NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

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DECISION NO	887/Med16/358P
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 LYNDA MARIE EMMERSON** of Whangarei, registered medical practitioner Practitioner

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HEARING held in Whangarei on 13 – 15 March 2017

TRIBUNAL: Mr K Johnston QC (Chair), Dr V Beavis, Dr B Howcroft, Dr J Kimber and Mr T Young (Members)

IN ATTENDANCE: Ms G Fraser (Executive Officer)
Ms J Kennedy (Stenographer)

APPEARANCES: Mr D La Hood and Ms A Garrick for the Professional Conduct Committee
Mr C Muston for the Practitioner

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Introduction

1. This case concerns a doctor who, by her own admission, wrote prescriptions for her [ ] and others in circumstances which contravened guidelines issued by the Medical Council of New Zealand, used methamphetamine and cannabis over a period of time during which she was practising, and consciously misled her professional body about her drug use.

2. The essential issue, as the Tribunal sees it, though not as it was seen, at the time of the hearing at least, by the PCC or the Practitioner, is whether the Tribunal can discharge its responsibilities to the public and the profession whilst allowing the Practitioner to maintain her registration as a doctor. In the end, we have concluded that we cannot, and that we have no option but censure the Practitioner and order the cancellation of her registration.

Charge

3. The Notice of Charge is dated 20 May 2016, and particularises the (two) charges of professional misconduct in these terms:

> *"**TAKE NOTICE** that a Professional Conduct Committee ("the PCC") established by the Medical Council of New Zealand ("the Council") pursuant to section 71 of the Health Practitioners Competence Assurance Act 2003 ("the Act") has determined in accordance with section 80(3)(b) of the Act that a disciplinary charge be brought against **Dr LYNDA EMMERSON**, medical practitioner of Whangarei.*
>
> *Pursuant to section 91 of the Act, the PCC has reason to believe that grounds exist entitling the New Zealand Health Practitioners Disciplinary Tribunal to exercise its powers under section 100 of the Act.*
>
> ***PARTICULARS OF CHARGES***
>
> *Pursuant to section 81(2) of the Act the PCC charges that:*
>
> ***Charge 1: prescribing medicine to family and friends***

Dr Emmerson committed professional misconduct as follows:

1. *Between on or about 1 September 2013 and 23 April 2015, Dr Emmerson prescribed medicine for [M] (…), [M's] mother (…) and her colleague (…) on the occasions set out in the* ***attached*** *Schedule*.

2. *In doing so, Dr Emmerson prescribed drugs of dependence to family members and a friend/colleague without appropriate monitoring or oversight.*

3. *The medicines prescribed by Dr Emmerson included Class B and Class C controlled drugs in accordance with the Misuse of Drugs Act 1975 as set out in the attached Schedule.*

4. *Dr Emmerson's conduct was in breach of her legal and ethical obligations including regulation 21(2) of the Misuse of Drugs Regulations 1977, regulation 39(1) of the Medicines Regulations 1984, and/or the Council's statements on Providing Care to Yourself and Those Close to You, Good Prescribing Practice, Good Medical Practice and/or Prescribing Drugs of Abuse.*

The conduct alleged above amounts to professional misconduct in that it:

(a) amounts to malpractice or negligence in relation to her scope of practice pursuant to section 100(1)(a) of the Act; and/or

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

Charge 2: personal drug use

Dr Emmerson committed professional misconduct as follows:

5. *While registered as a medical practitioner and practising as a Psychiatric Registrar, Dr Emmerson has engaged in recreational drug use, in particular:*

   (a) Dr Emmerson has used cannabis on a number of occasions, including in late November or early December 2015; and

   (b) Between January 2013 and April 2015, Dr Emmerson used methamphetamine on approximately six occasions.

6. *In December 2015, Dr Emmerson misled or attempted to mislead the PCC in relation to the full extent of her methamphetamine use, in that she stated she has used methamphetamine only once at the end of 2014.*

The conduct alleged above amounts to professional misconduct in that it has or is likely to bring discredit to the profession, pursuant to section 100(1)(b) of the Act."

4. The first charge is laid pursuant to s100(1)(a) and (b) of the Act. The second is laid pursuant to s100(1)(b) alone.

5. Sections 100(1) (a) and (b) provide that the Tribunal may impose a penalty on a practitioner if, following a hearing, it concludes 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 the 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 the conduct occurred …"*

6. Thus, the allegations made by the PCC are that the Practitioner's prescribing amounted to malpractice, negligence or conduct that has brought, or was likely to bring, discredit to the profession, and her drug use and lack of candour about it also brought, or was likely to bring, the profession discredit.

Evidence

7. The PCC called two witnesses, Ms Deborah Telford, the Convenor of the PCC, and Dr E, a [ ] who was employed by the Northern District Health Board during the time that the Practitioner was also employed there. The PCC filed and served a bundle of documents consisting of 37 documents, and running to 428 pages. The PCC witnesses also produced additional documentation during the course of the hearing.

8. The Practitioner gave evidence. Prior to the hearing she had filed and served proofs of evidence from two other potential witnesses. The PCC objected to the Practitioner calling the evidence foreshadowed in these proofs of evidence on broad relevance grounds. Having heard from the parties, the Tribunal ruled on this objection, permitting the Practitioner to call the witnesses, but directing that their evidence be led viva voce and that only evidence which was relevant to the issues in the case was to be led. In the end, in addition to giving evidence herself, the Practitioner called only one other witness, Dr Joanne Holdaway who, like Dr E, is a [ ]. She was employed by the Northern DHB between February 2006 and January 2011, so before the Practitioner was employed there. She is now the Medical Director of Health at International Health & Medical Services based in Sydney. She gave evidence by means of an audio-visual link. The Practitioner filed and served two bundles of documents prior to the hearing. Together, these included 105 documents and ran to 522 pages. The Practitioner's witnesses also produced additional documentation during the course of the hearing.

9. The Tribunal therefore received in excess of 950 pages of documentary evidence. Some of this material was referred to by counsel or witnesses during the course of the hearing. The Tribunal has not considered any material not so referred to.

10. The parties attempted to agree on a statement of facts, but were unable to do so. However, the Practitioner helpfully filed and served what amounted to a formal admission. This was dated 20 September 2016 and signed by her. We set this out in full because its impact was significantly to reduce the scope of what was in issue.

