ORDER PROHIBITING PUBLICATION OF NAME, ADDRESS OR PARTICULARS IDENTIFYING APPELLANT AND/OR COMPLAINANT.

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV-2007-485-2735

IN THE MATTER OF	an appeal pursuant to the Health Practitioners Competence Assurance Act 2003
BETWEEN	DR E Appellant
AND	THE DIRECTOR OF PROCEEDINGS First Respondent
AND	THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL Second Respondent

Hearing: 28 May 2008

Counsel: C Hodson QC for Appellant
T M Baker for First Respondent
No appearance for Second Respondent

Judgment: 11 June 2008 at 11 am

RESERVED JUDGMENT OF RONALD YOUNG J

Introduction

[1] Dr E and NN began living together in December 2002. Shortly afterwards, Dr E diagnosed NN as suffering from depression. He made no record of his diagnosis but from April 2003 he began prescribing her Aropax, an anti-depressant drug. This continued for about three years. While they lived together, he also prescribed her Paradex, an analgesic; Trisequens, a hormone replacement drug; and Losec, for gastric problems. The couple separated in May 2006.

[2] NN complained about the appellant's actions. After a hearing before the Health Practitioners Disciplinary Tribunal, it concluded that the conduct of the appellant amounted to professional misconduct. As to penalty, a censure was imposed. Dr E was required to undertake professional boundaries education, a competence review of his practice was to be undertaken, and he was fined $7,500 together with costs of $3,000.

[3] The appellant submits that none of the four particulars constituting the alleged misconduct were, if established, sufficient to prove professional misconduct either individually or collectively in the circumstances of this case. In addition, the appellant says that the Tribunal misdirected itself by refusing to take into account the personal circumstances of the appellant in reaching its decision. As to sentence, the appellant submits there was no basis to justify any enquiry into the appellant's practice and the fine was manifestly excessive.

Background facts

[4] The hearing before the Tribunal proceeded with an agreed statement of facts, together with documentary evidence. In addition, the appellant gave evidence and was cross-examined and questioned by the Tribunal.

[5] Dr E and NN began their relationship in 1998 and from 2002 they lived together. Between 2002 and 2006 NN did not consult another general practitioner, although the appellant's evidence was that he believed she was doing so from time to time. The appellant says that soon after they began living together, given NN's history, his observations of her mood fluctuations, impulsive behaviour and alcohol consumption, he concluded that she suffered from depression. He then prescribed her Aropax, an anti-depressant, initially in April 2003 and then on 29 subsequent occasions through until May 2006. Between October 2004 to June 2005 NN saw a counsellor. During the time the parties lived together, the appellant also prescribed Paradex on 13 occasions; Trisequens on nine occasions, and Losec on two occasions.

[6] In early April 2006 NN was seen by the emergency mental health team. She was unwell and was referred to the community health team. An assessment by a

Psychiatric Registrar on 19 April 2006 revealed no symptoms of a major depressive disorder. A programme of reduction of her Aropax from 40 milligrams a day to 10 milligrams a day was undertaken. By May it was agreed her Aropax use could cease and she would try another drug for her mood. Later that month after a heated argument, Dr E and NN separated. NN is not now suffering from depression, nor is she taking any medication.

Appellate court's approach to s 109 appeals

[7] Given the Supreme Court's decision in *Austin, Nichols & Co Inc v Stichting Lodestar* [2008] 2 NZLR 141 it is necessary to reconsider this Court's approach to the hearing of appeals from the Tribunal.

[8] Section 109 of the Health Practitioners Competence Assurance Act 2003 provides as follows:

> **109 Procedure on appeal**
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> …
>
> (2) An appeal under this Part is by way of rehearing.
>
> (3) On hearing the appeal, the appropriate court—
>
> (a) may confirm, reverse, or modify the decision or order appealed against; and
>
> (b) may make any other decision or order that the person or body that made the decision or order appealed against could have made.
>
> (4) The court must not review—
>
> (a) any part of a decision or order not appealed against; or
>
> (b) any decision or order not appealed against at all.

