mr D] and/or in [Mr D's] name as set out in Appendix A to the charge. In summary there were 60 prescriptions issued over 20 dates. On some dates there was only one medication prescribed, and on others up to 6 medications. [Dr S] agreed that she prescribed oxycodone, a Class B controlled drug with a risk of addiction, and that three times she prescribed tramadol, an opioid, also carrying a risk of addiction. In addition she prescribed gabapentin,[18] triptans and ondansetron.[19]

[30] Particulars 3 a), b) and c) were established.

[31] [Dr S] also agreed that between 5 June 2019 and 24 September 2020 she prescribed [Mr D] triptans and fluticasone at a rate which exceeded the therapeutic dose, as alleged in particular 3(d) but at the hearing the PCC's expert, Dr Holland, advised that he had reviewed his analysis of the prescribing and realised that some of the repeat prescriptions had not been filled. Therefore, he revised his opinion that this medication has been prescribed at a rate which exceeded the therapeutic dose.

[32] The Tribunal decided there was insufficient evidence to support a finding that fluticasone had been prescribed in excess of recommended doses, but the charge in relation to the triptans was made out. On that basis particular 3(d) is established.

Particular 4: prescription of medicines for [Dr S'] own use

[33] Particular 4 alleged that the prescriptions for the following medications were intended to be obtained and/or used by [Dr S] and/or were medicines she used herself.

[17] A steroid medicine used to treat nasal congestion and irritation
[18] Used to treat epilepsy and nerve pain
[19] Used to treat nausea and vomiting

(a) sumatriptan; and/or

(b) diclofenac; and/or

(c) omeprazole; and/or

(d) isotretinoin; and/or

(e) Flixonase (fluticasone); and/or

(f) ondansetron.

[34] In the agreed summary of facts, [Dr S] denied that she prescribed the medications with such an intention and says that she did not use any of the medications that were prescribed for [Mr D].

[35] Therefore, the Tribunal needed to consider the evidence and decide whether the PCC had established the factual allegations in particular 4.

[36] Included in the Agreed Bundle of Documents were [The Health Centre] clinical notes for [Mr D] from which it could be seen that on 17 December 2019 [Dr S] made a specialist referral for [Mr D] to Dr Keith Laubscher, a pain specialist, for management following a neck injury in an assault about two weeks earlier. The medical history section lists his medications as omeprazole, diclofenac and rizatriptan. In a handwritten referral dated 19 December 2019 [Dr S] listed [Mr D's] medications as Celebrex,[20] Panadeine,[21] tramadol, gabapentin and omeprazole. In a letter dated 20 January 2020 Dr Keith Laubscher described the referral as being from [Mr D's] partner, [Dr S]. This letter also included a list of [Mr D's] current medications as Ventolin and Symbicort[22] and rizamelt for migraine.

[37] The PCC called Dr Holland who had reviewed the records of medications prescribed for [Dr S] by her own GP and those prescribed for [Mr D] by [Dr S], as well as [The Health Centre] clinical records for [Mr D]. Dr Holland produced a spreadsheet from which he had reached some conclusions, and at the hearing he produced a revised spreadsheet with extra columns so that comparisons with actual dispensing could be made.

[20] A tradename for celecoxib
[21] A pain relief containing paracetamol and codeine
[22] Both Ventolin and Symbicort are used in inhalers for asthma

[38] In Dr Holland's opinion there was the potential that prescriptions written for [Mr D] were intended for [Dr S'] personal use for the following reasons:

(a) There was an acceleration in the quantity of medication prescribed by [Dr S] for [Mr D] from June 2019, as well as a new pattern for the prescribing of triptans,[23] NSAIDs,[24] omeprazole, Flixonase and isotretinoin[25] between June 2019 and September 2020.

(b) Most of the medications prescribed by [Dr S] for [Mr D] "were not in heavy, regular use by [Mr D] before June 2019".

(c) None of the medications rizatriptan, sumatriptan, Flixonase, isotretinoin and ondansetron were included in the list of [Mr D's] regular medications provided in [Dr S'] referral letter to Dr Laubscher despite being prescribed steadily by [Dr S] from July 2019.

(d) [Dr S] had been prescribed similar medications for her personal use by her own GP and some of the prescriptions for [Mr D] were written and dispensed during gaps in the prescribing of the same medication for [Dr S] by her own GP.

(e) Of particular concern was the prescribing of sumatriptan. This appeared to start only in June 2019 which corresponds to a time when it was not prescribed for [Dr S] by her own General Practitioner. Sumatriptan was also not included in the list of [Mr D's] medications in the referral letter from [Dr S] to Dr Laubscher. Before the period June 2019 to September 2020, [Mr D] was prescribed Rizatriptan, which, according to the consultation notes of 10 January 2019, he had described as being effective. When Dr Sung took over his care, there was an initial prescription on 21 October 2020 for sumatriptan tablets and then he was prescribed only rizatriptan.

(f) Dr Holland initially described [Dr S'] prescribing of triptans as "worryingly excessive" if they were solely for use by [Mr D]. As outlined below, he modified his opinion based on the actual quantities dispensed.

---

[23] Triptans is the name for the family of tryptamine-based drugs used for migraines and cluster headaches, including Sumatriptan and Rizatriptan

[24] Non-steroid anti-inflammatory drugs

[25] Used for treatment of skin disorders, in particular, severe acne.

(g) During the period he was being prescribed multiple triptans (sumatriptan and rizatriptan) by [Dr S], [Mr D] was also prescribed rizatriptan on 7 February 2020 by Dr Loo.

(h) There were instances of the deletion of medications in [Mr D's] prescription list of medicines that had actually been dispensed. This included ondansetron in September 2019 and diclofenac and Flixonase in July/September 2020. Dr Holland described this as puzzling.

[39] The Tribunal agrees that these circumstances indicate the potential prescription of these medications for [Dr S'] own use. The Tribunal must be satisfied on the balance of probabilities that this was the case, in other words that it was more likely than not.

[40] Dr Holland took the Tribunal through his revised table which, alongside a column for [Dr S'] prescribing for [Mr D], included a column for the medications that were actually dispensed. In summary:

(a) Although 510 Rizatriptan 10mg tablets were prescribed between June 2019 and September 2020, only 290 were dispensed, which averages at 19 per month over 15 months.

(b) Sumatriptan tablets and injectables were also prescribed for [Mr D]. Over the period from June 2019 to September 2020, he was dispensed 180 tablets, being an average of 12 per month and 12 injectables.

(c) Between May and August 2020 120 Rizatriptan tablets were dispensed and during the same period, 120 Sumatriptan tablets, meaning that during that period the prescribing exceeded the acceptable amount by over 100%.

(d) A lot of analgesics were prescribed, which could also have contributed to a problem of analgesia over-prescription leading to overuse headache, but that is to some degree conjecture because the absolute amounts prescribed were not particularly excessive.

(e) There was high prescribing of certain medications which were regular medications for [Dr S] (sumatriptan, NSAIDs, omeprazole, Flixonase and

ondansetron) during a period when there was no prescribing for [Dr S] in her own prescription record.

(f) Ondansetron would be used in quantity possibly for someone with severe migraine with vomiting, but it concerned Dr Holland that it was not a medication that [Mr D] had used prior or after this period in question.

[41] Dr Holland accepted in cross-examination that without the clinical records and/or further information about the reasons for the medications that [Dr S] was prescribed, then there was a lot of speculation about the medicines.

[42] The first instance of [Dr S] being prescribed sumatriptan in these records was June 2018. There was about 18 months before then when she had not had sumatriptan prescribed. Dr Holland agreed that would be consistent with someone who is not reporting three migraines a week. [Dr S] was then prescribed it in June, October and December 2018, January and April 2019, February 2020 and September 2020. Dr Holland accepted that there would have been no need to source these from her own GP if the sumatriptan that she prescribed for [Mr D] was for her own use.

[43] Mr Holloway put to Dr Holland a table setting out all of the triptans dispensed to [Mr D]. He agreed with Mr Holloway's calculation that the average doses per month between 5 June 2019 and 27 July 2020 was 27.42, but he added that during the period of May to August, the amount exceeded the quantities that would usually be prescribed.