> *"**ADMISSION OF FACTS BY PRACTITIONER***
>
> ***Professional background***
>
> *1. Dr Lynda Marie Emmerson graduated with an MB ChB from Otago University in 2012. Dr Emmerson was provisionally registered on 26 November 2012 and obtained registration in a general scope of practice on 27 November 2013.*

2. *Dr Emmerson was employed by Northland DHB and began working as a house surgeon at Whangarei Hospital in December 2012. In March 2014, she started working on the Tumanako (adult mental health inpatient) unit at Whangarei Hospital. In December 2014, she started work as a Psychiatric Registrar at Whangarei Hospital.*

3. *Dr Emmerson does not currently hold an annual practising certificate. Her practising certificate expired on 30 November 2015.*

Relationship with [M]

4. *Dr Emmerson [ ] [M] for approximately four years.*

[M]'s drug use

5. *In a written statement provided to the Professional Conduct Committee (**PCC**) on 10 December 2015, Dr Emmerson stated that when [ ] he briefly started using methamphetamine to cope with what was going on. At paragraph [146] Dr Emmerson stated:*

> *"[M] is not addicted to any drugs. He has at times in his past used various drugs but [ ] the only time I was ever aware of him using anything beyond the odd joint of cannabis was when [ ] over a year before this incident. He used methamphetamine on and off for around 6 weeks. … [M] has no criminal record and he has no history of addiction or drug seeking behavior on his medical records".*

[M]'s medical history

6. *On 19 November 2015, [ ] Medical Centre provided the PCC Mr [M]'s medical records. Mr [M] enrolled at [ ] Medical Centre on 24 July 2015. Prior to that time, his GP was Dr [T] from [ ] Medical Practice.*

7. *Dr [T] had prescribed Mr [M] (amongst other things) DHC Continus, zopiclone, tramadol, diazepam, augmentin, salbutamol, and omeprazole.*

Prescription to [M]

8. *On 9 September 2013, Dr Emmerson prescribed Mr [M] 60 x 50 mg tramadol capsules, with two repeats.*

9. *On 20 June 2014, Dr Emmerson prescribed Mr [M] 240 x 50mg tramadol capsules.*

10. *On 21 November 2014, Dr Emmerson prescribed Mr [M] DHU Continus (dihydrocodeine tartrate) 120x60mg long-acting tablets, with two repeats.*

11. *On 22 February 2015, Dr Emmerson prescribed Mr [M] 30x5mg diazepam tablets.*

12. *On 1 March 2015, Dr Emmerson prescribed Mr [M] 30x5mg diazepam tablets.*

13. *On 20 April 2015, Dr Emmerson prescribed Mr [M]:*

    (a) *10x60mg long-acting M-Eslon (morphine sulphate) tablets with one repeat; and*

    (b) *20 x20mg immediate-release Sevredol (morphine sulphate) tablets with one repeat.*

14. *Morphine sulphate is a Class B controlled drug under the Misuse of Drugs Act 1975. Diazepam and DHU [sic] Continus (dihydrocodeine tartrate) are Class C controlled drugs pursuant to the Misuse of Drugs Act 1975. These medicines are drugs of dependence and/or abuse.*

15. *Between 16 February 2013 and 30 April 2015, Dr Emmerson also prescribed Mr [M] pantoprazole, omeprazole, amoxicillin, prednisone, ferrous fumarate, flucoxacillin, and salbutamol.*

16. *In her submissions to the Medical Council dated 21 May 2015, Dr Emmerson stated that she had attended several GP consultations with Mr [M], so she was aware of his medical history. Dr Emmerson stated that Mr [M] had previously been prescribed M-Eslon and Sevredol, and that is why she prescribed them again.*

Prescription to [EM]

17. *[EM] is Mr [M]'s mother.*

18. *On 2 September 2013, Dr Emmerson prescribed Ms [M] 20x1mg Lorazepam tablets, which had not previously been prescribed to her. She also prescribed amoxicillin.*

19. *Lorazepam is a Class C controlled drug pursuant to the Misuse of Drugs Act 1975. It is a drug of dependence and/or abuse.*

20. *On 1 October 2014, Dr Emmerson prescribed Ms [M] 240x50mg tramadol capsules. She also prescribed doxycycline.*

Prescription to [S]

On 22 April 2015, Dr Emmerson prescribed Lorazepam 1mg tablets to [S]. Ms [S] was a nurse [ ] a colleague of Dr Emmerson.

Recreational drug use

Hair test

21. *In June 2015, Dr Emmerson provided a hair sample to the Medical Council Health Committee. The hair sample related to the period between approximately 18 February 2015 and 19 May 2015. This sample detected 0.07 ng/mg of delta8-tetrahydrocannabinol in Dr Emmerson's hair.*

22. *The sample returned a negative result for methamphetamine."*

11. The Practitioner is clearly an intelligent and talented person. She is from Whangarei. She grew up and was schooled there. She attended university in Auckland and graduated with a double degree in commerce and law at the end of 1996. After a little time abroad, she was admitted as a solicitor and practised as such for eight years in Whangarei. At that stage, she decided on a career change, and returned to university, studying in Dunedin and Wellington, and graduating with a degree in medicine at the end of 2012, whereupon she gained provisional registration.

12. Having done so, the Practitioner secured a position with the Northland DHB as a House Officer. During 2013 she rotated through various areas of Whangarei Hospital. She achieved full registration towards the end of that year. Having developed an interest in psychiatry, the Practitioner sought and obtained a position in the psychiatric ward of the Hospital. Between March 2014 and May 2015 she was employed there, initially as a House Officer and then as a Psychiatric Registrar. She explained to the Tribunal that Dr E was the person with [ ] within the Hospital and that her – the Practitioner's – [ ] was a Dr T.

13. The Practitioner gave detailed evidence of how things progressed for her. She explained that the Hospital's psychiatric unit – Tumanako – was seeing evidence of patients' progress being impeded by poor physical health. She described how she

devoted a considerable amount of time to writing a detailed (95 page) report on this, including comprehensive recommendations. She produced a copy of her report. She said that the report and her *"…ongoing vocalization about safety issues…"* seemed to cause problems for Dr T and *"… as a result she effectively washed her hands of me and had very little to do with me despite the fact that she was meant to be my supervisor."* She said that Dr T variously ignored her, and belittled and humiliated her. Ultimately, the Practitioner complained to the MCNZ and the Royal Australian & New Zealand College of Psychiatrists about this. Her evidence was in effect that these complaints were not taken seriously.

14. Focusing on the issue of Dr T's [ ], the Practitioner outlined her understanding of what [ ] should involve, and contrasted this with what she experienced. Dr T not having been called to reply to these criticisms, we are prepared to accept the Practitioner's evidence that she did not receive optimum, or perhaps even adequate, [ ].

15. The Practitioner suggested that this was not merely a matter of a busy [ ] devoting insufficient time to [ ], but that both Dr E and Dr T had taken against her and become hostile. She instanced a meeting she had with Dr E towards the end of the first quarter of 2015 which was apparently part of a round of *"… catch-ups…"* which Dr E was having with all Registrars. The Practitioner described Dr E as being *"… unfriendly and distant…"* and the meeting as *"… weird…"*

16. The Practitioner said that during this meeting she was nevertheless able to raise her concerns about Dr T's [ ], and that, shortly thereafter, Dr T reintroduced formal [ ] sessions. However, she said that she would come out of these *"… confused and upset…"* and *"… feeling a total failure as a doctor."* She continued: *"To top it off she was still using every opportunity in ward interviews to belittle me in front of patients. I knew that my performance was getting worse and the things I was good at like talking with patients were becoming worse not better because I was so nervous of what she*

was going to do or say next. I had no idea and seemingly no way of dealing with a [ ] who dealt with me in that way. All I could do was try to deal with it with her."

