Medical Practitioners Disciplinary Tribunal

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DECISION NO: 81/99/46D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **ANTHONY ANDREW BELL** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Mr P Budden, Dr A M C McCoy, Dr A D Stewart,

Dr A F N Sutherland (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Tuesday 22 June 1999

APPEARANCES: Ms T W Davis Director of Proceedings

Ms J Gibson for Dr Bell.

1. THE CHARGE:

1.1 **INITIALLY** Dr Bell was charged by the Director of Proceedings that he being a registered medical practitioner acted in such a way that amounted to professional misconduct in that he provided services of an inappropriate professional standard. In particular Dr Bell was charged that when supplying the drugs Diazepam and Acupan to his patient he failed to comply with Regulation 23 of the Medicines Regulations 1984.

1.2 **ON** Friday 18 June 1999 the Director of Proceedings amended the charge to one of conduct unbecoming a medical practitioner which conduct reflects adversely on his fitness to practise medicine.

2. AGREED STATEMENT OF FACTS:

2.1 **DR** Anthony Andrew Bell is a registered medical practitioner. He graduated MBBS 1970 London, is a member of the Royal College of Surgeons England, is a licentiate of the Royal College of Physicians London (1970) and a member of the Royal College of Physicians (1973) (UK).

2.2 **DR** Bell has been registered in New Zealand since 8 May 1975.

2.3 **AT** the material time, Dr Bell was practising at the White Cross Otahuhu Accident and Medical Centre. He was working the night shift from 10 pm to 8 am.

2.4 **AT** the material time during the night shift, there was one doctor and one nurse available. There was no receptionist.

2.5 **ON** 7 December 1996 at approximately 12.40 am, Dr Bell was asked to see a 21 year old female patient, who described a recurrence of shoulder pain. She had had the same problem two months ago, and she advised Dr Bell that it had been precipitated by lifting and helped by physiotherapy.

2.6 **ON** presentation the patient had the same symptoms as she had two months previously. There was however no precipitating factor. She had pain in her left shoulder radiating down to her middle three fingers. She had been employed as a paint tinter, until the day before the consultation when she had resigned. She was in pain and had been very busy and was tired.

2.7 **DR** Bell did a full examination of the shoulder and neck. The patient, on examination, had a full range of movement for shoulder and neck. She was very tender from cervical vertebra one through to four, on the left side of the neck. Pressure on the neck did not reproduce pain in the fingers.

2.8 **DR** Bell diagnosed cervical neuralgia. His plan was to prescribe the patient with diazepam to relax her muscles, and induce sleep. The patient was very upset and concerned with the pain she

was having. She complained of having difficulty sleeping. Dr Bell prescribed diazepam and acupan tablets. He gave her a continuing prescription for digesic tablets for pain, for filling the following day.

2.9 **AS** there was no pharmacy open at that time, Dr Bell was obliged to dispense medication to the patient. He did this after explaining the nature of the medication that he was giving the patient, the purpose of the medication, and the side effects as set out in paragraph 2.10. He placed two 30 mg acupan tablets (one dose of 60 mgs for that night if necessary) and six 10 mg diazepam tablets (for three nights 20 mg dose per night), in an unlabelled [small re-sealable type] plastic bag. Dr Bell told his patient to take two of the blue tablets (diazepam) that night and if in an hours time she was not feeling better then to take two of the white tablets (acupan). Dr Bell then told the patient to take two more blue tablets the following night and if necessary then to take the final dose the night after that. The patient understood these instructions. [Dr Bell did not sell the drugs to the patient].

2.10 **IN** relation to the diazepam tablets Dr Bell named the tablet and gave a description of its side effects. He told his patient that diazepam was a muscle relaxant and that he had taken the tablet himself on one occasion, and that the effects that he noted included having wobbly legs, feeling like he might fall over, and with difficulty focusing. He advised the patient that the object of taking diazepam was to help her difficulty sleeping.

2.11 **BECAUSE** the patient was in considerable pain, Dr Bell also prescribed acupan. This is a stronger painkiller and he advised the patient of the name of the painkiller and that that medication should only be taken if she was still in pain an hour after having the diazepam.