[44] Dr Holland agreed that [Mr D] had previously used sumatriptan in the injectable form and that [Mr D] had reported to Dr Laubscher migraine headaches three times a week which is very severe.

[45] Dr Holland agreed that there was no issue with the prescribing of isotretinoin and fluticasone.

[46] In submissions the PCC referred to the factors outlined by Dr Holland as evidence that the medications listed in the charge were likely for [Dr S'] use. It was also noted that [Dr S]

had recorded in [Mr D's] notes of a consultation on 10 January 2019 that rizamelt[26] worked well for him. When she first prescribed sumatriptan on 5 June 2019 she simply noted "Rpt script done today" with no record of why sumatriptan had been added to the prescription of rizatriptan.

[47] On behalf of the PCC, Ms Miller also noted that Dr Laubscher recorded [Mr D] as having an "aversion to medication" and being "not keen on tablets" and this seems inconsistent with the quantity of medication prescribed.

[48] Furthermore, several of the prescriptions were handwritten on a prescription pad from [Dr S'] former practice. It was submitted that this out of practice prescribing, with no corresponding records, increases the likelihood that the medications were for her own use, and she tried to conceal or distort the relevant records to avoid detection.

[49] It was also noted that [Mr D] had previously declined analgesia in 2018 despite attending hospital for pain arising from an infected finger. This is not consistent with the relatively high amounts of diclofenac [Dr S] prescribed for him.

[50] The PCC also referred to the previous Tribunal decision in which it was found that [Dr S] had prescribed prednisone[27] and zopiclone[28] for her partner and family members when it was actually intended for her own use. Ms Miller noted that none of the medications listed in particular 4 were the focus of monitoring by the Health Committee as a result of that previous Tribunal decision and it was submitted that [Dr S] would therefore have been aware that her prescribing of these medicines would not have been identified as part of the Health Committee process.

[51] Included in the Agreed Bundle of Documents was a letter dated 17 September 2021 on behalf of [Mr D] to the PCC, in which he claimed that the medications were for his own use. Ms Miller submitted that statement carries no weight whatsoever given in the same letter he confirmed the content of an earlier letter in which he had denied being in a relationship with [Dr S] – a statement that is not true.

---

[26] A tablet containing rizatriptan that is placed under the tongue
[27] A corticosteroid
[28] A sleeping pill

[52] The PCC also referred to issues with [Dr S'] credibility in light of her previous untrue denials that she was in a sexual relationship with [Mr D], and noted Dr Jansen's report of her description of her relationship with [Mr D] is at odds with the agreed summary of facts and her admissions.

[53] For the practitioner, Mr Holloway noted that the only evidence to support particular 4 are the dispensing and prescribing records; there is no longitudinal history of [Dr S'] use of triptans and the PCC had not subpoenaed [Dr S'] GP or at least her notes.

[54] Mr Holloway noted that [Mr D] was prescribed triptans both before and after his relationship with [Dr S] and the clinical records show that he had been prescribed Imigran (which is a trade name for sumatriptan) injections in the past.

[55] Mr Holloway noted that:

(a) [Dr S] was prescribed no sumatriptan by her GP between June 2017 (when the PCC's records commence) and 25 June 2018.

(b) She was then prescribed sumatriptan on 25 June 2018, 16 October 2018, 7 December 2018, 19 December 2018, 16 January 2019 and 24 April 2019. Mr Holloway submitted that this coincides with the likely stress of the 2018 Tribunal proceeding and aftermath.

(c) She was prescribed sumatriptan on 27 November 2019, 18 February 2020 and 9 September 2020, all within the period it is alleged she was obtaining the same medicine from [Mr D].

[56] On the prescribing of diclofenac, Mr Holloway noted that [Dr S] prescribed this for [Mr D] in June 2019 and it became a regular medicine for him, continuing to have it prescribed by other doctors during 2021, as seen in prescribing records provided in the Agreed Bundle. [Dr S'] GP prescribed diclofenac on 18 February 2020 and celecoxib on 5 June, 30 July and 9 September 2020.

[57] Omeprazole was prescribed with diclofenac, which is normal. The omeprazole was not initiated by [Dr S]; Dr Gulbransen had prescribed it in October 2017. Throughout the relevant period, [Dr S] was prescribed this by her own GP.

[58] Mr Holloway submitted that the prescription of ondensatron for [Dr S] by her own GP was consistent with increased prescriptions of sumatriptan and the increased stress of her previous Tribunal proceeding.

Discussion

[59] The Tribunal agrees that the prescribing patterns for [Mr D] raise a valid question as to whether some of those medications were in fact for [Dr S'] own use. We also accept Mr Holloway's submission that we should be careful of speculation. The Tribunal decided that without further evidence the PCC has not established on the balance of probabilities that the prescribing of diclofenac, omeprazole, isotretinoin or fluticasone was intended for [Dr S'] own use. The Tribunal accepts Mr Holloway's submissions in relation to these medications.

[60] However, on the prescribing of sumatriptan tablets, the combination of a number of factors outlined below led us to the logical conclusion that they were more likely than not for [Dr S'] use.

(a) Throughout the period from June 2019 and September 2020, the triptans dispensed for [Dr S] were three prescriptions of 15 Sumatriptan tablets in November 2019, February 2020 and September 2020 and 6 Sumatriptan injectables in September 2020. During that same period the prescribing of triptans for [Mr D] was in excess of the recommended dosage of 30 tablets or equivalent per month on a number of occasions. Although the average over that time might not have been in excess, the data shows that during the four-month period of May to August 2020 where there were four simultaneous prescriptions (and dispensings) of rizatriptan and sumatriptan. The amounts are in excess of recommended prescribing for triptans on a month-by-month basis and over that four month period exceed the dose by over 100%, as seen in the table below:

Month	Rizatriptan (100mg)	Sumatriptan tablet (100mg)	Sumatriptan injectable	**Total**	**In excess by**	**%**
May 2020	20	30	**6**	56	26	86%
June 2020	20	30		50	20	66%
July 2020	50	30	**0**	80	50	166%
August 2020	30	30	**0**	60	30	100%
	120	120	**6**	**246**	**126**	**105%**

(b) Prescribing of rizatriptan and sumatriptan together is both unnecessary and contraindicated.

(c) [Mr D] had not been prescribed sumatriptan tablets previously, but [Dr S] had.

(d) The use of sumatriptan is not mentioned in [Dr S'] referral documents nor in Dr Laubscher's report following his assessment of [Mr D]. Rizatriptan was listed, and yet following receipt of the complaint from the Medical Council, [Dr S] deleted certain medications from [Mr D's] medication history, including rizatriptan. This is discussed further under particular 6.

[61] The Tribunal has decided that the logical conclusion from these facts is that the sumatriptan was prescribed for [Dr S'] own use. Therefore particular 4 a) is established. Particulars 4 b), c), d), e) and f) are dismissed.

Particulars 5 and 6: inadequate records and alteration of records

[62] Dr Holland provided a detailed analysis of [Dr S'] prescriptions, referrals and appointments for [Mr D] set out in a table. On more than one occasion four different medications were prescribed and on at least four occasions the prescriptions were handwritten. On 5 July 2019 there was a handwritten prescription for flucloxacillin, ondansetron, promethazine, melatonin. No Special Authority number for the melatonin was provided.

[63] [Dr S] accepted that between in or around June 2019 and 24 September 2020, she failed to maintain adequate medical records with respect to consultations and/or prescribing

to [Mr D] on approximately 9 occasions between 11 July 2019 and September 2020, as set out in Appendix B to the Notice of Charge (particular 5 a)).

[64] [Dr S] agreed that she failed to create any medical records for consultations and/or prescribing to [Mr D] on approximately 7 occasions between June 2019 and September 2020 as set out at Appendix C to the Notice of Charge (particular 5 b)).

[65] It was further accepted that [Dr S] failed to ensure that [Mr D's] medical records were accessible to other health practitioners by using Medtech's confidential function to hide medical records for consultations on 6 July 2020 and 9 September 2020, meaning only someone with [Dr S'] password could access these records (particular 5 c)).