17. The Practitioner concluded this section of her evidence by saying:

> *"Dr T [ ] if I spoke out about things. I became extremely cautious when I had to meet with her alone. The day after she threatened me I had to meet with her for [ ]. I recorded the session on my cellphone because I was scared going into it. Although there are no threats Dr T talks extensively about her [ ] as if reinforcing the message she gave me the previous day."*

18. The Tribunal has of course listened to the recording. It is not especially clear. There are some references to [ ], but, as the Practitioner says, no threats.

19. The Practitioner identified a [ ] conducted by Dr T on 3 April 2015 as evidence of a further deterioration in the relationship. She said that prior to this all [ ] had been positive. The records which the Tribunal has seen bear that out. In marked contrast, Dr T's [ ] of 3 April 2015 was anything but positive. In evidence the Practitioner said that, contrary to usual practice, this [ ] appraisal was never discussed with her, and she effectively asked us to accept that it was not legitimate, that is to say that it had not been prepared on – or was possibly changed after – that date so that it could be used in proceedings before the Employment Relations Authority (to which we will come). Her evidence was that she could demonstrate that it must have been prepared after 7 April 2015 because her input into the document was in part based on material downloaded from the internet on 6 April 2015 and she put the document into Dr T's in-tray for completion on 7 April 2015. She added that 3 April 2015, the date which the document bears, was, in any event, Good Friday, that Dr T was not at work, and that she – the Practitioner – was on call all day. Of course, the explanation for all this might simply be that the document was originally dated 3 April 2015 but not completed for some days, and the date was never changed.

20. In any event, as already signalled, matters came to a head shortly after this when the Hospital received a complaint about aspects of the Practitioner's conduct. The Hospital investigated the complaint, and the outcome was that in May 2015 the Practitioner's contract of employment was terminated.

21. The Practitioner unsuccessfully pursued a personal grievance and the decision of the Employment Relations Authority was in evidence before the Tribunal. Indeed, Mr La Hood submitted that we were entitled to and should treat certain findings of fact in the ERA decision as evidence. We have of course read the decision. We do not think we need to rely on it in the way suggested. For completeness, we record that we were told by the Practitioner during the course of this hearing that she regarded the process adopted by the ERA as unfair, and had filed an appeal. Since the hearing, the Tribunal has become aware that the Practitioner's appeal has been dismissed by the Employment Court (though neither the Chair nor any other member of the Tribunal has read the Court's judgment).

22. In the course of giving evidence the Practitioner addressed the specific allegations contained in the Notice of Charge.

23. Insofar as the two prescriptions she wrote for [Ms M] in September 2013 and October 2014 are concerned, the Practitioner offered very little in the way of explanation, saying that she had had a good relationship with [Ms M] in the past but that that relationship was currently strained and she did not have permission to discuss her medical background or the circumstances in which the prescriptions were written. She told us that [Ms M] was generally distrustful of the medical profession as a result of events surrounding her late husband's death, and reluctant to go to her GP. She told us that on both occasions she had taken a history, examined the patient, and documented her findings before writing the prescription.

24. With respect to the allegations concerning prescribing for [M], she began by explaining [ ].

25. She said that [M] had been attending a GP on a regular basis – which is certainly borne out by his medical records which were produced in evidence. She gave details of [M's] various medical conditions which it is unnecessary to go into here.

26. She explained that [M's] GP had left Whangarei at the end of 2013, and that he did not *"… like the other doctors in the practice and was reluctant to see any of them."* She explained that, in addition to this, he, like his mother, and for the same reason, was distrustful of the medical profession. She said that she had encouraged [M] to establish a relationship with a new GP, but that he was disinclined to do so.

27. The Practitioner reiterated her admission that between September 2013 and April 2015 she had written the seven prescriptions (including for drugs of dependence) identified in the Notice of Charge for [M]. She said that on each occasion she had taken a history, examined him and made proper notes.

28. Referring specifically to the prescription written on 20 April 2015 for controlled drugs, she told the Tribunal that [M] was in *"… reasonably severe pain…"* after hurting his back at work on Friday 17 April 2015. She said that his pain worsened during the course of the weekend, that she had encouraged him to go to the hospital's accident and emergency department, but that he was reluctant to do so. She explained that she was worried about him, and, on Monday 20 April 2015, she returned home during the day to check on him. She said that she carried out a full assessment and documented her findings on her laptop. She said that she concluded that he needed stronger pain relief but was unsure about how to go about prescribing this for him. She said that before prescribing she checked her own copy of *Cole's "Medical Practice in New Zealand"*

(which she acknowledges was out of date) to ensure that it was not unethical for her to do so. She gave evidence, which we accept, that her edition of the text led her to the conclusion that prescribing for [M] *"... wasn't expressly prohibited."* She did not check the then current MCNZ guidelines. The guidelines were produced in evidence. Without going into detail, they provided then, as they do now, that practitioners should not, except in emergencies, prescribe or administer drugs – especially drugs of dependence (such as morphine sulphate, diazepam, DHC Continus, lorazepam and tramadol) – to anyone with whom he or she has a close personal relationship. The Tribunal's understanding is that the Practitioner now accepts that her prescribing as particularised in the Notice of Charge was contrary to these guidelines. Upon returning to the hospital, she told us, she enquired of a nurse whether Tumanako held forms for controlled drug prescriptions, and, with the nurse, she looked in the drug safe and found these forms and the Controlled Drug Register. She apparently told the nurse that she was going to take one for a patient and asked her to countersign for it. She told us that she also explained that the patient was [M], and that neither she nor the nurse were sure whether she was following the right procedure. She said that she took the Register to the nurses' station and completed it there. The entry read *"20/4/15 1x To Subacute [NHI number]"*. There is then some information about stock levels and what appear to be the signatures of the Practitioner and a nurse. She said that after this the Nursing Shift Coordinator came into the nurses' station and she told her too that she was writing a controlled drug prescription and recording the patients NHI number in the Register, and asked her if she needed to do anything else. The Nursing Shift Coordinator was apparently unsure. She added that while she was talking to the Nursing Shift Coordinator, the Nursing Manager also came into the room. She said that she explained what she was doing to the Nursing Manager who confirmed that the course of action she was adopting was the correct one.

29. So, the Practitioner's evidence was that she had told three nurses that she was writing a controlled drug prescription and entering the patient's NHI number in the Register so that the patient was identifiable, and that she told at least one of these nurses that the prescription was for [M].

30. The Practitioner accepts that in terms of the hospital's processes and procedures she was not allowed to write a prescription for a controlled drug for a patient who was not on the ward, but said that she was unaware of that at the time.

31. It was common ground that the word "Subacute" indicated that the prescription was being written for a patient on the ward.