2.12 **DR** Bell advises the Tribunal that dispensing of medication in the practice was a nightly occurrence. Mostly patients would be given tablets to take in the clinic with a script for the next day. With drugs like diazepam the patient would be given a dose to take once they had returned home with a script for the following day. Giving more than one dose to a patient to take home, would be unusual. His practice at that time was with one dose for the night to give written instructions if he thought that the patient had not understood his instructions. He has subsequently changed that practice and gives written instructions with medication.

2.13 **THE** Health & Disability Commissioner's Office received the patient's complaint in relation to this particular matter on 9 December 1996, two days following the consultation. The Health & Disability Commissioner issued her provisional opinion in April 1998. Dr Bell was charged with a breach of the Medicines Regulations in April 1999. Other matters were investigated which did not result in charges. Some of the delay in laying a charge was caused by a dispute between Dr Bell and the Commissioner as to her internal procedure and her process of referral to the Director of Proceedings. Further, the Director of Proceedings did not receive the Health & Disability Commissioner's file until March 1999.

2.14 **DR** Bell acknowledged in his letter of response to the Health & Disability Commissioner on 10 March 1997 that he should have labelled the plastic bag. He has subsequently altered his practice, provided a written apology to the patient, and re-read the provisions of the Medicines Regulations. A copy of the Commissioner's opinion has been placed on Dr Bell's file at the Medical Council.

3. EVIDENCE OF DR BELL:

3.1 **IN** referring to his note of his consultation with the patient, which is part of the agreed bundle of documents provided by the Director of Proceedings, he noted in his note under the heading *"Medication given"* a plan to give one dose of acupan and one dose of diazepam. Having subsequently noted under *"Plan"*, that he had increased the dose of diazepam to three nights worth, he is unclear now, why he did this, as the consultation occurred two and a half years ago. Noting that 7 December 1996 was a Saturday night, he may have increased the planned dose, to attempt to assist the patient over the weekend.

3.2 **PARAGRAPH** 12 of the Agreed Statement of Facts sets out his practice at the time he saw the patient. His practice at that time, was to issue one dose with script for the next day, and written instructions only if he considered a patient had not understood his instructions. With drugs like diazepam and a dosage of 20 mgs, his usual practice is to ask the patient what they have understood him to say. Giving more than one nights supply would be unusual, and written instructions usual. He cannot remember why he did not on this occasion. It seems likely that as his original plan was to give one nights supply, that he went with his usual practice for one nights supply.

3.3 **NIGHT** work in clinics is only occasional work for him now. More commonly he works for a house visiting service. He carries small plastic bags and a container of sticky labels and labels any medication he hands out that is not used in his presence. With regards to night clinic work, all medication given to patients to take at home is now labelled. His past usual practice is or was common practice amongst other night doctors, several of whom he has asked.

4. SUBMISSIONS:

4.1 IN brief summary the principal submissions made by the Director of Proceedings were:

(1) Medicine is poison particularly if used inappropriately. It is extremely important that the correct dose and frequency is taken by a patient. Simply telling a patient what medicine is to be supplied, its nature, the dose and frequency, is not enough. It is vital that the name of the medicine, its dose, and frequency be recorded in writing.

(2) Failure to comply with Regulation 23 of the Regulations, and in particular failing to write down the name of the medicine, its dose and the frequency, is an extremely irresponsible act on the part of the practitioner. No reasonable medical practitioner would provide a patient with unlabelled medications, particularly medicines as potent as those supplied by Dr Bell.

(3) Whilst neither the Medical Council of New Zealand nor the Ministry of Health have published any guidelines for doctors supplying medicine, to label medicines and the required dose and frequency is so fundamental that guidelines are not required.

(4) By failing to record the name of the drug and dose and frequency of the dose, Dr Bell has conceivably placed the safety of a member of the public at risk.

4.2 AGAIN in brief summary the principal submissions made by Ms Gibson on behalf of Dr Bell were:

(1) It is clear that while Dr Bell did not re-label the re-sealable plastic bag that he gave his patient, he did in all other respects, comply with Regulation 23 of the Medicines Regulations 1984. He:

(a) Identified and named for the patient, the medications diazepam and acupan.

(b) Both he and the patient were aware of the patient's name, and the doctor's name and the name of the surgery

(c) The patient and the doctor both understood that the medication was for internal use, the dose of the medication to be taken, and the frequency of that dose.