[66] Finally, on 23 July 2019 [Dr S] retrospectively created medical records for a consultation with [Mr D] on 20 July 2019 when none previously existed (particular 5 d)).

[67] The factual allegations of particular 5 are therefore established. The significance of these failures is discussed below under "Grounds for discipline".

[68] Particular 6 concerns [Dr S'] alteration of records after the Medical Council notified her on or about 9 October 2020 of the complaint about her alleged relationship with [Mr D]. She accepts that she made the retrospective amendments to his medical records, including adding more detail about chronic conditions and prescribing and that she added illness and injury classifications as set out in Appendix D to the Notice of Charge. Those are:

(a) On or about 12 October 2020 [Dr S] updated [Mr D's] "classifications" to include asthma, allergic rhinitis and cervical spondylosis and radiculopathy.

(b) On or about 14 October 2020 [Dr S] made the following addition to the notes:

> [Mr D] transferred to Dr G's surgery in Dec 2019 and so has medical records there regarding his cervical spondylosis with neuropathic pain, also regarding his migraines, eczema, asthma, shoulder and ankle pain. He has started on Nortriptyline for migraine prophylaxis by the GP there. He was also given anti-inflammatories and more migraine medication. He knows to only see hi GP there in the future rather than to request prescriptions from us in the future.

(c) On or about 16 February 2021 [Dr S] added to the 23 December 2019 clinical record:

> Patient transferred to Dr G's surgery in [location] in December 2019 who have clinical records of his visits since this date. His Musculoskeletal Specialist Dr Keith Laubscher sent his MRI scan report and specialist letters to Dr G's Surgery in January 2020.

[69] Particular 6 is established.

Particular 7: breach of conditions

[70] Particular 7 concerns the breach of conditions imposed by the Medical Council in accordance with the Tribunal's order under section 101(1)(c) of the Act in its 28 November 2018 decision:

> *That for the period of three years thereafter the practitioner not self-prescribe or prescribe or treat her family members, being those referred to in the particulars of the Charge and any other partner or children she may have at that time. Compliance with this condition may be monitored by the MCNZ by obtaining dispensing information from the Ministry of Health every 3 months.*

[71] [Dr S] accepts that by prescribing for and providing care to [Mr D] she breached the conditions imposed on her practising certificate. Particular 7 is established.

Grounds for discipline

[72] In the Agreed Summary of Facts, the parties had agreed that admitted facts, (those covered by particulars 1 to 3 and 5 to 7) amounted to professional misconduct. Despite admissions by the practitioner, the Tribunal must still be satisfied that the test for professional misconduct is met and must make findings about particular 4 (a), the prescription of sumatriptans for [Dr S'] own use.

[73] The Tribunal's grounds for discipline of a health practitioner are found in section 100(1) of the Act. For particulars 1 to 6, the PCC relies on paragraphs (a), (b), saying that conduct amounts to professional misconduct. The breaches in particular 7 fall under paragraphs (f) and (g):

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

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

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

…

(f) the practitioner has failed to observe any conditions included in the practitioner's scope of practice; or

(g) the practitioner has breached an order of the Tribunal under section 101.

[74] Determining professional misconduct under sections 100(1)(a) and (b) is approached in a two-step test:[29]

(a) The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can reasonably be regarded by the Tribunal as constituting malpractice and/or negligence and/or conduct having brought or likely to bring discredit to the profession;

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

[75] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct",[30] and as:

> *1. Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer … 2. Gen. A criminal or illegal action: wrong doing, misconduct."*[31]

---

[29] *F v Medical Practitioners Disciplinary Tribunal* [2005] 3NZLR 774, subsequently confirmed in the High Court on appeals from the Health Practitioners Disciplinary Tribunal, see for example *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [16].

[30] *Collins English Dictionary* 2nd Edition. Definition accepted in many cases, including *Leach* 389/Nur11/179P and *Rodrigues* 384/Ost11/173P.

[31] *New Shorter Oxford English Dictionary* (1993 edition) See paragraph 34 of *Jackson* (Decision No. 35/Nur35/20P

[76] A finding of negligence requires the Tribunal to determine:[32]

> Whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal.

[77] The Tribunal has adopted the test for bringing, or likely to bring "discredit to the practitioner's profession" from the High Court decision on appeal from the Nursing Council. The Tribunal must ask itself:[33]

> … whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good-standing of the [profession] was lowered by the behaviour of the [practitioner] concerned.

[78] The second step in assessing professional misconduct requires the Tribunal to be satisfied that the practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the practitioner. In *F v MPDT*[34] the Court of Appeal expressed it this way:

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

[79] This was further discussed in *Martin v Director of Proceedings* where the High Court said:[35]

> … While the criteria of "significant enough to warrant sanction" connotes a notable departure from acceptable standards it does not carry any implication as to the degree of seriousness. Given the wide range of conduct that might attract sanction, from the relatively low-level misconduct to misconduct of the most reprehensible kind, the threshold should not be regarded as unduly high. It is certainly a threshold to be reached with care, having regard to both the purpose of the HPCAA and the implications for the practitioner, but the measure of seriousness beyond the mere fact that the conduct warrants sanction is a matter to be reflected in penalty. The degree of seriousness does not form part of the Tribunal's inquiry at the second stage of the two-step process.

---

[32] *Cole v Professional Conduct Committee* [2017] NZHC at [41]

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

[34] *F v MPDT* [2005] 3 NZLR 774 at [80]

[35] *Martin v Director of Proceedings* [2010] NZAR 333 at [32]

[80] More recently the position has been summarised in *Williams*,[36] where the following conclusion was reached:

> …The Tribunal must assess whether the departure from acceptable standards has been significant enough to warrant a finding of professional misconduct against the practitioner. It should bear in mind that a finding of professional misconduct carries considerable stigma. It sends a very strong message about the practitioner's failure to properly discharge his or her professional responsibilities. An adverse finding will likely be keenly felt by the practitioner, and it will inevitably be noted by his or her peers. A finding of professional misconduct is a significant matter, which is reserved only for serious conduct. [37]

[81] And in *PCC v R*,[38] a decision issued a week after *Williams*, Powell J in overturning a Tribunal decision observed:

> It is after all a threshold rather than a substantive hurdle, and it is not necessary to show that the respondent's conduct was as serious as that of others that have received penalties. I note in particular that in addition to protecting the public and punishing the practitioner, a penalty can provide clarity to the profession and assist the practitioner through the imposition of conditions on practice.

[82] Findings under paragraphs 1(f) and (g) are more straightforward. This Tribunal has previously noted:[39]

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

[83] This is the same approach as charges of practising without a practising certificate. These "strict liability" offences are simply a matter of fact, the severity of which may be considered at the penalty stage.

Relevant standards

[84] The PCC referred the Tribunal to:

---

[36] *Williams v Professional Conduct Committee* [2018] NZHC 2472 at [36]

[37] Footnotes included in the original: *Collie v Nursing Council of New Zealand [2001] NZAR 74*; *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [30]–[31*]. Vatsyayann v Professional Conduct Committee* HC Wellington CIV-2009-485-259, 14 August 2009 at [8]; and *Johns v Director of Proceedings [2017] NZHC 2843* at [69]. *Cole v Professional Conduct Committee of the Nursing Council of New Zealand [2017] NZHC 1178* at [45]

[38] *PCC v R* [2018] NZHC 2531 at [31]

[39] *Harypursat* 975/Med18/413P

(a) *Good Medical Practice* 2016 which contains the standards "which the public and profession expect a competent doctor to meet"

(b) *Sexual boundaries in the doctor patient relationship* (November 2018)

(c) *Professional boundaries in the doctor-patient relationship* (November 2018)

(d) *Statement on providing care to yourself and those close to you* (November 2016)

(e) *Good prescribing practice* (November 2016)

[85] The first established particular is that [Dr S] entered into a close personal and sexual relationship with [Mr D] who was a patient and that [Dr S] knew or ought to have known that he had been diagnosed with depression and anxiety and PTSD.

[86] The PCC referred to a number of cases where the Tribunal has found professional misconduct for conduct similar to some of the particulars in this case. They are referred to under Penalty.

[87] For the practitioner, Mr Holloway did not resist a finding of professional misconduct.

[88] Irrespective of any diagnoses of depression or anxiety, the Tribunal has routinely upheld charges of professional misconduct for entering into sexual relationships with patients, for the reasons set out in the Medical Council's Statement on Sexual Boundaries in the Doctor-patient Relationship, the heading of which includes the following clear principles:

- Doctors are responsible for maintaining sexual boundaries in the doctor-patient relationship.
- There is an inherent power imbalance in the doctor-patient relationship which can result in breaches of trust.
- Sexual misconduct is an abuse of the doctor-patient relationship and can cause significant and lasting harm to patients.
- It is never appropriate for a doctor to engage in a sexual relationship with a patient.

[89] The Statement provides extensive guidance on this issue and paragraph 7 of the Statement reads:

Breaches of sexual boundaries are unacceptable

7. It is never appropriate for a doctor to engage in a sexual relationship with a current patient. The Council has a zero-tolerance position on doctors who breach sexual boundaries with a current patient. This is because:

(a) A breach of sexual boundaries in the doctor-patient relationship has proven to be harmful to patients and may cause psychological, emotional or physical harm to both the patient and the doctor.

(b) The doctor-patient relationship is not equal. Doctors can influence and potentially manipulate patients, so even if a patient has consented to a sexual relationship that is not a sufficient excuse. It is still considered a breach of sexual boundaries.

(c) Sexual involvement with a patient can impair your judgement about diagnosis or treatment because your emotions are involved. That may influence your decisions about seeking and providing good care to the patient.

[90] The Statement on Providing Care to Yourself and Those Close To You sets out clear prohibitions on the provision of care to family and others in certain circumstances and also provides reasons for not treating those with whom they have a personal relationship. This includes the following relevant guidance at paragraph 3:

3. Best practice involves clinical objectivity. Clinical objectivity can be compromised, however, when providing care to family members or those close to you. For example:

a. You may be inclined to care and treat problems that are beyond your skill or competence and/or be expected, or placed under pressure to do so by someone you are close to.

b. You may hold preconceived notions about the health and behaviour of someone you are close to, or make assumptions about that person's medical history or personal circumstances.

c. You or those close to you may be reluctant to discuss personal and sensitive issues, which could impact on their care and the clinical decisions that are made.

d. You may wrongly assume that you are aware of all relevant information about those close to you and that asking questions and taking a full history or conducting a medically indicated examination, is unnecessary.

e. You may not have all the relevant clinical information (records or notes) relating to your patient and this may result in poorer patient outcomes.

f. Your existing relationship, strong feelings for and attachment to that person may lead you to over treat or provide care beyond what would normally be provided. Conversely, you may trivialise a concern if you consider that the person you are providing care to is exaggerating.

[91] There is a risk of sub-optimal care because of the lack of objectivity that accompanies the treatment of those close to the medical practitioner. There is the potential to exploit the privileged position that medical practitioner holds by diagnosing or prescribing in circumstances that amount to abuse, and there is also the danger of being manipulated by the patient to provide care that does not meet with accepted practice, including prescriptions for medicines.

[92] The fact that [Mr D] had a history of depression and anxiety with PTSD makes [Dr S'] decision to enter into a relationship with him more serious. It is an aggravating feature of her conduct.

[93] The Tribunal found that Particular 1 on its own amounts to negligence in that it is a departure from professional standards. This was a significant departure from a standard which has a "zero-tolerance" of sexual relationships with patients. It was clearly unethical and is therefore malpractice and is also conduct likely to bring discredit to the profession and it is sufficiently serious to warrant a disciplinary finding and therefore found it amounted to professional misconduct.

[94] Particular 2 is the entering into a lease with [Mr D] to provide him with accommodation at her home in circumstances where he was a patient and [Dr S] had recently prescribed medication. Not all breaches of professional boundaries involve a sexual relationship. The Tribunal considered the gravity of the conduct in particular 2 on its own without particular 1.

[95] The Medical Council Statement, Professional Boundaries in the Doctor-patient relationship starts with the following statements in the heading:

- Doctors are responsible for maintaining appropriate professional boundaries in the doctor-patient relationship.
- It is usually considered unethical to accept gifts, monetary or otherwise from your patient.
- Financial dealings with patients (other than the fees for care provided) are generally unacceptable.

[96] Again, there is guidance on a number of issues and the first paragraph of the Statement also refers to the power imbalance:

> 1. There is an inherent power imbalance in the doctor-patient relationship. Your patient is vulnerable, whether seeking assistance, guidance or treatment. This can cause problems in different ways: in breaches of trust, non-therapeutic motives or incentives intended to benefit the doctor, and the development of inappropriate personal relationships.

[97] And paragraph 10 deals with financial transactions:

> **Financial transactions**
>
> 10. Financial transactions between a doctor and patient, other than the fees for care provided, may compromise the professional relationship. Your access to personal and confidential information about patients under your care could place you in situations that result in personal, monetary or other benefits to you or others.

[98] [Dr S'] decision to enter into a residential tenancy was a departure from accepted standards in that it was a breach of professional boundaries. There was the potential for financial exploitation as well as the risk of compromising the care provided. The Tribunal found it sufficiently serious to warrant a disciplinary sanction, albeit at the lower end of the scale of professional misconduct when considered in isolation from particular 1.

[99] Particular 3 concerns inappropriate prescribing. [Dr S] prescribed for [Mr D] when she was in a sexual relationship and a close personal relationship (particular 3 a)).

[100] The Medical Council Statement on Providing Care to Yourself and Those Close to you also contains some clear prohibitions on prescribing at paragraph 4 which include:

> a. Prescribing or administering medication with a risk of addiction or misuse.
>
> …

c. Prescribing controlled drugs as specified and described under the Misuse of Drugs Act 1975.

[101] The prescription of medications to a patient to whom she was providing accommodation (particular 3 b)) is also a breach of boundaries, and is probably subsumed by particular 2. [Dr S] provided accommodation to a patient. Therefore she was providing care to a patient who was also a tenant. That led to prescribing to her tenant. The real wrongdoing was in having the personal relationship with her patient.

[102] The prescribing of controlled drugs, tramadol and oxycodone which carry a risk of addiction or misuse as found in particular 3 c) in itself may have been negligent. However, to prescribe such medications to someone close to the medical practitioner is a clear breach of the Medical Council Statement as outlined above. It is a significant departure from accepted practice and amounts to negligence.

[103] The prescribing of the triptans in excess of the recommended dose is also negligent. The combination of the conduct in particulars in 3(a), (b), (c) and (d), is sufficiently serious to warrant a disciplinary sanction and amounts to professional misconduct.

[104] The Tribunal found that [Dr S] prescribed Sumatriptan for [Mr D], intending it for her own use (Particular 4 (a)). That prescribing was also found to amount to negligence, malpractice and conduct likely to bring discredit to the profession and is sufficiently serious to warrant a disciplinary sanction.

[105] Particular 5 concerns inadequate records and alteration of records. There are two relevant Medical Council Statements. "Managing Patient Records" sets out the reasons clinical records are important:

> Patient records reflect a doctor's reasoning and are an important source of information about a patient's care.
>
> Patient records are a crucial part of medical practice. They help ensure good care of patients and clear communication between doctors and other health practitioners.

[106] The statement goes on to set out requirements which include clear and accurate patient records that note: a clinical history, relevant clinical findings, results of tests and

investigations ordered, information given to, and options discussed with, patients, decisions made and the reasons for them, consent given, requests or concerns discussed during the consultation, and the proposed management plan and follow-up.

[107] The PCC also referred to the Statement on Good Prescribing Practice, which requires doctors to keep "a clear, accurate and timely patient record containing all relevant clinical findings; decisions made; adverse drug reactions…; information given to the patient about the medicines and any other treatment prescribed".