[9] This Court in such cases as *Tizard v Medical Council of New Zealand & Anor* HC AK M2390-91 10 December 1992; *Brake v Preliminary Proceedings Committee of the Medical Council of New Zealand* [1997] 1 NZLR 71; *F v The Medical Practitioners Disciplinary Tribunal* HC AK AP21-SW01 5 December 2001;

T v Director of Proceedings HC CHCH CIV 2005-409-002244 21 February 2006; and *Zimmerman v Director of Proceedings* HC WN CIV 2006-485-000761 29 May 2007 has approached appeals under this and earlier similar legislation in this way (as summarised by the respondent):

> 1 The Court is not bound to accept the Council's findings of fact – *G v New Zealand Medical Council* [1991] NZAR 1.
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> 2 That it "ought to give due and proper weight to the expressions of opinion of tribunals composed largely of medical men": *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375, citing the statement by Walsh J in *Ex Parte Meehan* [1965] NSWLR 30, 39:
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> > Although this Court must exercise its own judgment upon the case, it is right for it to give weight to the decision made by a tribunal composed mainly of medical men whose knowledge and experience qualify them to evaluate the seriousness of the conduct of which the Appellant was found guilty, and to assess the appropriate method of dealing with it. We should be slow to interfere with this judgment upon such a question.
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> 3. That, the usual onus lies on the appellant to satisfy the Court that the decision in the Court below was wrong: *Powell v Streatham Manor Nursing Home* [1935] AC, 243, 255; applied in the professional disciplinary context in *Ongley v Medical Council of New Zealand* (supra) at 376. In *Gurusinghe v Medical Council of New Zealand* (supra) at 176, the ultimate issue was seen as the consideration whether or not the error complained of had resulted in "a miscarriage of justice". The same position is implicit in the statement –
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> > (a) By Lord Radcliffe in *Fox v General Medical Council* [1960] 3 All ER 225, 229, that an appeal must fail unless some defect is shown "that may fairly be thought to be of sufficient significance to the result to invalidate the committee's decision";
> >
> > (b) By Lord MacKay in *Doughty v General Dental Council* [1987] 3 All ER 843, 846, that a misdirection by the legal assessor did not invalidate the Council's decision, as it had not "prejudiced the appellant nor caused a miscarriage of justice"; and
> >
> > (c) By Cooke P in *Duncan v Medical Council of New Zealand* [1986] 1 NZLR 513, 548, that this is a field in which "the spirit of justice is more important than the letter".

And further, the respondent says based on the current approach to such appeals the appellate court in deciding whether to allow the appeal:

> … is nevertheless constrained to do so only in the context of determining whether:
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> [a] The decision-maker got the law wrong;
>
> [b] A relevant consideration has not been taken into account;
>
> [c] An irrelevant consideration has been taken into account; or
>
> [d] The decision is plainly wrong, i.e. a clear failure to balance properly the relevant considerations.

[10] The respondent submits that this Court's approach to such appeals should not change as a result of *Austin Nichols* and that the approach in *F v The Medical Practitioners Disciplinary Tribunal* is correct. The respondent submits that this appeal from a finding of professional misconduct is the exercise of a discretion and involves specialist expertise. In particular, the respondent emphasises the use of the word "judgment", relating to the Tribunal's decision, in s 100 of the Act, which deals with disciplining health practitioners. The respondent submits that the Tribunal in making a decision under s 100 is therefore making a discretionary decision in the sense meant in *Austin Nichols.*

[11] In my view, the approach identified in [9] to appeals under s 109 should now be reconsidered. Elias J for the Court in *Austin Nichols* identified the correct approach to such general appeals as follows:

> [16] Those exercising general rights of appeal are entitled to judgment in accordance with the opinion of the appellate court, even where that opinion is an assessment of fact and degree and entails a value judgment. If the appellate court's opinion is different from the conclusion of the tribunal appealed from, then the decision under appeal is wrong in the only sense that matters, even if it was a conclusion on which minds might reasonably differ. In such circumstances it is an error for the High Court to defer to the lower Court's assessment of the acceptability and weight to be accorded to the evidence, rather than forming its own opinion.
>
> [17] In the present appeal there was no basis for caution in differing from the assessment of the tribunal appealed from. The case entailed no question of credibility. It turned on a judgment of fact and degree, not the exercise of discretion entrusted to the tribunal. We are of the view that the Court of Appeal was not correct to suggest that, because the decision turned on a value judgment apparently open to the Assistant Commissioner, "the High Court Judge ought not to have embarked on a reconsideration of the issue without considering, and giving weight to, the Assistant Commissioner's conclusion". The High Court Judge was obliged to reconsider the issue. He was entitled to use the reasons of the Assistant Commissioner to assist him

> in reaching his own conclusion, but the weight he placed on them was a matter for him.

[12] An appeal under s 109 is a general appeal in that it is an appeal by way of rehearing. I consider the approach identified by the Court in *Austin Nichols* must therefore be applied in this case, as in all cases coming before this Court from the Tribunal.

[13] The formula set out in [9] is concerned with an appellate court's approach to a discretionary decision. To take a simple example, a discharge of a defendant in a criminal case without a conviction under s 106 of the Sentencing Act is clearly a discretionary decision. A Tribunal's disciplinary decision is generally based on coming to a conclusion having assessed the facts and the law. The Tribunal finds the facts, applies the law and then asks whether the prosecution has established each of the individual disciplinary charges to the standard required. This is not the exercise of a discretion, save for one aspect, but a decision based on a finding of fact and analysis of the appropriate law. I reject the respondent's argument that the terms of s 100 illustrate that this was an appeal from the exercise of a Tribunal discretion.

[14] Section 100(1) provides as follows:

> **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—
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> (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

> (c) the practitioner has been convicted of an offence that reflects adversely on his or her fitness to practise; or
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> (d) the practitioner has practised his or her profession while not holding a current practising certificate; or
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> (e) the practitioner has performed a health service that forms part of a scope of practice of the profession in respect of which he or she is or was registered without being permitted to perform that service by his or her scope of practice; or
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> (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.

[15] Subsection (a), for example, obliges the Tribunal to: make a finding of fact as to the relevant act or omission; decide if in their "judgment" the relevant facts constitute negligence or malpractice; and decide if in turn the negligent acts or malpractice are sufficient to constitute professional misconduct. The finding of fact and the conclusion of negligent conduct or malpractice are not exercises in discretion. They require a comparison of the conduct of the practitioner against appropriate standards. If the practitioner falls below the requisite standard then they are negligent or have acted with what amounts to malpractice. Where the Tribunal does have a narrow discretion is in deciding whether this negligence or malpractice constitutes guilt of professional misconduct. This is essentially a discretionary judgment akin to a sentencing decision in a criminal case. It will be a question of discretionary judgment whether, given the negligent conduct or malpractice, taking into account all relevant considerations, it is appropriate to find the practitioner guilty of professional misconduct.

[16] As I understand the position, typically a finding of negligence or malpractice is followed by a finding of professional misconduct. However, in those cases where the appellate challenge is to the exercise of this discretion, namely whether to find guilt of professional misconduct after a conclusion of negligence or malpractice, then in my view the *May v May* (1982) 1 NZFLR 165 (CA) approach remains appropriate for the Court.

[17] Given the facts of this case there was no specialist medical expertise being exercised by the Tribunal save for one aspect I will refer to later in the judgment. The Tribunal identified a standard of conduct in these circumstances to which it expected the particular medical practitioner to adhere. It identified the appropriate standards from an examination of those set by the New Zealand Medical Council. Whether the appellant had breached the standard is a judgment of the Tribunal based on fact and law. It required no particular medical expertise. In those circumstances the *Austin Nichols* approach to an appeal relating to the finding of malpractice was appropriate. Where the appeal was a challenge to the finding that the malpractice justified professional misconduct charges the *May v May* approach is appropriate.

[18] The only factor in appeals from the Tribunal justifying particular deference is the Tribunal's specialist medical expertise if relevant in the particular appeal. As to this, Elias J in *Austin Nichols* said:

> [5] The appeal court may or may not find the reasoning of the tribunal persuasive in its own terms. The tribunal may have had a particular advantage (such as technical expertise or the opportunity to assess the credibility of witnesses, where such assessment is important). In such a case the appeal court may rightly hesitate to conclude that findings of fact or fact and degree are wrong. It may take the view that it has no basis for rejecting the reasoning of the tribunal appealed from and that its decision should stand. But the extent of the consideration an appeal court exercising a general power of appeal gives to the decision appealed from is a matter for its judgment. An appeal court makes no error in approach simply because it pays little explicit attention to the reasons of the court or tribunal appealed from, if it comes to a different reasoned result. On general appeal, the appeal court has the responsibility of arriving at its own assessment of the merits of the case.

[19] To return to [9] and the factors previously seen as relevant. The weight to be given to the Tribunal's opinion arises where medical knowledge is a factor in the resolution of the disciplinary proceedings, otherwise the medical expertise of some members of the Tribunal is not relevant.

[20] To speak of an onus on an appellant in such a situation is not appropriate. The High Court's function is to decide if, in its opinion, the decision is wrong. If it is wrong then the appeal should be allowed. If it is not wrong the appeal should be rejected.

[21] Nor is it any longer the law that a defect of sufficient significance to the result need be shown by an appellant. The focus must now be on whether this Court agrees with the Tribunal's findings of fact and conclusions of law and result. Of course appropriate acknowledgement of the Tribunal's advantage over an appellate Court in deciding credibility of witnesses, where it has seen and can assess those witnesses, should be given.

[22] In summary:

(i) The previous authorities of appeals from Health Practitioner Tribunals should now be seen in light of the *Austin Nichols* decision *Austin, Nichols* decision and will mostly not reflect the law in such appeals.

(ii) A Tribunal decision whether a practitioner's conduct is negligent, malpractice or brings the profession into discredit (s 100(1)(a) and (b)) is not a discretionary one.

(iii) The Tribunal decision in (ii) is to be assessed at an appellate level on the basis of whether the appellate Court considers it is wrong.

(iv) Deference to the Tribunal's decision may be appropriate where the Tribunal has a particular advantage such as medical expertise or an assessment of credibility of witnesses.

(v) If the Tribunal finds the practitioner's conduct is negligent, malpractice or brings discredit on the profession, then whether the conduct justifies a finding of guilt of professional misconduct is an exercise in discretion entrusted to the Tribunal. The principles of *May v May* (1982) 1 NZFLR 165 (CA) apply to an appeal from this aspect of the Tribunal's decision.

I therefore approach this appeal on that basis.

Appeal grounds and discussion

[23] The appellant's first submission is that the Tribunal misdirected itself when, having concluded the appellant's actions constituted malpractice, it refused to take into account the personal circumstances of the appellant and the knowledge of the appellant when deciding whether this was professional misconduct. As to this the Tribunal said:

> 17. There are two steps involved in assessing what constitutes professional misconduct:
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> (a) The first step involves an objective analysis of whether or not the health practitioner's acts or omissions can be reasonably regarded by the Tribunal as constituting: malpractice; or negligence; or otherwise meets the standard of having brought, or was likely to bring discredit to the practitioner's profession;
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> (b) The second step of the process 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 warrant maintaining professional standards and/or punishing the health practitioner.
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> 18. This approach to the assessment of professional misconduct under the statute is well established under previous decisions of the Tribunal, and in authorities such as *McKenzie v MPDT & Anor* [2004] NZAR 47.
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> 19. In *McKenzie*, Venning J said:
>
> > "In summary, the test for whether a disciplinary finding is merited is a two stage test based on first, an objective assessment whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the disciplinary tribunal or the Court to become engaged in a consideration of or to take into account subjective considerations of the personal circumstances or knowledge of the particular practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner." (paragraph 71)

> 20. Mr Hodson submitted that the passage did not mean that in no case could the circumstances be taken into account, and that "… subjective considerations may well relate to the motivation of the practitioner ...". He submitted that it was necessary, in order to reach a just determination, that all of the circumstances of the case were considered.
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> 21. The passage just cited refers to the question of whether the Tribunal's assessment of the case is to be from an objective stand point or a subjective stand point. What the Court decided in that case, after a detailed and careful review of relevant New Zealand decisions, and overseas decisions, was that a subjective assessment of the doctor's position is inappropriate. Of course, however, a good understanding of the situation in which the alleged departure from the relevant standards has occurred, must be undertaken; and the Court was not suggesting otherwise.

[24] Counsel agree that once the Tribunal have found the relevant facts then the decision as to whether a doctor's actions are negligent or malpractice is an objective assessment. Counsel differed, however, as to whether the Tribunal can take into account the personal circumstances and knowledge of the appellant in deciding whether it is satisfied the practitioner's actions justify a disciplinary sanction. As the quote from *McKenzie* in the Tribunal's judgment illustrates, Venning J's view was that subjective considerations of the personal circumstances or knowledge of the practitioner had no part to play in this second assessment.

[25] I would not be prepared to go quite so far as Venning J. I consider there may be personal circumstances which substantially affect the seriousness of the particular negligence or malpractice which are therefore relevant to the decision as to whether a disciplinary sanction is required. A failure to consider these in appropriate circumstances could constitute a failure to take into account a relevant consideration.

[26] It is open to the Tribunal to conclude a practitioner has been negligent but conclude, given the explanation received from the practitioner, that the negligence (or malpractice) is not sufficiently serious to justify disciplinary intervention.

[27] In this case, however, the subjective factors are not in the category that should have affected the Tribunal's decision. As the respondent submitted, they are mostly about the appellant's belief regarding his treatment of NN. The fact the appellant may have believed that he was acting in her best interests and that she accepted the prescriptions could not properly be taken into account by the Tribunal

when deciding whether this was a case for a disciplinary intervention. This ground of appeal, therefore, fails.

Diagnosis

[28] The first particular of the charge the appellant faced is that, being in a de facto relationship with NN, he diagnosed her with depression. The Tribunal identified the relevant Medical Council of New Zealand guidelines as to diagnosis of family members. It then said:

> 50. As a general proposition, the Tribunal observes that not all breaches of a MCNZ statement will necessarily constitute professional misconduct; obviously a fact specific analysis is required and an assessment made of the seriousness of the departure. But such guidelines are a helpful indicator of proper practice and ethical standards.
>
> …
>
> 55. Had Dr E been truly objective, he would have realised he could not be involved in his partner's care, given the complexity of the issues she was facing; and he would have ensured that independent professional advice was sought. The moment he made a diagnosis, he inevitably – and foreseeably – became involved in a continuing course of mental health treatment.
>
> …
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> 59. At the time Dr E entered into the relationship with NN, he must have been aware of potential mental health issues, because, over a period of some months prior to the commencement of the period when the couple lived together, she had attended counselling for self esteem and historical relationship issues, on Dr E's recommendation. The subsequent difficulties which arose, and which resulted in the diagnosis being made by Dr E himself, were therefore foreseeable.
>
> …
>
> 61. None of the exceptions referred to in the MCNZ Statement applied. Counsel for Dr E submitted that there was no doctor in New Zealand who had not at one stage or another of his or her life made a diagnosis as to the condition of a family member, even if it was only to say that the family member had flu and should go to bed. The statement clearly recognises that kind of situation, with its reference to a "minor or self limiting condition". The present circumstances were serious, not minor.
>
> 62. The Tribunal is well satisfied that the diagnosis of depression was not one that should have been made by Dr E in the circumstances, particularly given the absence of any reliable evidence that there was another health professional involved in caring for NN.

63. The Tribunal considered the established facts amount to malpractice.

[29] The appellant submits it is "hard to know where the evil lies" in a practitioner diagnosing a family member. The appellant says the Tribunal's reasoning, taken to its logical end, could endanger family members of doctors if the doctor could not identify illness in his/her own family.

[30] This submission fails to distinguish between a casual observation and a diagnosis. To take the example used by counsel, "My wife has the flu" is simply no more than an observation by a doctor. This is in quite a different category than a diagnosis. Here, the appellant admits that, upon becoming concerned about NN's mental health, he observed her conduct, undertook other standard diagnostic techniques and as a result concluded she suffered from depression. He communicated this diagnosis to her. This is in quite a different category from a practitioner who observes worrying behaviour in a family member and suggests they see another medical practitioner for help. Such would fall well short of a diagnosis.

[31] The purpose of a diagnosis (as opposed to a general expression of opinion) is presumably to inform the patient of their condition and identify options for treatment, if any. The other perspective to be brought to this case is that the diagnosis here was of depression. It was not a diagnosis of the flu. A diagnosis of depression is especially sensitive in a family setting, emphasising the need for great caution on the family member/medical practitioner's behalf. The Medical Council of New Zealand guidelines especially mention the difficulties in providing care where there are close emotional ties. This must be especially so when the patient is suspected of having a mental illness. Nor does this situation come within any of the exceptions to treating family members identified by the Medical Council of New Zealand.

[32] I am satisfied that the Medical Council's conclusion about the first particular was correct. This behaviour constituted professional misconduct.

Record

[33] The second particular relates to the appellant's failure to keep records of the appellant's consultations and treatment. The statement of facts states:

> 13. Dr [E] himself made no records of consultation or treatment of [NN] relating to the Aropax prescriptions. Dr [E] says that the letters given to him from time to time by [NN] provided indications of her state of mind and mood.

[34] As to this, the Tribunal said:

> 69. In evidence, he said that he had not kept "conventional" medical records of diagnosis and prescribing. He said he did ask NN to write down from time to time how she was feeling. He also said that he obtained an ultrasound – because he was concerned about an issue of back pain – and blood tests shortly before the period of separation, and after NN had contacted a psychiatric registrar about stomach problems. That was the full extent of the medical records.
>
> …
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> 72. Counsel for Dr E submitted that the information retained by Dr E was sufficient for record keeping, and in order to understand where the patient was at from time to time. He also submitted that it was not known exactly what records had existed, because, following the separation when Dr E went to find the file, it was empty.
>
> 73. The Tribunal does not agree with this submission. Dr E accepts his record keeping was not "conventional". It merely consisted of letters from NN. There was no record whatsoever of Dr E's own observations, or his reasons for reaching them. Consequently, it was never going to be possible to re-examine the history of this matter using the medical record.

[35] The Tribunal said, given this case involved the long-term treatment of someone with mental health problems, the failure to keep records was a sufficiently serious departure to constitute professional misconduct.

[36] The appellant says this complaint was only with respect to one patient and not a finding generally of poor record keeping. This was, therefore, not sufficiently serious to constitute professional misconduct.

[37] I disagree. The important factor here is context. The appellant was treating his partner with anti-depressants for a serious illness. In such circumstances keeping proper detailed records was of particular importance. Records establish the justification for the diagnosis and the continuing treatment. This applies here as much to the prescriptions for the other drugs as it does to the Aropax. Proper record keeping could have avoided many of the issues raised at the hearing which gave rise to Tribunal concern. For example: what were the time gaps in the hormone replacement treatment for; was the diagnosis of depression continually reassessed and on what basis; did NN identify who the appellant claimed was her other GP who was keeping an eye on her; did the appellant ever speak to the other GP, for example, about co-ordination of prescriptions?

[38] This failure to keep basic notes, in my view, was a serious failure in the particular circumstances of this case. I agree it constituted professional misconduct.

Prescribing

[39] The third particular of the charge was that the appellant prescribed Aropax 30 times to NN. As to this the Tribunal said:

> 79. Counsel for Dr E accepted that Aropax is a psychotropic medication (specifically referred to in the 2007 MCNZ "Statement on Providing Care to Yourself and Those Close to You"; a practitioner should specifically avoid prescribing a psychotropic medication to himself or to a family member).
>
> 80. In the context of a diagnosis of depression on an ongoing basis, and also on the basis of an untested assumption that there was a GP seeing the patient from time to time, the continuous prescribing of Aropax over a period of years was most unwise.
>
> 81. The Tribunal concludes that the facts are established, and that they amount to malpractice, and the bringing of discredit on the profession.

[40] The appellant says it was unfair to hold him to the 2007 medical standard (see 79). However, the MCNZ standards at the time of these events made it clear that treating a family member was to be avoided unless within the exceptions. None of the exceptions were relevant here. As I have previously observed, to prescribe anti-depressant drugs over many years to a family member is obviously in quite a

different category than, say, the prescription of an antibiotic for a week. This was serious prescribing of a serious drug for a serious condition.

[41] The appellant also submits that the Tribunal failed to take into account the appellant's belief that the complainant was being monitored by another GP. This "evidence" by the appellant was unsatisfactory. Obviously, if a medical practitioner in such a situation knew that his family member/patient's condition and his prescribing was being properly peer-reviewed on a regular basis by another doctor then any culpability would be significantly reduced if not disappear altogether. But this was not the case here. Here, the appellant's evidence on this point was vague and unhelpful. He admitted he did not know who was monitoring his treatment, he did not specifically ask his partner whether there was monitoring of his treatment, and he did not attempt to contact any medical practitioner who may have been monitoring his treatment. His evidence was, as I have said on this aspect, imprecise and equivocal.

[42] Prescribing Aropax in such circumstances to a family member was clearly professional misconduct.

Other prescriptions

[43] The final ground of appeal relates to the Tribunal's conclusion with regards to the prescription of the other drugs. As to Paradex it said:

> 85. Paradex was prescribed on 13 occasions. It is a medication which should not be prescribed for patients who are potentially suicidal, who are on antidepressant medicines, or where there are issues as to the intake of alcohol. Drug dependency can also occur.

[44] The appellant submits that the Tribunal did not "explore the appellant's awareness of its allegations in para 85". In addition, the appellant complains the Tribunal did not take into account the proposition that Dr E had withheld a prescription for Trisequens so that the complainant could see a GP and obtain a cervical smear. In those circumstances, the appellant says that he was entitled to rely upon the complainant seeing a GP and obtaining the appropriate care.

[45] As to this, the Tribunal said:

> 86. The Tribunal also had some concerns over the prescribing of Trisequens. Dr E prescribed Trisequens for NN for a period of approximately three years. Trisequens is used for hormone replacement therapy. When prescribing hormone replacement therapy it is recommended that practitioners monitor their patients. Investigations, in particular mammography, should be carried out in accordance with currently accepted screening practices.
>
> 87. At the time in question, accepted practice was for women between the ages of 50 and 65 years to have two yearly screening mammograms. NN was aged 51-53 in the period under review.

[46] This is the one area in this case where the Tribunal exercised its medical knowledge. The complaint on appeal, however, is that the Tribunal did not raise its concerns about Paradex dependency or Trisequens monitoring with the appellant to give him the opportunity of responding. The appellant submits the Tribunal failed to take into account that he relied upon the complainant seeing another GP for her care, especially with respect to Trisequens.

[47] I accept that it is appropriate, where a Tribunal tentatively concludes a criticism of a medical procedure by a medical practitioner is justified, that they provide the practitioner with an opportunity to respond before the Tribunal makes a decision. The Tribunal's conclusions with regard to Paradex and Trisequens were extremely important - namely, that Paradex should not be prescribed for patients who are on anti-depressant medicines and its addictive nature, and Trisequens should not have been prescribed for over three years unless there was clear monitoring including a mammography. These propositions should expressly have been put to the appellant for a response.

[48] The appellant says that he relied upon the complainant seeing another GP and a cervical smear being obtained. However, in the absence of it being clear that in fact NN had the protections associated with the taking of the hormone replacement drug, it was clearly inappropriate to continue to prescribe it. Here, the appellant did not know whether NN was seeing another medical practitioner and he did not know whether another medical practitioner was providing her with the required monitoring and investigation. As I have previously observed, his knowledge of whether anyone

was treating his partner was vague in the extreme and certainly not sufficiently clear for him to rely upon it.

[49] I consider that the primary basis for finding professional misconduct with respect to particular (4) was the combination of prescribing Paradex and Aropax, together with dependency risks, along with the failure to monitor NN while prescribing Trisequens. These are the two aspects of particular (4) which were not put to Dr E to enable him to respond. Without these aspects of particular (4) it was doubtful a prosecution would have been brought for prescribing Paradex, Trisequens, and Losec by themselves.

[50] Ordinarily, where a decision is based on alleged misconduct not put to the person charged, the case would be returned to the Tribunal to provide that doctor with a chance to respond and for the Tribunal to reconsider the charge in light of the further response.

[51] Here, however, there seems little point in doing so. The appellant did prescribe the drugs described in particular (4) to a family member. This was clearly inappropriate. Given the other allegations were serious particulars in (1), (2) and (3) there is little point in prolonging this disciplinary process further. I therefore quash the Tribunal's conclusion with respect to particular (4).

Appeal against sentence

[52] The Tribunal imposed the following penalties:

(i) A censure;

(ii) A recommendation the Medical Council of New Zealand undertake a competence review of the appellant's practice with particular focus on women's mental health and record keeping;

(iii) A fine of $7,500;

(iv) An order for costs of $3,000, half for the Tribunal and half to the Director of Proceedings.

[53] The appellant says:

(i) It was unnecessary for the Tribunal to recommend the Medical Council of New Zealand undertake a competence review;

(ii) The fine of $7,500 was manifestly excessive.

[54] It is common ground that disciplinary proceedings for a medical practitioner's diagnosis and prescribing for family members is rare. Only one other disciplinary case could be found by counsel. That involved a 2002 case (*Complaints Assessment Committee v Van Rhyn* Decision No 214/01/74C) where a practitioner was convicted of failing to obtain a patient's consent to forcibly administering psychotropic medication and anti-depressants. The charge illustrates the seriousness. The doctor there was fined $5,000, only able to practice subject to conditions, censured and ordered to pay $28,000 in costs. I note that the maximum penalty then was $20,000 whereas the maximum penalty now is $30,000.

[55] The appellant submits that the recommendation to the Medical Council that they undertake a competence review was unnecessary. He says that there is nothing to suggest that his general medical practice (currently only half a day a week) suffered from any of the problems or difficulties exhibited by these disciplinary proceedings. The appellant submits that his conduct here was clearly a one-off, and part of a difficult and unhappy domestic situation.

[56] As to the fine, the appellant says that the fine, when compared with the other case of inter-family prescribing was very high. He says this case had none of the serious forcible elements of the other case.

[57] As to the recommendation that the Medical Council undertakes a competence review, this was a decision properly open to the Tribunal and in my view was appropriately made. The Tribunal did not know whether the appellant had brought

the same standards to his general practice that he had brought to his treatment of his partner. Their recommendation was no more than an invitation to the Medical Council that it reassure the public he had not.

[58] As to the fine, it was clearly out of line with the other decision. The facts of that case were, on the face of it, extremely serious. It could be said that the penalty imposed on the medical practitioner in the *Van Rhyn* case was modest. This case, while serious, did not involve any suggestion of coercion or any suggestion that the treatment provided was anything other than what the appellant believed was genuinely required and helpful. In those circumstances I am satisfied that the fine was manifestly excessive. I quash the fine of $7,500 and reduce it to $5,000.

"Ronald Young J"

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