(2) In addition:

(a) Dr Bell issued the medication in a re-sealable plastic bag, that complied with the Act and Regulations.

(b) Dr Bell did not sell the medications to his patient. He gave a dose for administration (in respect of the acupan) and this was also initially his plan for the diazepam tablets.

(c) In addition to the requirements of the Medicines Regulations 1984, Dr Bell provided an explanation of the side effects of the medication.

5. DISCUSSION AND FINDING:

5.1 **ALTHOUGH** there is an Agreed Statement of Facts, the Tribunal must determine in relation to the charge and in relation to each particular of the charge, whether the facts alleged have been proved to the required standard.

5.2 **IF** proved, the Tribunal must go on to determine whether the conduct established by the proven facts amounts to conduct unbecoming which reflects adversely on fitness to practise medicine.

5.3 **THE** onus of proof rests on the Director of Proceedings. She must discharge this onus on the evidence that she calls. The evidence before the Tribunal is essentially an Agreed Statement of Facts together with Dr Bell's brief of evidence.

5.4 **IT** is clear from the Agreed Statement of Facts that Dr Bell did not comply with Regulation 23 of the Medicines Regulations 1984. The Director of Proceedings clarified that Dr Bell failed to label the medication and record the name of them and the dose and frequency that the patient was required to take them.

5.5 **IT** is a simple enough finding for the Tribunal to make, which it does, that Dr Bell did not comply with Regulation 23 of the Medicines Regulations 1984.

5.6 **IT** is now necessary for the Tribunal to determine whether the established conduct warrants the making of a determination that Dr Bell should be disciplined.

6. DETERMINATION:

6.1 **THE** Director of Proceedings submitted that if one considers the purpose of Regulation 23 then the error is one for which the practitioner should be disciplined.

6.2 **THE** Director of Proceedings said she accepted that if Dr Bell had complied with the naming or describing the nature of the medicine supplied, and had recorded the dose and frequency of doses but failed to comply with the rest of the Regulation, then this would be an error, but not one justifying disciplinary action. The Director of Proceedings argued that in this instance Dr Bell

supplied diazepam and acupan which are potentially abusive drugs and have a street value. Given these factors the Director of Proceedings argued there is an even higher duty on a medical practitioner to fundamentally comply with the Regulations.

6.3 **MS** Gibson helpfully noted that a breach of Regulation 23 is not of itself an offence pursuant to the Medicines Regulations 1984. Offences pursuant to those Regulations are identified at Regulation 64. Every person who commits an offence against the Regulations is liable on summary conviction to a fine not exceeding $500.00.

6.4 **DR** Bell has been charged with a breach of the Regulations. That breach is the action that the Director of Proceedings says warrants a finding of conduct unbecoming as reflecting adversely on fitness to practise medicine. In Ms Gibson's submission no other matter can be taken into account by the Tribunal. Does a breach of the law automatically attract disciplinary sanction? Ms Gibson argued the answer is no, because it is clearly a question of degree.

6.5 **IN** respect of a conviction, the Tribunal only has jurisdiction (Section 109 of the Act) to look into the details of that conviction if the conviction has been for an offence punishable by imprisonment for a term of 3 months or longer and the circumstances of the offence reflect adversely on the practitioner's fitness to practise medicine.

6.6 **WE** accept there is some relevance in Ms Gibson's submission, because of the way the charge is framed, and the assumption that a breach of the Regulations must almost automatically bring disciplinary sanctions, that the Medical Practitioners Act 1995 illustrates that a breach of the law does not bring automatic disciplinary sanction.

6.7 **THERE** are now a number of Decisions defining conduct unbecoming, and more recently *“reflecting adversely on the practitioner’s fitness to practise medicine”*. (The rider).

6.8 **THE** most commonly referred to ruling setting out the essential features of conduct unbecoming was made by Elias J (as she then was) in *B v Medical Council* (High Court, Auckland, 11/1996, 8 July 1996) at p 15:

“There is little authority on what comprises "conduct unbecoming." The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission ... that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. .... The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. ...”

6.9 **FROM** this statement three basic and essential principles emerge:

(a) The departure must be significant enough to attract sanction for the purposes of protecting the public.

(b) A finding of conduct unbecoming is not required in every case where error is shown.