[108] Dr Holland's evidence was that it is usual practice to indicate whether a prescription is a repeat arranged by phone without a face to face contact, or the result of a dedicated phone (virtual) consultation with the patient. Making such a record establishes that a repeat without seeing a patient has been responsibly considered and it serves to distinguish a repeat prescription from a consultation where the patient was seen, but the doctor has failed to make a record for the consultation.

[109] The Tribunal accepts the PCC submission that even if there is some reference to the consultation or treatment in another part of the practice computer system, for the records in question there was no, or very little, surrounding context as to why a particular treatment had been provided. The Tribunal agrees with Dr Holland's opinion that the overall quality of the clinical notes is "poor and well below acceptable standards for a general practitioner" and "the absence of adequate records for consultations increases the risk of mismanagement especially where others are involved in the care."

[110] Ms Miller drew attention to the clinical record for 18 November 2019 when [Mr D] had been hit by a sharp piece of metal requiring suturing. In submissions made to the PCC [Dr S] had noted that she had provided antibiotic from a supply on premises so that [Mr D] would not have to pay for a prescription. This was not recorded in the original record. The Tribunal accepts Dr Holland's opinion that [Dr S] notes showed "inadequate recording of dispensing".

[111] There were also 7 occasions when [Dr S] made no record at all of the treatment provided (particular 5 b)). Prescriptions were provided without any corresponding medical record. It was therefore impossible for another practitioner (or [Dr S] herself) to consider that treatment when providing further treatment. This included two occasions when tramadol

was prescribed. The Tribunal agrees that these omissions created an unnecessary risk to [Mr D]. [Dr S'] failures were negligent.

[112] [Dr S] also used the confidential function on records for consultations with [Mr D] on 6 July 2020 and 9 September 2020 (particular 5 c)). This meant that [Dr S'] password was required to access the records. There is nothing to suggest that this confidential function was being used to protect [Mr D's] interests and so it naturally raises speculation about [Dr S'] motivation. As Dr Holland noted, it "could be construed as a naïve attempt to cover the lack of notes with a deception that the relevant clinical records were present but not accessible," or it may have been improperly used to bypass some charges for the patient, which is not its intended purpose. And as Ms Miller submitted, it may have been an attempt to obscure her consultations with [Mr D]. In fact there were no notes made for these patient contacts. It was an inappropriate use of the function.

[113] Finally, on 23 July 2019, [Dr S] created a clinical record for a consultation that took place on 20 July 2019. It was therefore not a contemporaneous record. This was poor practice and negligent.

[114] The Tribunal found that the inadequate recording as alleged in 5(a) amounts to negligence. On its own this sub-particular may not reach the disciplinary threshold, but particular 5(b), which is the absence of records for consultations, is negligent and sufficiently serious to warrant a disciplinary sanction. The use, without any explanation, of using the Medtech's confidential function to hide medical records as particularised in particular 5(c) is poor practice and again may on its own amount to professional misconduct. Similarly, the completion of the record on 23 July for a consultation on 20 July is poor practice and a departure from accepted practice and therefore is negligent. The Tribunal found that the failings in the clinical records cumulatively, as set out in particular 5, are sufficiently serious to warrant a disciplinary sanction and reach the threshold of professional misconduct.

[115] Particular 6 concerns alteration of records, making retrospective amendments, adding more details and adding illness and injury classifications. Although [Dr S] was not charged with an intent to mislead the Medical Council, the charge is framed in the context of her having been advised on or about 9 October 2020 by the Medical Council of the complaint

about her alleged relationship with [Mr D], and then 3 and 5 days later, making some alterations, and again on 16 February 2021.

[116] The Tribunal accepts the PCC submission that the retrospective amendments were not for clarification or to correct errors but were made to minimise and conceal [Dr S'] misconduct; the conduct was not simply naïve or unwise, but was deliberate and unethical.

[117] The Tribunal found that there was a departure from accepted standards and therefore the conduct is negligent, and also that it was unethical, and therefore amounts to malpractice. The Tribunal found that the alterations as particularised in particular 6 are sufficiently serious to warrant a disciplinary sanction, and so the conduct amounts to professional misconduct.

[118] And finally, as found in particular 7, [Dr S] breached the conditions that had been imposed by the Tribunal on 28 November 2018 because she prescribed and treated her partner [Mr D]; therefore she breached the order and did not comply with conditions, and so that is a ground for discipline under both sections 100(1)(f) and (g).

Penalty

[119] Section 101(1) of the Act provides:

> **101 Penalties**
>
> (1) In any case to which section 100 applies, the Tribunal may—
>
> (a) order that the registration of the health practitioner be cancelled:
>
> (b) order that the registration of the health practitioner be suspended for a period not exceeding 3 years:
>
> (c) order that the health practitioner may, after commencing practice following the date of the order, for a period not exceeding 3 years, practise his or her profession only in accordance with any conditions as to employment, supervision, or otherwise that are specified in the order:
>
> (d) order that the health practitioner be censured:
>
> (e) subject to subsections (2) and (3), order that the health practitioner pay a fine not exceeding $30,000:

[120] In *Roberts v Professional Conduct Committee,*[40] Collins J discussed eight relevant factors in determining an appropriate penalty in this jurisdiction. These factors have more been summarised in the decision of *Katamat v Professional Conduct Committee:*[41]

1. most appropriately protects the public and deters others;
2. facilitates the Tribunal's "important" role in setting professional standards;
3. punishes the practitioner;
4. allows for the rehabilitation of the health practitioner;
5. promotes consistency with penalties in similar cases;
6. reflects the seriousness of the misconduct;
7. is the least restrictive penalty appropriate in the circumstances; and
8. looked at overall, is a penalty which is "fair, reasonable and proportionate in the circumstances".

[121] In the 2008 decision *A v Professional Conduct Committee*[42] Keane J discussed the penalties of cancelling and suspension:

> [81] First, the primary purpose of cancelling or suspending registration is to protect the public, but that 'inevitably imports some punitive element'. Secondly, to cancel is more punitive than to suspend and the choice between the two turns on what is proportionate. Thirdly, to suspend implies the conclusion that cancellation would have been disproportionate. Fourthly, suspension is most apt where there is 'some condition affecting the practitioner's fitness to practise which may or may not be amenable to cure'. Fifthly, and perhaps only implicitly, suspension ought not to be imposed simply to punish.

PCC submissions

[122] The PCC sought censure and cancellation, along with a condition that [Dr S] not be able to apply for re-registration for a period of 12 months. It was further submitted that [Dr S] should be asked to consent to a condition under section 102(1)(b) to undergo appropriate medical assessment.

[123] Alternatively, the PCC sought suspension for three years and sought conditions on [Dr S'] practice on her return.

---

[40] [2012] NZHC 3354 at [44] to [51]
[41] *Katamat v Professional Conduct Committee* [2012] NZHC 1633
[42] *A v Professional Conduct Committee* CIV 2008-404-2927, Auckland 5 September 2008

[124] The PCC emphasised certain aggravating features. The following are those extrinsic to the allegations within the charge:

(a) The misconduct took place over 18 months, with [Dr S] continuing to treat [Mr D] for a further year after entering into a sexual relationship, only stopping after the Medical Council had received a notification about the relationship.

(b) There was a sustained deception with [Dr S] repeatedly lying about the nature of her relationship with [Mr D] for 26 months:

  (i) First, she lied to the Medical Council in submission in October 2020 when she denied being in an intimate relationship with [Mr D], referring to him as a tenant and a friend.

  (ii) [Dr S] lied to her employer. [Dr Y] said in her witness statement filed on 6 December 2022 that [Dr S] had told her that the couple were friends and flatmates.

  (iii) [Dr S] repeated her lie throughout the PCC's investigation until December 2022.

(c) It is likely that [Mr D] lied to the Medical Council because [Dr S] made him aware that she intended to deny the relationship. Ms Miller referred to documents in the Agreed Bundle of Documents that indicate that only 3 days after [Dr S] was notified of the complaint to the Medical Council, [Mr D] presented to CADs (where the records refer to [Dr S] as his partner) and requested his file, saying that he needed them for his lawyer. The PCC suggests this shows [Dr S'] influence of [Mr D].

(d) [Dr S'] care of [Mr D] demonstrated the risks associated with providing care to someone close to you in that she failed to document the care provided or discuss preventative medication with him. The quantity and combination of medications prescribed was inappropriate and had the potential to cause him harm.

(e) [Dr S] has not learned from the previous disciplinary processes. Only 7 months after the Tribunal's earlier decision, she prescribed for [Mr D] with whom she had entered into a close personal relationship. And the Tribunal's November 2018

decision would have made her well are of the professional obligations in the Medical Council Statements. Ms Miller submitted that [Dr S'] inability to learn from her prior wrongdoing, and her lack of truthfulness and insight were demonstrated in the following submission made on her behalf to the PCC in November 2021:

> [Dr S] takes her responsibilities to the Medical Council very seriously and is well aware of the conditions in place. She has acted in strict adherence with them, being very much aware of the consequences of failing to do so.

(f) Previous monitoring has not prevented misconduct. [Dr S] has been involved in previous disciplinary processes and the Health Committee in relation to other incidents of inappropriate medication use:

  (i) Within 3 years of being registered as a doctor, [Dr S] was under the monitoring of the Medical Council's Health Committee for opiate and amphetamine abuse and abuse of alcohol. This monitoring continued for 5 years until 2022.

  (ii) For 9 months in 2013 [Dr S] was under further monitoring of the Health Committee following allegations of misuse of Duromine and Isotane.

  (iii) The current monitoring by the Health Committee has been in place since 2016 and continued after the Tribunal case in 2018.

(g) [Dr S] has relied on and referred to the same explanations she gave to the Tribunal in 2018 regarding her health and personal matters.

[125] The PCC recognised the following matters in mitigation:

(a) A belated acceptance of relevant facts in [Dr S'] signature of an agreed statement of facts on 8 March 2023, which meant some witnesses did not need to be summonsed and slightly reduced the length of the hearing.

(b) [Dr S'] health issues may have contributed to her poor decision-making.

[126] However, the PCC noted that in [Dr S'] submissions to the PCC in November 2021 it was said that since the 2018 hearing [Dr S] had committed to address her health issues, and "With dedication, and the support of family, friends, her employer and the Health Committee, [Dr

S] – three years on – is much changed from the person she was at the time of the Tribunal hearing. She is happy and healthy, she enjoys her work… is well regarded and has good relationships with her colleagues and patients there."

[127] Ms Miller submitted that [Dr S'] health was relevant but cannot be used to justify a penalty that continues to place her and the public at risk, especially given she has already had the benefit of attempted rehabilitation. Her evidence indicates that she might not currently be safe to practise. It was submitted that the measures put in place by the Health Committee and the Tribunal have not been sufficient to prevent further misconduct and harm.

[128] Ms Miller referred to the following excerpt from *Katamat*:[43]

> … the case law reveals that several factors will be relevant to assessing what penalty is appropriate in the circumstances. Some factors, such as the need to protect the public and to maintain professional standards, are more intuitive in their application. Others, such as the seriousness of offending and consistency with past cases, are more concrete and capable of precise evaluation. **Of all the factors discussed, the primary factor will be what penalty is required to protect the public and deter similar conduct.** The need to punish the practitioner can be considered, but is of secondary importance. The objective seriousness of the misconduct, the need for consistency with past cases, the likelihood of rehabilitation and the need to impose the least restrictive penalty that is appropriate will all be relevant to the inquiry. It bears repeating, however, that the overall decision is ultimately one involving an exercise of discretion. (emphasis added)

Practitioner submissions

[129] Although [Dr S] did not give evidence before the Tribunal, she had affirmed a document in relation to penalty. The Tribunal also heard from [Dr K] and Dr Jansen.

[130] [Dr S] outlined her own history with depression and anxiety, including eating disorders and unhappy relationships. The details do not need to be recorded here, but it was clear that by the age of 11, her mental health was suffering, and there have been a number of stressors in her life for which she has self-medicated from time to time.

[43] Above, note 2

[131] [Dr K] is [Dr S'] colleague. They have known each other since medical school and she holds [Dr S] in very high regard. She describes [Dr S] as an intelligent, conscientious and kind doctor, with a deep and broad medical knowledge and the skills to establish a warm and genuine rapport with all patients and staff members. [Dr K] said that because of her kind nature, [Dr S] has difficulty saying "No" to people who approach her in an aggressive or confrontational way. She described [Dr S] being upset in December 2022 when she was trying to extricate herself from her relationship with [Mr D]. [Dr S] had described [Mr D's] distress and she felt guilty that she could no longer support him. [Dr K] thought that [Mr D's] behaviour at this time sounded like manipulative and emotionally/psychologically abusive behaviour and [Dr S] was vulnerable to being exploited in this way.

[132] [Dr K] said she and [Dr Y] wanted to support [Dr S], and [Dr K] intended to invite [Dr Y] to her GP peer group. At the time of the hearing this had not occurred because of matters beyond [Dr S'] control.

[133] [Dr K] was aware of [Dr S'] previous appearance before the Tribunal and commented that at the time she and [Dr Y] were taken aback by the lack of support [Dr S] had received from her husband, who did not attend the hearing with her. That marriage has since ended.

[134] [Dr K] had also been aware of [Dr S'] relationship with [Mr D] and that he had been a patient. She said:

> I understood from what she said that it hadn't been an intense doctor-patient relationship, and that it had been sort of things like writing his sickness benefit form and a couple of scripts and that and a couple of accidents, sort of thing, and that once he had moved in to her place, that they felt, given her past history, that it would be safer for him to attend a different practice and a different doctor.

[135] Karl Jansen is a consultant psychiatrist. There was no dispute that he has the necessary expertise to provide his opinion on [Dr S'] mental wellbeing and in particular any mitigating factors. He provided a report based on his meetings with [Dr S] via audiovisual link on 31 December 2022 and 1 January 2023 and a review of her medical history. He summarised his findings:

> [Dr S] has long been a vulnerable person affected by low self-esteem, depression, anxiety, needing to please others, sleep issues, concern about her appearance and acceptability to others, migraines worsened by stress, and some impairment in her capacity to deal

> with difficult feelings which has sometimes resulted, in the past, in substance abuse issues and other unfortunate decisions.

[136] In Dr Jansen's opinion, [Dr S] has a recurrent mood disorder, and the depressive symptomology which comes with that has contributed to her poor decisions in this case. He assessed her as currently experiencing, "fairly severe depression" and "severe anxiety".

[137] For [Dr S], Mr Holloway submitted that this is a sad and tragic case, and her conduct should be seen in the context of recurrent depression and severe anxiety. [Dr S] accepted that the Tribunal may consider a period of suspension is appropriate. It was submitted that a return to work could be facilitated by:

(a) Requiring ongoing oversight by the Health Committee, which would require periodic review by a psychiatrist and/or psychologist with reports provided to the Committee.

(b) Requiring an additional ongoing therapeutic relationship with a psychiatrist whose role would not be to provide reports to the Health Committee (although they would remain subject to section 45 of the Act.

(c) Limiting [Dr S'] work to the [Health Centre] (or another practice pre-approved by the Medical Council)

[138] Referring to [Dr S'] affidavit evidence, Mr Holloway noted that the 2018 proceeding led to the slow undoing of [Dr S'] marriage, which left her vulnerable, lonely and unwell again. At this low point she succumbed to the advances of a patient, [Mr D]. When the relationship was suspected and reported to the Medical Council, [Dr S] did not have the resilience to face up to the truth. She despaired at the thought of another Tribunal proceeding and losing one of her few friends. She regrets her decision immensely. In fact the relationship was in some ways toxic and it was only once it was forced out in the open that [Dr S] felt sufficiently supported to ask [Mr D] to move out of her home and cease using her money.

[139] Mr Holloway submitted that there are no concerns about [Dr S'] general competence, that she can stay well and work safely. This process will allow her to properly grapple with her mental health and seek care beyond the Health Committee clinicians whose periodic reviews [Dr S] did not find therapeutic.

Discussion

[140] Similar cases referred to by the parties were:

(a) Sexual relationships and breaches of professional boundaries with current/former patients: *Dr Bennett*,[44] *Dr L,*[45] *Dr N,*[46]*Dr M*.[47]

(b) Providing care within a close personal relationship: *Dr E*[48] and *Dr M.*[49]

(c) Breaching conditions on practice: *Dr Harypursat.*[50]

[141] The Tribunal has considerable sympathy for [Dr S] in light of her personal background outlined in her affidavit, and in Dr Jansen's report. [Dr S] had been under the oversight of the Health Committee and the Tribunal recognises the limitations [Dr S] would have felt in forming a fully trusting therapeutic relationship with a medical practitioner who is required to report to the Medical Council. [Dr S'] fragile mental health may well have made her more vulnerable to breaching her professional boundaries by forming a relationship with a patient. The Tribunal does not need to find that [Mr D] was in any way persistent in his pursuit of [Dr S].

[142] However, the Tribunal has considerable concerns about [Dr S'] "fitness" to practise as a doctor at present. As noted in previous cases, "fitness to practise" includes a consideration of whether the practitioner's conduct was immoral or unethical[51] and a consideration of character.[52]

[143] [Dr S'] lack of "fitness" relates to a history of dishonesty with her professional regulator, the investigating body and her colleagues, as outlined by the PCC. [Dr S] has continued to be inconsistent in her characterisation of her relationship with [Mr D]. In Dr Jansen's report he says that [Dr S] "did have concerns about [Mr D] having been an ex-patient when they started the relationship". Dr Jansen talked about the combination of psychological and psychiatric

[44] 1148/Med20/488P
[45] Med20/489P
[46] Med12/230P
[47] 487/Med12/215P
[48] 136Med07/76D
[49] 941Med17/382P
[50] 975Med18/413P
[51] *Murdoch* 6/Phys06/45P
[52] *Pellowe* 137/Phar/07/74P

issues reducing [Dr S'] capacity to resist pressure from [Mr D] to commence a relationship. [Drs Y] and [K] also had an impression of [Dr S] being manipulated and even financially exploited. And yet, [Dr S] also told Dr Jansen that she had unwillingly ended the relationship on or about 30 December 2022 only so that she could keep her registration.

[144] [Dr S] has also shown herself unable to comply with conditions imposed on her practising certificate as a result of previous disciplinary action.

[145] [Dr S] was described by her colleagues as being a competent doctor, and yet over the period of the conduct covered in the charge, her conduct was not only unethical and breached professional boundaries but was negligent. She did not reach the standards expected of a reasonable general practitioner in her prescribing or record-keeping. Her care of [Mr D] was not that of a competent doctor.

[146] Although [Dr S] may not have found her engagement with the Health Committee process helpful for rehabilitation, that did not prevent her from seeking her own mental health support or intervention.

[147] In imposing the following penalty, the Tribunal took into account the totality of the conduct. A sexual relationship with a patient frequently, but not always, leads to suspension or cancellation of registration. Not only did [Dr S] breach professional boundaries in a significant way by entering into a sexual relationship with a patient, her conduct in altering patient records was dishonest and unprofessional, and she prescribed inappropriately. She also breached the conditions imposed by the Medical Council following by the Tribunal's orders. This is her second appearance before the Tribunal.

[148] With the protection of the public in mind, the Tribunal wanted to ensure that [Dr S] took some steps in her rehabilitation before she returns to providing services to patients. If a term of suspension is imposed, conditions may be imposed only upon her return to practice, whereas cancellation enables the Tribunal to impose pre-conditions to her reapplication for registration. In this instance rehabilitation includes ensuring she is "fit" to practise in all senses, including being mentally fit. It is important that any psychological issues do not impair judgement not only in the treatment of patients but also in maintaining the reputation of the profession. It is hoped that she will be assisted to reflect on the underlying

causes of her inability to comply with conditions and at times lie to her colleagues and regulator.

[149] The Tribunal therefore imposes the following penalty on [Dr S]:

(a) Cancellation of the practitioner's registration under section 101(1)(a).

(b) Under section 102(1)(a) she is not to apply for registration for a period of 12 months from the date of this written decision.

(c) Two conditions under section 102(1)(b) that before she applies for registration, [Dr S]:

(i) must undergo a psychiatric assessment with a psychiatrist of her choosing approved by the Medical Council, the psychiatrist to confirm [Dr S'] engagement with the therapeutic process and her engagement with any recommendations for counselling or other medical treatment.

(ii) complete an education programme designed to address medical ethics, sexual and professional boundaries and clinical record-keeping, and on completion of that, to provide proof of learning including a formal self-reflection to the Medical Council.

(d) [Dr S] is censured under section 101(1)(d).

Costs

[150] Under section 101(1)(f), the Tribunal may order a contribution to costs where a charge has been upheld. The general legal principles which apply to costs against professional people facing disciplinary charges include:

(a) The fact that professional groups ought not to be expected to fund all the costs of the disciplinary regime; and members of the profession who come

before disciplinary bodies must be expected to make a proper contribution towards the costs of the inquiry and hearing;[53]

(b) Costs are not in the nature of a penalty or to punish;[54]

(c) The practitioner's means should be taken into account;[55]

(d) A practitioner has a right to defend himself or herself;[56]

(e) The level of costs should not deter other practitioners from defending a charge;

(f) The starting point for a reasonable order of costs is 50% of reasonable costs, and that in some circumstances downwards or upwards adjustment will be appropriate. [57]

[151] The 50% starting point may be increased or decreased taking into account various factors, including:

(a) the way in which the parties have conducted themselves, including whether any party unnecessarily prolonged the proceedings (including the hearing time) with meritless arguments or irrelevant evidence;

(b) whether there were any novel points that merited further argument and determination, even if eventually unsuccessful;

(c) the health practitioner has produced satisfactory evidence of their limited financial position or inability to pay any award; and

(d) part of the charge was not established or a charge or particulars were withdrawn and costs can be attributed to that charge or particular.

[152] The PCC provided an estimate of costs based on a three-day hearing, totalling $131,000, and the Tribunal's costs were estimated at $72,944.61 based on a four-day hearing.

[153] The PCC submitted that an order in the region of 40% of costs was appropriate, whereas Mr Holloway submitted it should be a lower percentage, noting that since December

[53] *G v New Zealand Psychologists Board* HC Wellington, CIV-2003-485-2175, 5 April 2004, Gendall J; *Vasan v Medical Council of New Zealand* AP 43/91, 18 December 1991.

[54] *Gurusinghe v Medical Council of New Zealand [*1989] 1 NZLR 139 at [195].

[55] *Kaye v Auckland District Law Society* [1988] 1 NZLR 151.

[56] *Vasan v Medical Council of New Zealand* AP 43/91, 18 December 1991.

[57] *Cooray v Preliminary Proceedings Committee* (Unreported, High Court Wellington Registry, AP 23/94)

or January [Dr S] had admitted the charge. Mr Holloway submitted that on the whole [Dr S] "has not driven costs into the proceedings."

[154] The Tribunal agrees that there is nothing in [Dr S'] conduct that would give rise to more than a 50% contribution. On the other hand, she did not plead guilty at the earliest opportunity. We have allowed a small reduction for her cooperation with an agreed summary of facts and not putting the PCC to proof on all matters, but the Tribunal did find [Dr S] guilty of one aspect of the denied conduct.

[155] The Tribunal orders a contribution of 40% of the PCC and Tribunal's costs. At the hearing this was calculated as $81,577.84, but that was on the basis of the estimate of the Tribunal's costs being based on the hearing lasting four days. Some adjustment has been made to sitting times itemised in that estimate and it has been reduced from $72,944.61 to $65,928.61. The total is therefore $196,928.61 of which 40% is $78,771.44.

Name suppression

[156] [Dr S] applied for name suppression.

[157] Section 95(1) of the Act provides that all Tribunal hearings are to be in public.[58] Section 95(2) provides:

> (2) If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on application by any of the parties or on its own initiative) make any 1 or more of the following orders:
> …
> (d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person.

[158] Therefore, in considering an application prohibiting publication, the Tribunal must consider the interests of the practitioner and the public interest. If we think it is desirable to make an order for non-publication, we may then exercise our discretion to make such an order.

[159] The public interest factors have been established:[59]

[58] This is subject to section 97 which provides for special protection for certain witnesses

[59] As set out in *Nuttall 8Med04/03P* and subsequent Tribunal decisions

(a) Openness and transparency of disciplinary proceedings;

(b) Accountability of the disciplinary process;

(c) The public interest in knowing the identity of a health practitioner charged with a disciplinary offence;

(d) Importance of free speech (enshrined in section 14 of the New Zealand Bill of Rights 1990); and

(e) The risk of unfairly impugning other practitioners.

[160] In the course of Dr Jansen's evidence he was asked about the possible impact of publication of [Dr S'] name. He considered it would raise her risks, which included the risk of suicide. On the basis of Dr Jansen's evidence about [Dr S'] mental health, Ms Miller obtained instructions from the PCC who consented to [Dr S] having permanent name suppression.

[161] In light of the risk of serious harm to [Dr S] and the PCC's consent to suppression, the Tribunal has decided that the public interests in publication, which are considerable, are nonetheless outweighed by [Dr S'] personal interests. It is desirable to order non-publication of the names and identifying details of [Dr S] and [Mr D] under section 95(2) of the Act. Those identifying details include the names of [Dr S'] colleagues, [Dr Y] and [Dr K] and the name and location of their practice.

Results and orders

[162] The Tribunal did not uphold the charge that fluticasone was in excess of the recommended therapeutic dose for one person or that the prescribing of diclofenac, omeprazole, isotretinoin, fluticasone and ondansetron was intended for [Dr S'] own use.

[163] The Tribunal found that [Dr S]:

(a) entered into a sexual relationship with her patient whom she knew suffered from anxiety and PTSD and she entered into a residential lease with him.

(b) prescribed medicines for [Mr D] with whom she was in a sexual and close personal relationship and provided him with accommodation; the medicines prescribed included controlled drugs, oxycodone and tramadol which have risk of addiction or misuse and the triptans were in excess of the recommended

therapeutic dose for one person; and the prescription of sumatriptan was intended for [Dr S'] use.

(c) failed to maintain adequate clinical records for her treatment of [Mr D]

(d) retrospectively altered clinical records

[164] The Tribunal upheld the charge of professional misconduct under section 100(1)(a) and (b) and found that she had breached conditions imposed on her scope of practice as a result of a Tribunal order, which amounts to a ground for discipline under section 100(1)(f) and (g).

[165] The Tribunal imposed the following penalty:

(a) Cancellation of the practitioner's registration under section 101(1)(a).

(b) Under section 102(1)(a) she is not to apply for registration for a period of 12 months from the date of the Tribunal's penalty decision dated 7 June 2023.

(c) Two conditions under section 102(1)(b) that before she applies for registration, [Dr S]:

(i) must undergo a psychiatric assessment with a psychiatrist of her choosing approved by the Medical Council, the psychiatrist to confirm [Dr S'] engagement with the therapeutic process and her engagement with any recommendations for counselling or other medical treatment.

(ii) complete an education programme designed to address medical ethics, sexual and professional boundaries and clinical record-keeping, and on completion of that, to provide proof of learning including a formal self-reflection to the Medical Council.

(d) Censure under section 101(1)(d).

(e) A contribution of $78,771.44 towards the PCC and Tribunal's costs which equates to 40% of the total costs of $196,928.61.

[166] Under section 95(2) there is an order prohibiting publication of the names and identifying details of:

(a) [Dr S]

(b) [Mr D]

(c) [Dr K]

(d) [Dr Y]

(e) [The Health Centre]

[167] Under section 157 of the Act the Tribunal directs the Executive Officer:

(a) To publish this decision and a summary on the Tribunal's website; and

(b) To request the Medical Council of New Zealand to publish either a 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 Feilding this 8th day of September 2023

T M Baker
Chair
Health Practitioners Disciplinary Tribunal

APPENDIX: NOTICE OF CHARGE[60]

Pursuant to sections 81(2) and 91 of the Act, the PCC charges that between on or around June 2019 and February 2021 [Dr S] acted in breach of her professional and/or ethical obligations in the following ways:

Inappropriate relationship with a patient

1. In June 2019 [Dr S] entered into a close personal relationship with [Mr D] and, in October 2019, [Dr S] entered into a sexual relationship with [Mr D] in circumstances where:
   (a) [Mr D] was a patient of [Dr S]; and/or
   (b) [Dr S] knew or ought to have known that [Mr D] had been diagnosed with depression and/or anxiety and/or PTSD; and/or

2. On or about 24 June 2020, [Dr S] entered into a lease with [Mr D] to provide him with accommodation at her home, in circumstances where:
   (a) [Mr D] was a patient of [Dr S]; and/or
   (b) [Dr S] had recently prescribed medication for [Mr D] (and/or in [Mr D's] name); and/or

Inappropriate Prescribing

3. Between 5 June 2019 and 24 September 2020, [Dr S] prescribed medications for [Mr D] and/or in [Mr D's] name as set out in **Appendix** A, in the following circumstances:
   (a) [Dr S] was in a sexual relationship and/or a close personal relationship with [Mr D]; and/or
   (b) From on or around 24 June 2020, [Dr S] was providing [Mr D] with accommodation at her home; and/or
   (c) The medicines prescribed included medicines with a risk of addiction or misuse and/or controlled drugs, namely oxycodone and tramadol; and/or
   (d) Some of the medicines prescribed, namely triptans and fluticasone, were in excess of the recommended therapeutic dose for one person; and/or

4. Certain of the prescriptions described at paragraph 3, namely those prescriptions for:

[60] As amended at the start of the hearing

a. sumatriptan; and/or
b. diclofenac; and/or
c. omeprazole; and/or
d. isotretinoin; and/or
e. Flixonase (fluticasone); and/or
f. ondansetron;

were for medicines intended to be obtained and/or used by [Dr S] herself; and/or were medicines used by [Dr S] herself; and/or.

Inadequate and/or retrospectively created or altered medical records

5. Between in or around June 2019 and 24 September 2020, [Dr S]:
    a. failed to maintain adequate medical records with respect to consultations and/or prescribing to [Mr D] on approximately 9 occasions between 11 July 2019 and September 2020 as set out in **Appendix B**; and/or
    b. failed to create any medical records for consultations and/or prescribing to [Mr D] on approximately 7 occasions between 21 June 2019 and 24 September 2020 as set out at **Appendix C**; and/or
    c. failed to ensure that [Mr D's] medical records were accessible to other health practitioners by using Medtech's confidential function to hide medical records for consultations on 6 July 2020 and 9 September 2020, meaning only someone with [Dr S'] password could access these records; and/or
    d. created, on or around 23 July 2019, medical records for a consultation with [Mr D] on 20 July 2019 when none previously existed; and/or

6. On or around 9 October 2020 the Medical Council advised [Dr S] of the complaint about her alleged relationship with [Mr D] and sought her response. On or around 12 October 2020, 14 October 2020, and 16 February 2021 [Dr S]:
    a. made retrospective amendments to [Mr D's] medical records (as set out in **Appendix D**), including adding more detail about chronic conditions and/or prescribing; and/or
    b. added illness and/or injury classifications to [Mr D's] medical records.

The conduct alleged above in paragraphs one to six amounts to professional misconduct in that, either separately or cumulatively, it amounts to malpractice or negligence in relation to [Dr S']

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

Failed to observe conditions / breach of order of the Tribunal

7. Some or all of the prescribing described paragraph 3 above amounted to a breach of an order of the Health Practitioners Disciplinary Tribunal made on or around 28 November 2018 under s 101(1)(c) of the Act, which imposed conditions on [Dr S'] scope of practice including, relevantly:

   That for the period of three years thereafter the practitioner not self-prescribe or prescribe or treat her family members, being those referred to in the particulars of the Charge and any other partner or children she may have at that time. Compliance with this condition may be monitored by the MCNZ by obtaining dispensing information from the Ministry of Health every 3 months.

The conduct alleged above in paragraph 7 is grounds on which a health practitioner may be disciplined under s 100(1)(f) and/or s 100(1)(g) of the Act.