32. A colour photocopy of the Register was produced. On the face of the document it appeared that an attempt had been made to obliterate both the word "Subacute" and the NHI number. There was much debate during the course of the hearing about whether the entry in the Register was made in the terms that it was in an attempt to deceive anyone reading it into thinking that the intended recipient was a patient on the ward, and when, how and why sections of the entry were obliterated. The suggestion was made on behalf of the PCC was that this was done to disguise the person for whom the prescription had been written. The Practitioner maintained that she had written the word "Subacute" in error (because one of the nurses was using the word at the time) and then crossed it out immediately. She said that she had not crossed out the NHI number, and that what appeared to be a crossing out of the NHI number was in fact an ink blot. In this regard, she produced her diary for this period which was covered with blots of ink, and explained that, at the time, her fountain pen was not functioning correctly. After the hearing, the parties arranged for the original of the Register to be made available to the Tribunal. In the end, it became too difficult to arrange for all members to view the original together within a reasonable timeframe, and the decision was made not to view it at all. In any event, the Tribunal has heard no evidence from

a handwriting expert. The members of the Tribunal are ill-equipped to make any assessment of this. We are not prepared to speculate. We pass over this issue as a curiosity, and conclude that the PCC has not established to the necessary standard that the Practitioner set out to deceive with this entry in the Controlled Drug Register.

33. The Practitioner then explained that when she returned home that day she told [M] that she could not act as if she were his GP, and that he needed to make arrangements to get a new GP.

34. On 22 April 2015, the Practitioner wrote a prescription for lorazepam (a class C controlled drug) for a nurse on [ ].

35. The Practitioner gave evidence that she did not have the nurse's permission to discuss the background. Nevertheless, she told us that the nurse had asked her about obtaining a prescription, apparently for travel purposes, a week earlier and that she had encouraged the nurse to see her GP. Apparently, the nurse subsequently told her that she was having difficulties arranging to do so, and texted the Practitioner several times in the week before her departure saying that she needed a prescription. She then told us that her understanding was that after she had relented and written the prescription, the nurse had attended a pharmacy, dropped the prescription in, picked up the drugs, taken a photograph of the drugs as dispensed next to a newspaper identifying the date (this photograph was produced in evidence) and then returned the lorazepam to the pharmacist, which, it has to be said, all seems very odd.

36. The Practitioner told us that the nurse was close to Drs E and T, and was one of the staff who had subsequently made what she maintained was a false complaint about her, and asked the Tribunal to infer that Drs E and T and the nurse concerned had conspired to entrap her by persuading her to write the prescription in these circumstances.

37. No formal application was made to exclude this evidence. In any event, this is not a criminal trial. The Practitioner accepts that this prescription was written contrary to

MCNZ guidelines, and we propose to deal with the case on that basis, without reaching any conclusion about the motivations of those involved.

38. As already recorded, the Practitioner told us that she had made notes of the consultations which preceded her prescribing as referred to in the Notice of Charge. She produced notes which she said were made at the time of the consultations in 2015. She said that she could not provide the earlier notes because her laptop had been stolen in late 2014. There was some evidence about this. We do not need to outline it because this case is not primarily about whether or not the Practitioner's judgment was justified from a clinical perspective.

39. A good deal of evidence was led relating to the charges that the Practitioner had used methamphetamine and cannabis, and the circumstances in which the PCC became aware of her use of the former. With one exception, the Practitioner's admission renders this evidence irrelevant, and we do not propose to canvas it.

40. The exception concerns how the PCC became aware of the Practitioner's use of methamphetamine, and relates to paragraph 6 of the Notice of Charge in which it is alleged that the Practitioner misled the PCC.

41. It will be recalled that the Practitioner was employed by the Northern DHB between December 2012 and May 2015.

42. The evidence was that, following the Northland DHB complaint to the MCNZ, that complaint was referred to a Health Committee. The Committee engaged a Dr C.C. Page to advise in connection with those aspects of the complaint concerning the Practitioner's recreational drug use. Dr Page met with the Practitioner at an early stage. In evidence were passages from Dr Page's subsequent report to the Committee, and an e-mail to the Committee from the Practitioner directed at correcting what she said was an inaccuracy in that report.

43. Dr Page's report included the following:

> *"From 2013 Dr Emmerson was smoking methamphetamine, one or two points at the weekend around once every four to six weeks. The methamphetamine helped by improving her energy levels and lifting her mood and she would ensure that she used it only when she had four days off work. Dr Emmerson believed the last time she used methamphetamine would have been at Easter 2015 and that she did not intend to use anymore methamphetamine."*

44. The material section of the Practitioner's letter or e-mail written in response was in these terms:

> *"I used methamphetamine on Easter Saturday prior to that it was over the Christmas break – I do not know how much a point is but it was a small amount I used. I have sat down and tried to work out my methamphetamine use this week and have probably used methamphetamine on around six occasions in total over my entire life and this was in the period January 2013 to April 2015".*

45. It will be evident from that material that the Practitioner admitted to Dr Page using methamphetamine on *"…around six occasions…"* between January 2013 and April 2015, during which period she was engaged by the Northland DHB.

46. In fairness to the Practitioner it should be mentioned also that in the course of the Committee's investigation she underwent a drug test. The result of that drug test was in evidence. The test was conducted on 3 and 4 June 2015, and covered the period 18 February – 19 May 2015. The Practitioner tested negative for methamphetamine and positive for cannabis. All this means is that the evidence indicates that the Practitioner did not use methamphetamine during that three-month period.

47. Following its investigation, the Health Committee concluded that the Practitioner did not have an ongoing problem with drug use. It wrote to her on 18 September 2015 saying just that.

48. The PCC conducted its interview with the Practitioner on 16 December 2015, and the relevant section of the notes of interview (at paragraphs 69 – 73) is in these terms:

"69. Dr Emmerson admitted that she has a couple of smokes of cannabis on her own when she is stressed out. She said that this was also in relation to her chronic pain in her arm. She also stated that, when she was not working, she had used methamphetamine on one occasion. This was when Dr Emmerson and [M] had gone on holiday to Fiji at the end of 2014. She told the PCC that she was approached by a number of people from dodgy resorts offering to sell her methamphetamine.

70. Dr Emmerson was asked whether or not she had ever used methamphetamine in New Zealand. Dr Emmerson said that she had never used methamphetamine in New Zealand. Dr Emmerson then said to [M]: "I don't think I have, have I?" to which [M] said "no, not with me".

71. The PC then asked her why she asked [M] this question, and Dr Emmerson said that she just wanted to make sure.

72. She also stated that she had used cannabis around two to three weeks ago to cope with what was going on.

73. She explained that there was a time [M] was using methamphetamine regularly for around two to three weeks to cope with [ ]. She stated that [M] was not being very discreet about his methamphetamine use. Because of this she approached Dr Van Altvorst to notify her that [M] was using methamphetamine. Dr Emmerson explained that she and [M] had a [ ] when he was using methamphetamine and that they [ ]."

49. It is accepted by the Practitioner that this section of the record is an accurate reflection of the discussion.

50. So, despite her earlier admission to Dr Page, she told the PCC, when the issue was raised with her, that she had only done so on one occasion and that was while she and [M] were abroad. At that stage, the PCC did not have access to Dr Page's report or the Practitioner's response, and there was no reason for the Practitioner to think that the PCC would ever obtain access to that material.

51. During the course of the hearing extensive submissions were made on behalf of both parties as to whether or not the Practitioner set out deliberately to deceive the PCC in relation to this or whether it was simply an error (a "stuff-up" as she called it) on her part.

52. The PCC's contention was that it was clear from the start that the PCC's investigation included the Practitioner's use of recreational drugs; that she must have been aware that she would be asked about that; that she must be taken, therefore, deliberately to have lied to the PCC in the expectation that Dr Page's report would remain confidential; that she had, during the meeting and subsequently, every opportunity to correct what she told the PCC; and that her failure to do so until she had no choice, when the PC obtained a copy of Dr Page's report, establishes that she set out to deceive her professional body.

53. The Practitioner's position was that because the MCNZ Health Committee had already accepted that she had overcome any issue with drugs that she may have had (it will be recalled that the Committee's letter in this regard dated 18 September 2015 preceded the PCC's meeting with the Practitioner), she attended the meeting thinking that all issues concerning her recreational drug use were off the table, and that the only issue for discussion was her prescribing; that the questions about her drug use came as a surprise; that she simply made an error in saying that she had only used methamphetamine once when abroad; and that, having done so, she could see no way of getting out of the conundrum that that presented without undermining her credibility. In cross-examination it was put to her that, both at and following the 16 December 2015 meeting, she had had any number of opportunities to correct what she had said, and that her ongoing failure to do so demonstrated that she had been dishonest. She was offered repeated opportunities to provide an alternative explanation.

54. The Practitioner's denial of having deliberately misled the PCC as to the extent of her methamphetamine use has stretched the Tribunal's credulity to breaking point. In our

judgment, it could scarcely be clearer that the Practitioner lied to the PCC about the extent of her methamphetamine use, and maintained that lie for as long as it remained possible to do so.

55. Insofar as cannabis is concerned, the Practitioner admits to having used this drug both to counter stress and for pain relief (she apparently suffers from chronic pain as a result of a motorbike accident some time ago).

56. In short the evidence overwhelmingly establishes that whilst she was employed as a doctor by the Northland DHB (including as a House Officer and Psychiatric Registrar on Tumanako) between late 2012 and mid-2015, she used both methamphetamine and cannabis. The precise number of occasions on which she did so is not especially important. Methamphetamine is a class A and cannabis a class C controlled drug. Possession and use of either is a criminal offence punishable by imprisonment. Methamphetamine is a scourge on our society, responsible for ruining countless lives, especially amongst young New Zealanders.

Liability

57. The High Court in *McKenzie v MPDT*[1] and the Court of Appeal in *F v MPDT*[2] described the approach to be taken in determining whether the prosecutorial authority in professional disciplinary proceedings has made out a case of misconduct. These cases concerned earlier legislation and some of the discussion is not applicable to the 2003 Act. But the essential approach to be adopted remains the same. The two-stage approach described by the High Court in *McKenzie* was endorsed by the Court of Appeal in *F* in terms requiring the Tribunal to: *"... decide if there has been a departure from acceptable standards, and then ... whether the departure is significant enough to warrant sanctions."*

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1 [2004] NZAR 47
2 [2005] 3 NZLR 774

58. Since *F*, this two-stage approach has consistently been adopted by the Tribunal.[3]

59. The analysis of whether or not a practitioner has departed from acceptable standards must of course start from the legislation, so in a case such as this, where the charges are laid under s100(1)(a) and (b), the question is whether the Practitioner's conduct constitutes malpractice or negligence, or has brought, or was likely to bring, discredit to the profession.

60. *Collie v Nursing Council of New Zealand*[4] is generally cited for the most helpful guidance in relation to these terms. In that case, Gendall J emphasised that the *"... standards applicable by competent, ethical and responsible practitioners ..."* were the touchstone by which the Tribunal should measure whether a practitioner's conduct constituted malpractice or negligence and went on to say that in order for the practitioner to be held liable for professional misconduct the prosecuting body must prove *"... behaviour which falls seriously short of that which is to be considered acceptable and not merely inadvertent error, oversight or for that matter carelessness..."*. His Honour went on to emphasise that the malpractice or negligence must *"... be of a serious degree such as to be substantially below the standards expected of a [practitioner]..."* In the same case Gendall J helpfully focused on the notion of discredit in the following terms:

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

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3 *Nuttal* (HPDT 8/Med04/03); *Aladdin* (HPDT 12/Den05/04 and 13/Den04/02D); *Dale* (HPDT 20/Nur05/09D).
4 [2000] NZAR 74

61. Here of course, the only aspect of the Notice of Charge in respect of which there is a challenge concerns the second component of the second charge, that the Practitioner misled the PCC.

62. Nevertheless, the Tribunal's obligation is to reach its own conclusions on all aspects of the charges.

63. We have had no difficulty in concluding that the PCC has made out the first charge (paragraphs 1 – 4). The circumstances in which the Practitioner prescribed for [M's] mother, [M] and her colleague contravened MCNZ guidelines as she acknowledges. The Tribunal's view is that that amounts to malpractice on her part. The label *"negligence"* is not generally apt to describe deliberate actions, but it is apt here, given the Practitioner's failure to make even the most elementary enquiries as to the circumstances in which she was entitled to prescribe for family, friends and colleagues. It seems to us also that the Practitioner's conduct in ignoring her responsibilities in this regard calls seriously into question her fitness to practise and either brought or was likely to bring discredit to the medical profession.

64. Nor have we had any difficulty in concluding that the first limb of the second charge has been made out. It appears to the Tribunal that for any doctor to commit serious criminal offences and, most particularly, regularly to use prohibited drugs such as methamphetamine and cannabis during a period when he or she is practising, unquestionably brings the profession into disrepute.

65. Finally, we have concluded that the second limb of the second charge has been made out. To recapitulate on this point, the PCC, during the course of its meeting with the Practitioner on 16 December 2015, specifically asked about her use of methamphetamine. The Practitioner lied to the PCC, saying that she had only used the drug once when abroad. It was not until she filed her admission on 20 September 2016 that she acknowledged the extent of her methamphetamine use. Even during the course

of the hearing the Tribunal had to endure the unedifying spectacle of the Practitioner prevaricating when it was put to her that she had lied to the PCC about this. This misconduct too has brought, or was likely to bring, the profession into disrepute.

66. That brings us to the question of whether this professional misconduct on the Practitioner's part is a sufficiently serious departure from the standards which the public and the profession are entitled to expect of doctors to justify the imposition of a penalty.

67. Plainly it is. We will need to return to aspects of this when discussing penalty. For present purposes, we limit ourselves to saying that the guidelines promulgated by the MCNZ exist for good and proper reasons, most importantly that, in the interests of public and patients, doctors are expected to maintain a degree of objectivity. Any breach of the MCNZ guidelines is serious. Insofar as the second charge is concerned, it hardly requires detailed analysis to conclude that for a doctor to commit serious criminal offences and in particular to use class A and C prohibited drugs during a time when he or she is in practice is extremely serious. So too is any professional person, in the context of an examination into the propriety of his or her conduct, not to be entirely candid with his or her professional body.

68. In summary then, the Tribunal has concluded that the PCC has made out all aspects of both charges, that the Practitioner's conduct constitutes a serious departure from the standards which the public and the profession are entitled to expect, and that a penalty must necessarily follow.

Penalty

General

69. In recent decisions, the Tribunal's approach to determining the appropriate penalty has been outlined in considerable detail. We see no useful purpose in repeating the analysis. We will briefly summarise the principles involved.

70. Section 3(1) of the Act is clear that the principal purposes of disciplinary proceedings are the protection of the public and the maintenance of professional standards. There is well settled authority as to how those purposes apply to determining penalties. *Roberts*[5] is generally cited as the leading authority, on account of Collins J's helpful summary. To the extent that Collins J appeared to be suggesting that punishment is an objective of the professional disciplinary process, His Honour's observations were clarified by Ellis J in *Singh*[6] where it was explained that whilst punishment is an inevitable outcome of the imposition of any penalty, it is not, in and of itself, an objective. That point of clarification aside, Collins J's decision in *Roberts* obliges the Tribunal to:

70.1 First and foremost, have regard to the principal purposes of professional disciplinary proceedings as already explained, that is to say, the protection of the public and the maintenance of professional standards;

70.2 Balance the inevitable punitive impact of the imposition of any penalty against the Practitioner's prospects of rehabilitation;

70.3 Have regard to previous Tribunal decisions involving comparable circumstances, so as to ensure a degree of consistency between outcomes. In relation to this point, we would observe that times change and, along with them, public attitudes. As a result it will sometimes be necessary to change approach. When such change occurs, it must of course be done expressly and on a principled basis;

70.4 Consider all available options in order to identify the least punitive outcome which meets the seriousness of the Practitioner's conduct. This means that, before imposing any particular penalty or combination of penalties, the

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5 *Roberts v PCC* [2012] NZHC 3354
6 *Singh v Director of Proceedings* [2014] NZHC 2848

Tribunal must satisfy itself that a less severe penalty or combination of penalties will not meet the case;

70.5 Identify a penalty which is fair, proportionate and reasonable.

The first charge

71. As already signalled, the Tribunal views it as important to reinforce that the guidelines promulgated by the MCNZ in relation to prescribing for family and others exist for very good reasons.

72. It is a hallmark of the learned professions – the law and medicine in particular – that they insist on practitioners maintaining a degree of independence from their clients or patients. This is perceived, rightly, in our judgment, to be necessary in the interests of the public who are the users of professional services, so as to ensure that practitioners bring an objectivity of judgment to their task, enabling them to offer advice which will help the client or patient to make the best possible decisions as to the course of action to be followed, uninfluenced by personal considerations.

73. None of this is of course to say that a practitioner should approach his or her responsibilities without empathy, but there is all the difference in the world between a proper level of professional empathy and a lack of professional objectivity.

74. The MCNZ issue guidelines to assist practitioners in making difficult judgments as to whether or not it is appropriate for them to treat family, friends and colleagues.

75. We have already concluded that the Practitioner's actions in this case in prescribing for [M], [EM], and a colleague were contrary to current MCNZ guidelines. This case is a classic illustration of the importance of adhering to those guidelines. Focussing on the [M] and the prescription written on 20 April 2015, the evidence establishes he was a very heavy user of medical services, and was regularly prescribed powerful drugs. The Practitioner herself said that she had concerns about [M's] frame of mind and whether

he might be depressed. In addition to that, the evidence established that he was a user of recreational drugs including methamphetamine. In those circumstances, one might be forgiven for thinking that before any drugs of any description - but especially morphine-based drugs – were prescribed for him, the situation cried out for an objective assessment by a doctor who was genuinely independent.

76. Against that background, the Practitioner elected to prescribe him class B and C controlled drugs of dependence. Incidentally, the professional members of the Tribunal would question the appropriateness of the drugs prescribed, but that is not in issue here.

77. The Tribunal regards this (admitted) professional misconduct on the Practitioner's part as very serious. It illustrates an elementary lack of judgment on the Practitioner's part. We do not accept that it is relevant exactly what the Practitioner was or was not taught, or does or does not recall, from her medical school days. Nor do we accept that the evidence that others with whom she has come into contact during her career have breached the rules (Dr Holdaway was called to give just such evidence) is of any assistance to the Practitioner. The reason that professional people are described as "practising" is that professional life involves continual learning. In short, it is every doctor's responsibility either to know precisely what the current rules about such matters are, or, if they do not, to find out. A fundamental step in that process, it seems to us, would be to consult the current MCNZ guidelines. Instead, the Practitioner consulted an out-of-date handbook which she happened to have available. That is simply not good enough. The Practitioner's irresponsible approach, and consequential professional misconduct, had the effect of depriving [M] of the objective professional advice to which he was entitled, and put him at risk.

78. If this case involved only the first charge, the Tribunal's inclination would be to consider a suite of penalties along the lines originally proposed by the PCC, that is to say a censure, a period of suspension to mark the seriousness of the case and a series of

conditions on the Practitioner designed effectively to ensure that there would be no repetition of her conduct. However, there is also the second charge to be considered.

The second charge

79. Rightly or wrongly, the sense that the Tribunal got as this case was heard over three days was that the first charge, and all the peripheral evidence which we heard relating to it, tended to overshadow the second charge concerning the Practitioner's recreational drug use. That is the only explanation that the Tribunal is able to see for the apparent downplaying of the second charge, which we regard even more seriously than the first. To put the matter bluntly, a doctor engaged by a major provincial hospital, and involved in the treatment of the patients on a psychiatric ward, admits to having used methamphetamine on *"about six occasions"* and cannabis regularly during the time she was engaged there.

80. Not only is that an admission of serious criminal conduct, it undermines in a fundamental way the confidence that the public is entitled to have in doctors engaged in treating some of our most vulnerable citizens.

81. There are of course examples of cases in which the MCNZ (and other comparable professional bodies) have taken a benign attitude to practitioners who have become addicted to various substances, and sought actively to assist them to get back into practice. But a feature of the evidence in this case was the Practitioner's categorical denial that she has ever had a drug addiction, and it follows that she must be taken to have made a conscious choice, unaffected by compulsion, to use methamphetamine and cannabis during the time that she was practising.

82. Frankly, the Tribunal does not think it would be easy to over-emphasise the significance of this. In the end, the public and the profession are entitled to expect more of doctors.

83. During the course of the hearing, Mr La Hood referred us to four Tribunal decisions.[7] He did not suggest that any were directly applicable here, and the Tribunal agrees that they are not. *E* concerned a doctor who treated his partner by diagnosing her with depression and prescribing drugs for this. The Tribunal censured him and imposed conditions requiring him to undertake a course concerning boundaries. *T* concerned a doctor who fraudulently prescribed drugs for a fictitious patient on more than 50 occasions to feed her own addiction. Understandably, in such circumstances, the Tribunal focussed on rehabilitation. Again, the penalties imposed were a censure and detailed conditions designed to protect the public and enable the doctor to return to practise safely. *Dabous* was a different type of case. It involved a pharmacist who had been convicted of possession for supply purposes of class B and C drugs. The Tribunal censured and deregistered the practitioner. It is quite clear that the Tribunal took the view that the convictions were simply too serious to allow of any other outcome. Like the doctor in *T*, the doctor in *Y* fraudulently prescribed drugs for fictitious patients for his own purposes. The outcome too was similar, though the Tribunal clearly regarded this doctor's misconduct as more serious than that of the doctor in *T* as, in addition to a censure and the imposition of conditions, it suspended him for three months (observing that the period would have been longer but for certain mitigating considerations).

84. Of those cases, *Dabous* appears to the Tribunal to have the most obvious application here. Like Dr Emmerson, the pharmacist in that case was unlawfully in possession of drugs. The mere fact that, there, the pharmacist had been charged and convicted does not appear to the Tribunal to be of great significance if all the elements of criminal offending are made out (and here of course they are admitted). It is true that in *Dabous*

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[7] *E* HPDT 136/Med08/76D; *T* HPDT 636/Med14/272P; *Dabous* HPDT 695/Phar14/303P; *Y* HPDT 716/Med15/310P

the practitioner was convicted of possession for supply, but, by the same token, that case did not involve class A drugs as this case does, and, of course, there is the added aspects in this case of the irregular prescribing and lack of candour.

85. Mr La Hood also referred us to Justice Palmer's recent decision in *McCaig v PCC.*[8] As the Tribunal understands it, the purpose of putting this case forward was to illustrate the principle that in imposing a period of suspension the Tribunal must be mindful of any period during which a practitioner has been unable to practise as a result of the professional disciplinary proceeding or the surrounding circumstances.

86. Mr La Hood submitted that there are a number of aggravating factors in this case. In this regard, he submitted that the Practitioner lacks insight and has taken no steps to address her drug use; that her misconduct was "sustained"; that her conduct involved a clear breach of professional standards; that she put those for whom she prescribed drugs at risk; that she breached the trust of her employer; that she was dishonest with the PCC; and that she presented a risk to the public and future patients. There is a good deal in those points, in the Tribunal's assessment.

87. He went on to submit that there were no mitigating features of the case. That is a little unfair. Mr Muston said everything there could possibly be said in the Practitioner's favour in this regard, pointing out that she was a relatively junior doctor; that there was evidence that she was not getting the level of support within the hospital and from her supervisor that one might normally expect; that she did raise the question of treating [M] with her supervisor; and that throughout the relevant period of time she was under pressure from various things which were going on in her life.

88. Mr Muston also referred us to a number of previous Tribunal decisions.[9] With one exception, these cases all involved doctors fraudulently writing prescriptions for legal

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8 [2015] NZHC 3063

9 *Craig* HPDT Med16/348P; *Hodgson* HPDT Med/15/315P; *Kleszcz* HPDT Med16/353P; *Y* (supra); *T* (supra); *S* HPDT Med/11/197P; *Aitcheson* HPDT Med/07/80P

drugs for their own use. Some involved convictions. Others did not. The exception is *S*, where the issue was reckless prescribing for a patient, putting him or her at risk. That would appear to be an entirely different category of case. As Mr Muston submitted, the outcomes in these cases involved censures and the imposition of conditions. But none of these cases are comparable to the present case which also involves the use by a doctor of unlawful class A and C drugs, and a lack of candour.

89. Taking the view which the Tribunal does of the seriousness of the Practitioner's misconduct, and having regard to the fact that the PCC in its submissions on penalty did not seek an order for her deregistration, the Tribunal, having deliberated on the matter following the hearing, concluded that it should advise both parties that it was considering the full range of penalties available under s 101, including an order for cancellation, and invite further submissions on penalty in the light of that. This was done by way of a Minute dated 23 March 2017. The Tribunal received further submissions from both parties on the issue, and of course has had full regard to those in its subsequent deliberations.

90. On behalf of the PCC, Mr La Hood responded by Memorandum dated 27 March 2017. He began by indicating that, following the hearing, the PCC's position had changed, and that he was instructed to submit that it was open to the Tribunal to order the cancellation of the Practitioner's registration. He explained that this reflected how the evidence had emerged at the hearing, and the Practitioner's evidence in particular.

91. In relation to the first charge, Mr La Hood referred us to *Nuttall.*[10] That case involved a doctor who became involved in a sexual relationship with a patient and effectively continued as her doctor. Over a period of approximately six years he wrote something like 80 prescriptions, including prescriptions for drugs of dependence. On one view, it might be said that the only difference between a case such as *Nuttall* and the present

[10] HPDT 18 April 2005 (8/Med04/03P)

circumstances is whether the personal or the professional relationship came first. However, focusing on the first charge, *Nuttall* is clearly a more serious case than the present. But *Nuttall* did not have the same additional aspects to it as this case.

92. As to the first limb of the second charge (recreational drug use), Mr La Hood referred us to two additional cases, *Pulman*[11]and *Cullen.*[12] In both of those cases the Tribunal cancelled the practitioner's registration. It is fair to record that in both cases substantial quantities of class A drugs were involved and there was clearly a commercial element to the practitioner's conduct. There is no commercial element here.

93. Finally, as to the second limb of the second charge (lack of candour), Mr La Hood referred us to a number of previous decisions of this Tribunal.[13] As Mr La Hood submitted, there is no obvious pattern that emerges out of these cases. Clearly the Tribunal regards a lack of candour by practitioners who are the subject of professional disciplinary enquiries as unacceptable. Clearly also penalties imposed which can be seen to reflect lack of candour differ. On the other hand, in all cases, lack of candour was only one component of the charges.

94. In the Tribunal's judgment, the most helpful case in fact involves a legal practitioner. In *Hart*[14] the High Court accepted that a lack of candour by the practitioner there was a very serious element of the case, observing:

> *"The manner in which Mr Hart treated his obligations to the Tribunal was, in our view, an extremely serious matter. Public confidence in the legal profession depends significantly upon the premise that practitioners will cooperate fully in the investigative phase of the disciplinary process. By cooperation, we mean, as a minimum, that they will comply promptly with lawful requests made by investigating bodies and with timetables imposed. Mr Hart did not meet that*

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11 HPDT 11 May 2011 (375/Phar11/171P)
12 HPDT 6 December 2007 (139/Med06/44P)
13 *N* HPDT 31 August 2006 (58/Med05/15D); *O* HPDT 21 May 2007 (104/Psy07/58D); *Tolland* HPDT 9 September 2010 (325/Med10/146P); *Streat* HPDT 22 May 2014 (630/Med13/269P); *Thampy* HPDT 17 May 2016 (811/Nur15/329P)
14 *Hart v Auckland Standards Committee* [2015] 3 NZLR 103 at [224].

> *minimum requirement. Rather, he deliberately obstructed the investigation and misused the processes of the disciplinary bodies for the purpose of delay. We therefore agree with the Tribunal's conclusion that the manner in which Mr Hart elected to respond to the disciplinary process was highly relevant to the issue of penalty."*

95. For the Practitioner, Mr Muston responded to the Tribunal's Minute by Memorandum dated 5 April 2017. We are grateful to him for the obvious care and attention he has given to the matter. His submission not only canvassed previous decisions of this Tribunal, but also the decisions of equivalent bodies in the United Kingdom and Australia.

96. Addressing the first charge, Mr Muston referred to the same Tribunal cases as Mr La Hood had done, which we have already discussed. He emphasised that many appeared to be more serious than the present case, and yet the penalties imposed generally ranged from a censure to a period of suspension. He acknowledged, as he had to of course, that *Nuttall* was an exception, quite rightly pointing out that that was a case with additional dimensions. The same might be said of this case.

97. It is not especially easy to know what to make of the UK and Australian cases to which Mr Muston referred us. The circumstances vary considerably, as do the outcomes. But standing back, the broad sweep of them seems to be that prescribing for family, friends, and colleagues, other than in an emergency, even where this is more than a one-off event, and involves drugs of dependence, is not generally regarded as the most serious category of misconduct, and, at least in the absence of anything else, has generally attracted penalties ranging from a censure to a period of suspension, sometimes coupled with the imposition of conditions on the practitioner. We have already said that if the first charge here were the only charge, an outcome along those lines is what we would have considered appropriate.

98. Mr Muston approached the authorities relating to recreational drug use and lack of candour in much the same way.

99. Overall, acknowledging the assistance which Mr Muston's submissions have provided us, we are minded to observe that this case is one which involves three types of serious misconduct. Considering any one of them in isolation it is possible to contend that the Practitioner's registration ought not to be in jeopardy. But when they are considered cumulatively, as we said in the introductory section of this decision, the fundamental issue for us is whether we can discharge our responsibilities to the public and the profession as we have described them while allowing this Practitioner to continue to hold registration.

100. The Practitioner was able to put before us a number of references from professional colleagues and others, all of which speak highly of her.

101. We have of course considered these, and taken into account the views of those referees as to her character and professional acumen.

102. Regrettably, we have reached the conclusion that we cannot discharge our responsibilities to the public and the profession in this case whilst allowing the Practitioner to continue to hold registration as a doctor. The key considerations which have brought us to this conclusion are the following:

102.1 Our views as to the seriousness of both charges in this case, and in particular the two limbs of the second;

102.2 The cumulative effect of the various components of these charges. To elaborate on this, the Practitioner has ignored her responsibilities in terms of prescribing for family, friends and colleagues, used methamphetamine and cannabis during a period of time when she was in practice as a doctor, and deliberately set out to deceive the PCC. Not only has the Practitioner demonstrated an acute lack of judgment, but also an irresponsible attitude to complying with her professional

obligations, the criminal law and the duty of candour which she owes to her professional organisation;

102.3 In the course of both prescribing when it was inappropriate to do so, and by her apparent willingness to use illegal drugs, the Practitioner, in the Tribunal's assessment, has put a variety of people at serious risk including the patients for whom she prescribed, the patients for whose care she had responsibility on the ward and her medical, nursing and other colleagues;

102.4 It became quite clear to the Tribunal as the hearing professed that the Practitioner has no appreciation of the extent to which she has failed to discharge her professional responsibilities.

102.5 Our assessment is also that she presents an ongoing risk to the public and the profession. In short, our view is that she is not safe.

103. We should mention that in reaching this conclusion we would not like to think that the medical career of this Practitioner, who we have described as intelligent and talented, and who obviously has the respect of a number of professional colleagues judging by the references which are in evidence, will come to an end permanently.

104. We can envisage a situation in which this Practitioner, after a period of time, during which she may perhaps be able to employ her talents in another direction and bring some stability to her life, might well be able to persuade the New Zealand Medical Council that she is fit to practise and obtain re-registration.

105. Judging from everything that we have seen, it appears to us that a significant period away from practice might well be of considerable assistance to her.

Costs

106. The Tribunal proposes to deal with costs very briefly. The Tribunal's costs in this matter amount to $4,371. The costs of the PCC in prosecuting the case amount to $29,002.

107. The usual starting point in this jurisdiction is to identify half of the total costs and then consider whether there are reasons for increasing or decreasing the order made against a practitioner, the object of the exercise being appropriately to apportion costs between the profession and the practitioner who is responsible for those costs being incurred in the first place.

108. One of the considerations which is sometimes relevant is the practitioner's financial position. The Practitioner has put unchallenged evidence before the Tribunal indicating that her financial position is parlous. She has been out of work since May 2015, has little in the way of significant assets and has substantial liabilities.

109. In those circumstances, the Tribunal has decided that it should make no award of costs in this case.

Publication

110. At the conclusion of the hearing Mr Muston signalled to the Tribunal that the Practitioner wished to apply for permanent name suppression (an interim order has been in force for some time). But, it became clear that Mr Muston was not in a position to advance that submission on the day. Given that the Tribunal had already indicated that it proposed to reserve its decision, the parties were asked to provide short written submissions as to name suppression. These have been received and of course considered.

111. The default position in all proceedings before this Tribunal is that the Tribunal's decision is published in full. Section 95 confers on the Tribunal jurisdiction to suppress

information, including the names of practitioners. In considering any application it must have regard to in the public interest and the interests of any individual (including the Practitioner). The Court of Appeal's judgment in *Y v Attorney General* [2016] NZCA 474 makes it clear that an applicant for an order for suppression of any aspect of the Tribunal's decision does not have a formal burden in that regard. Nevertheless the Tribunal must be satisfied that there are good reasons for departing from the default position. Generally, that requires evidence that publication will have an unusually adverse effect.

112. There is no doubt in this case that the publication of the Practitioner's name will have an adverse effect on her. However, there is no basis for suggesting that that adverse effect will be out of the ordinary.

113. There is another important factor in this case which is that the case has already attracted considerable publicity so that the Practitioner's name is already in the public arena.

114. In those circumstances, the Tribunal does not accept that there are proper grounds for making an order permanently suppressing her name. We will however make an order suppressing the Practitioner's name for one month from the date of this decision in order to enable her to take advice and make a judgment about whether or not to appeal and, if necessary, seek an interim order in relation to publication.

Conclusion

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

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

115.2 Pursuant to s101(1)(a), the Tribunal orders that the Practitioner's registration be cancelled;

115.3 Pursuant to s95(2)(d), the Tribunal makes a permanent order prohibiting the publication of the names of any of the persons for whom the Practitioner wrote prescriptions and any identifying details or any information about their medical conditions, and the published version of this decision is to be redacted accordingly;

115.4 Pursuant to s95(2)(b), the Tribunal makes an order prohibiting the publication of any report of this decision for a period of 20 working days from the date hereof, which order shall expire at the conclusion of that period;

115.5 Pursuant to s157, the Executive Officer is directed to publish a copy of this decision, and a summary, on the Tribunal's website. The Tribunal further directs the Executive Officer to publish the summary of, or a reference to, the Tribunal's decision in the New Zealand Medical Journal, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Wellington this 12th day of May 2017

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Kenneth Johnston QC
Chair
Health Practitioners Disciplinary Tribunal