(c) The question is not whether error was made, but whether the practitioner’s conduct was an acceptable discharge of his or her professional obligations.

6.10 **THE** rider has been the subject of a Decision in the District Court, Doogue DCJ *Complaints Assessment Committee v Colin David Mantell* District Court Auckland NP 4533/98 7 May 1999. At page 16 His Honour says:

"The focus of the enquiry is whether the conduct is of such a kind that it puts in issue whether or not the practitioner whose conduct it is, is a fit person to practise medicine. In order to satisfy the requirements of the rider, it is not necessary that the proven conduct should conclusively demonstrate that the practitioner is unfit to practise. The conduct will need to be of a kind that is consistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standard will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."

6.11 **MS** Gibson submitted that the Director of Proceedings has not discharged the onus of proof. She argued the Director of Proceedings has sought to rely only on the non-labelling as the basis for disciplinary proceedings.

6.12 **WE** note that no evidence was led by the prosecution as to the level of divergence from recognised standards. The Director of Proceedings did not present us with an expert witness in accident and medical work to say everyone automatically writes labels. The Director of Proceedings case is that because Dr Bell did not write a label, therefore he is guilty of conduct unbecoming which reflects adversely on his fitness to practise medicine.

6.13 **ALTHOUGH** the Director of Proceedings submitted that no reasonable practitioner would have done what Dr Bell did, this is somewhat at odds with a letter received in evidence from Ms Gibson, being a letter addressed to her dated 21 June 1999 from Dr Richard Hulme, the Medical Director of Westcare Accident & Medical Clinics in Auckland. Dr Hulme explained if he issues one dose of a medication only, he does not usually label this and he said he did not realise this was a legal obligation. In Dr Hulme's experience, the requirements of the Medicines Regulations

are not well understood by medical practitioners, as they are not usually required to supply any medication without prescriptions, in contrast with pharmacists.

6.14 **DR** Bell's evidence was that his usual practice at the time has now changed, and that he cannot now remember two and a half years after the event, why he increased his initial planned administration dose of diazepam.

6.15 **IT** is clear to us that in relation to the diazepam Dr Bell made a mistake which was at odds with his usual practice at the time.

6.16 **THERE** may still be widespread ignorance of the Medicines Act and Regulations. It is noted that the Ministry of Health has not issued any prescriber information about Regulation 23 specifically in the last 7 years.

6.17 **WE** note that Dr Bell had complied with all matters set out in Regulation 23, in verbal form, and the patient understood this. As Ms Gibson rightly observed, non-compliance with Regulation 23 of the Medicines Regulations is not a strict liability offence. The Tribunal must be clear that there has been a significant departure from accepted professional standards significant enough to attract sanction for the purpose of protecting the public. The Tribunal is not satisfied this is so in this case.

6.18 **SUPPORT** for our conclusion that this is not an appropriate case for disciplining Dr Bell can be drawn from *B v Medical Council* and *CAC v Mantell* (both supra)

6.19 **WE** do not consider that the departure in Dr Bell's case is sufficiently significant to attract sanction for the purposes of protecting the public.

6.20 **CERTAINLY** Dr Bell's failure to comply in all respects with the requirements of Regulation 23 was an error of omission on his part. However, as was made clear in *B* a finding of conduct unbecoming (as now statutorily qualified) is not required in every case where error is shown.

6.21 **LIKEWISE** as was clarified in *Mantell*, not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise medicine. In this case it is the judgment of the Tribunal, of whom three members can be seen as Dr Bell's peers, that the degree of divergence from recognised standards is not of a sufficient degree that it reflects adversely on fitness to practise medicine. In this respect a pertinent observation was made by Mr Budden, the member representing the public on this Tribunal, Mr Budden is a pharmacist by occupation. He commented that it would have been another matter had Dr Bell not explained to the patient the nature of the medication, its purposes and likely side effects.

6.22 **DR** Bell has set out for the Tribunal the changes he has made to his practice to ensure compliance with the Medicines Regulations. These changes mean that there is no current issue of protecting the public. This incident occurred on 7 December 1996. The patient's complaint was registered some two days later. In our view no action of a disciplinary nature is warranted.

6.23 **AS** was indicated at the conclusion of the hearing, the charge is dismissed.

DATED at Auckland this 21st day of July 1999

....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal