PUBLIC RECORD

Dates: 13/08/2025 - 15/08/2025
01/10/2025

Doctor: Dr Mark MACKENZIE

GMC reference number: 6046440

Primary medical qualification: MB ChB 1993 University of Stellenbosch

Type of case	Outcome on facts	Outcome on impairment
New - Determination by other regulator	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 9 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Claire Lindley
Lay Tribunal Member:	Mrs Maeve Holland
Registrant Tribunal Member:	Dr Gabrielle Downey

Tribunal Clerk:	Mrs Rachel Horkin

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Ms Catherine Stock, Counsel
GMC Representative:	Ms Ceri Widdett, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts and Impairment - 15/08/2025

1. This determination will be handed down in private. However, as this case relates to a determination of an overseas body against Dr Mackenzie, it will be published in redacted form in due course.

Background

2. Dr Mackenzie qualified as a doctor in 1993 from the University of Stellenbosch in South Africa and practised there as a GP from 1995 until 2002.

3. In 2018, he registered as a GP in Australia, having become a Fellow of the Royal Australian College of GPs in 2010. He then worked as a GP in Australia in 3 different surgeries (known in this determination as Practice A, Practice B, and Practice C,) up until March 2021.

4. On 7 April 2021, Dr Mackenzie was suspended by the Medical Board of Australia ('the Board') pending an investigation by the Australian Health Practitioner Regulation Agency ('Ahpra') into his conduct at Practice A. Later, concerns were raised about his clinical practise at Practice C.

5. Dr Mackenzie returned to the UK on 26 May 2021 but did not continue his work with the NHS while the Australia investigation and proceedings were underway.

6. On 2 July 2024, the Board found that Dr Mackenzie had engaged in professional misconduct, - as defined in s5 of the Schedule to the Health Practitioner Regulation National Law 2009 (Qld) as implemented by the Health Practitioner Regulation Application Act 2024 (WA). As a result, Dr Mackenzie was reprimanded by the Board, and his registration was cancelled. He was also disqualified from reapplying for registration for a period of 12 months and ordered to pay a sum of $15,000 towards the Board's costs.

7. The GMC first became aware of the investigation into Dr Mackenzie's conduct and practise by an email dated May 2021 from Ahpra. It was later informed of the outcome on 5 July 2024 and sent a link to the Board's determination document.

8. The detail of the professional misconduct found against Dr Mackenzie is set out below under the heading '*Facts of the Professional Misconduct.'*

9. In essence, the Board found that Dr Mackenzie failed to maintain appropriate professional boundaries with colleagues and patients while working at Practice A. Also, at Practice C, Dr Mackenzie inappropriately prescribed restricted drugs to at least 8 patients, did not keep adequate clinical records, and failed in his clinical care.

The Outcome of Applications Made during the Facts Stage

10. The Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit further evidence. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

11. The Allegation made against Dr Mackenzie is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 2 July 2024, the Medical Board of Australia determined:

    a. that you had engaged in professional misconduct as defined in section 5 of the Schedule to the Health Practitioner Regulation National Law 2009 (Qld) as implemented by the Health Practitioner Regulation Application Act 2024 (WA)('National Law');
    Admitted and Found Proved

    b. to:

        i. reprimand you, pursuant to section 196(2)(a) of the National Law;
        Admitted and Found Proved

        ii. cancel your registration, pursuant to section 196(2)(d) of the National Law;
        Admitted and Found Proved

        iii. disqualify you from applying for registration for a period of 12 months from the date of the order, pursuant to section 196(4)(a) of the National Law;
        Admitted and Found Proved

        iv. order you to pay a contribution towards the Medical Board of Australia's costs, fixed in the sum of $15,000.00, within a time to be agreed between the parties.
        Admitted and Found Proved

        And that by reason of the matters set out above your fitness to practise is impaired because of the determination by an overseas body that your fitness to practise is impaired.

        To be Determined

The Admitted Facts

12. At the outset of these proceedings, through his counsel, Ms Catherine Stock, Dr Mackenzie made admissions to all of the paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules').

13. In accordance with Rule 17(2)(e) of the Rules, the Tribunal therefore announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Determination on Impairment

14. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Mackenzie's fitness to practise is impaired by reason of a determination by an overseas body.

The Evidence

15. The Tribunal had regard to the documentary evidence provided by the parties.

16. The Tribunal received from the GMC:

- correspondence between the GMC and Ahpra;
- decision of the Medical Board of Australia and its Annex;
- correspondence with NHS England in relation to Dr Mackenzie's present work agreements;
- Dr Mackenzie's Rule 7 response;
- Letter from Every Doctor dated 22 September 2022.

17. The Tribunal received from Dr Mackenzie:

- Witness statement dated 5 July 2025;
- Reflective statement dated 5 July 2025;
- Various CPD certificates;
- Independent Opinion for Ahpra by Dr I dated 4 April 2022;
- XXX;
- Professional Standards Group (PSG) outcome letter and related undertakings dated 16 January 2025;
- Letter of support from Ms H, Clinical Psychologist, Practice C dated 4 July 2025;
- Mentor Report, Dr F, 24 July 2025.

Dr Mackenzie's Oral Evidence

18. Dr Mackenzie gave oral evidence to the Tribunal. He firstly adopted the two statements that he had made dated 5 July 2025. He was then asked questions by Ms Ceri Widdett, on behalf of the GMC. A summary of his evidence is outlined below.

19. Dr Mackenzie was firstly asked about the issues relating to prescribing.

20. Dr Mackenzie informed the Tribunal that, in the main, he did obtain appropriate permissions prior to prescribing but admitted that there were *'lapses'.* Dr Mackenzie was asked about the harm posed to a specific number of the patients, and he accepted that his prescribing did cause a risk of harm. When asked why this was not reflected in his written statement, Dr Mackenzie advised that there is no reason for this.

21. Dr Mackenzie was asked why he did not prescribe correctly, and he explained that, in some cases, the documents can create an appearance of excessive prescribing rather than there actually being excessive prescribing. Sometimes, it was an omission in the notes rather than a prescribing issue.

22. However, Dr Mackenzie did accept that, in some cases, there was excessive prescribing, and this should not have happened. Dr Mackenzie stated that some of these patients were very complex and, in hindsight he could have done with more support in dealing with them. He said that he '*should have done better,'* it was an *'honest mistake'* and it *'shouldn't have occurred.'*

23. Dr Mackenzie informed the Tribunal that there is not up to date data in Australia and that there are no joined up IT systems. He said that this meant that information was not available in real time and this is how some of the prescribing incidents occurred. Dr Mackenzie stated that when he did not have full disclosure from a patient it made prescribing challenging. He said that he was prescribing with the *'best of intentions,'* and that he had a number of patients with very complex issues, and he could have done with more support.

24. Dr Mackenzie stated that there are several more checks and balances in the UK when it comes to prescribing and, if he were allowed to work in UK practice, he would be happy to work with a prescribing advisor or a local board to monitor his prescribing practice.

25. Dr Mackenzie informed the Tribunal that he saw between 15,000 and 18,000 patients without incident and disagreed when asked by Ms Widdett if he had a tendency to minimise the prescribing incidents. When also asked by Ms Widdett why he had not undertaken any CPD regarding prescribing prior to this year, Dr Mackenzie stated that the prescribing issues only became apparent after he'd been suspended in 2021. He then returned to the UK shortly after. Dr Mackenzie indicated that he did not feel the need to undertake the CPD before as he was not working.

26. Upon being questioned by the Tribunal, Dr Mackenzie outlined his understanding of GMC Good Medical Practice ('GMP') and said that he would have to refresh himself on other

aspects of UK prescribing requirements. Dr Mackenzie also outlined his understanding of the individual doctor's responsibility in prescribing.

27. Dr Mackenzie said that in hindsight he should have got a mentor whom he could have consulted with. Dr Mackenzie stated that the COVID-19 lockdown had exacerbated the issues.

28. Dr Mackenzie stated that he has not sought to reapply for registration in Australia and does not intend to. Dr Mackenzie also stated that he is allowed to practice in the UK under the terms of the Interim Orders Tribunal but decided not to due to this substantive hearing as the outcome would impact his proposed personal development plan and reintegration into practice.

29. Dr Mackenzie was next asked about the issues relating to professional boundaries.

30. Regarding the sexual comments and jokes made, Dr Mackenzie said that he was trying to *'trying to engage on a friendly basis, and it went a bit too far.'* He said that it was an '*incremental thing'* that happened over a period of time. Dr Mackenzie said that he was not seeking to make excuses and takes full responsibility for what happened. Dr Mackenzie also said that he did not perceive a power imbalance between him and his junior colleague, but he has come to appreciate that there was, and this is not the standard expected of a doctor. Dr Mackenzie stated that he responded to the request to cease this behaviour and thought that he had improved but that he lapsed back '*into things*'.

31. Dr Mackenzie disagreed with Ms Widdett that he had a deeply ingrained attitudinal problem and stated that he will continue to address his behaviour going forward. Dr Mackenzie further stated that he did not have any complaints made against him of this nature whilst he worked at Practice B or Practice C.

32. Dr Mackenzie was then asked about record keeping. He explained that he overbooked his surgeries to try and accommodate patients who are keen to have appointments as soon as possible which can lead to time pressures. Dr Mackenzie said that he would address this moving forward. Dr Mackenzie also stated that some of the patients were shared with other colleagues and the mental state examinations would have been noted in the colleague's notes. Dr Mackenzie said that the documents before the Tribunal are a snapshot of the number of patients that he saw and he stated that he would be happy to have a regular review of his notes going forward.

33. When questioned about the letter from his then barrister dated 22 September 2022, Dr Mackenzie stated that he does not remember ever having seen the document from Every Doctor and he does not remember giving instructions to the effect of strenuously denying the allegation or that they were being *'defended vigorously'.* At that time there were negotiations to try and resolve areas in dispute that took almost three years.

34. Dr Mackenzie stated that his insight started developing very rapidly on the evening of 20 August 2019 when his contract at Practice A was terminated and it had evolved ever since. Dr Mackenzie stated that he did do some courses from the medical indemnity provider in Australia prior to his suspension and he had been exploring his behaviours with Ms H a clinical psychologist colleague at Practice C. Dr Mackenzie stated that this has been a long process of self-reflection and improvement. When asked, Dr Mackenzie clarified that he did some CPD in 2019 and 2020.

35. XXX

Submissions

On behalf of the GMC

36. On behalf of the GMC, Ms Widdett submitted that all three limbs of the overarching objective were engaged in this case. She reminded that Tribunal that there was no burden or standard of proof, and that it should consider whether the matters are remediable, have been remediated and whether there is a risk or repetition.

37. In terms of the *Grant* test, Ms Widdett said that Dr Mackenzie had put patients at risk of harm, brought the medical profession into disrepute and breached fundamental tenets of the profession. Ms Widdett also submitted that Dr Mackenzie's conduct represented a serious departure from the expected standards of conduct that can be identified in GMP and the prescribing guidance.

38. Ms Widdett reminded the Tribunal that the complaints about professional boundaries were from female colleagues, one of whom was a young staff member. These comments were prolific and took place over a six month period despite Dr Mackenzie being asked not to continue. Ms Widdett further reminded the Tribunal that there were not only sexual comments but also unwanted physical contact over that period.

39. Ms Widdett submitted that Dr Mackenzie's attempts at remediation have come very late and are insufficient, and his insight is at an early stage.

40. Ms Widdett stated that Dr Mackenzie had breached paragraphs 1 and 65 of GMP (which are set out below.)

41. Regarding the prescribing concerns, Ms Widdett submitted that Dr Mackenzie represented a risk to patient safety as a result of over prescribing, mixed prescribing and not taking an adequate patient history. Ms Widdett submitted that Dr Mackenzie did not deal with these concerns in his evidence and had no insight into the risks to patient safety with regards to prescribing.

42. Ms Widdett submitted that Dr Mackenzie breaches key tenets of GMP because it requires him to keep up to date and to follow guidance. She drew the Tribunal's attention to

the prescribing guidance and pointed out that Dr Mackenzie had breached a number of its paragraphs (set out below).

43. Ms Widdett submitted that Dr Mackenzie tends to minimise the impact of his poor prescribing in terms of the impact on patients indicating that there were a '*few*' incidents where he inadvertently exceeded the 90 milligrams morphine dose. Ms Widdett invited the Tribunal to find that it was more than a few incidents and instead there were various instances of double prescribing. Ms Widdett submitted that Dr Mackenzie does not really explain why he made these mistakes.

44. Ms Widdett submitted that there are a number of patients where there was insufficient record keeping. She said that this was a breach of paragraphs 19 and 21 of GMP (set out below). She further said that the CPD course details that Dr Mackenzie provided were completed only recently.

45. Ms Widdett stated that Dr Mackenzie had faced a range of issues in Australia, and his insight was in its early stages, with no insight into the issue relating to prescribing. She summarised by stating that a finding of impairment is necessary therefore, to satisfy all three limbs of the overarching objective.

<u>On behalf of Dr Mackenzie</u>

46. Ms Stock reminded the Tribunal that the purpose of this hearing is not to punish the doctor but to protect the public and that the Tribunal should look forward and not back. Ms Stock reminded the Tribunal that this is not a rehearing of the matters that were found in Australia.

47. Ms Stock asked the Tribunal to be mindful that the purpose of a reflective document is not to deal in detail with each and every allegation but rather to focus on learning rather than what has gone wrong.

48. Ms Stock accepted the aggravating factors that were present in this case and pointed out the mitigating factors. She reminded the Tribunal that Dr Mackenzie had not had any complaints against him at Practice B or Practice C. Ms Stock asked the Tribunal to take into account the reports from Dr B, Ms H and Dr I. She confirmed that Dr Mackenzie had taken full responsibility and shown remorse, and had plans in place for the future

49. Ms Stock reminded the Tribunal that Dr Mackenzie had admitted the allegations. She submitted that Dr Mackenzie has reflected a great deal and has gained significant insight. She said that Dr Mackenzie was not minimising his behaviour, but she reminded the Tribunal that XXX.

50. Ms Stock submitted that Dr Mackenzie has taken steps to modify his behaviour - including thinking before he speaks, and a 'no touch' policy which he implemented in Practices B and C. Ms Stock acknowledged that this is not definitive proof that there will be

no repetition of the behaviour but that it is a good indicator. Ms Stock also submitted that Dr Mackenzie was making use of his mentor, Dr F, and there were relevant courses that Dr Mackenzie had undertaken, and he has implemented the learning.

51. Ms Stock submitted that this is not a deeply ingrained attitudinal problem. Dr Mackenzie is remorseful, has reflected and remediated and his behaviour is unlikely to be repeated.

52. Regarding clinical issues, Ms Stock submitted that she disagrees with the GMC position that Dr Mackenzie has a tendency to minimise the risks. Dr Mackenzie has undertaken CPD and has taken the decision not to practise until these matters are resolved. Ms Stock reminded the Tribunal of the report of Dr I which was commissioned by Ahpra. It stated that Dr Mackenzie's prescribing did not represent a significant risk, and that his performance was adequate for someone with his qualifications and skills.

53. Ms Stock informed the Tribunal that Dr Mackenzie offers an unreserved apology to all involved and fully appreciates the impact of his actions. Should he return to practise there is an agreement in place with NHSE Professional Advisory Group to allow a return to practise safely.

54. Ms Stock submitted that there is no risk to the public and impairment is not justified solely to maintain public confidence in the profession. Ms Stock submitted that a member of the public who would be conversant with all of the facts of this case would be of the view that this is in fact a doctor who has taken full responsibility, has acted in a professional manner since and as such he has remediated his past.

The Legally Qualified Chair's legal advice

55. The Legally Qualified Chair (LQC) gave advice to the Tribunal about the approach it should take. She reminded the Tribunal that it is considering an Allegation that Dr Mackenzie has admitted. It is that on 2 July 2024, the Medical Board of Australia determined that Dr Mackenzie had engaged in professional misconduct and sanctioned him accordingly.

56. The Tribunal must now consider if, by reason of the determination by an overseas body, Dr Mackenzie's fitness to practice is currently impaired.

57. The Tribunal was reminded that there is no burden or standard of proof to adopt at this stage and that decision as to impairment is a matter for its judgement alone. Whilst there is no statutory definition of impairment, the LQC advised the Tribunal that it is assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC & Grant (2011) EWHC 927 (Admin.)* Dame Smith sets out some features that are likely to be present when impairment is found. These are where the doctor has in the past or is liable in the future to

a. act so as to put a patient or patients at unwarranted risk of harm.

b. bring the medical profession into disrepute.

c. breach one of the fundamental tenets of the medical profession; and/or

d. Have acted dishonestly and or is liable to do so in the future.'

58. The Tribunal was advised that it must determine whether Dr Mackenzie's fitness to practise is impaired today, taking into account the past actions which led to the overseas determination and his conduct at the time of the events, and any relevant factors since then. It should consider whether the matters are remediable, have been remedied and whether there is any likelihood of repetition. To assist it in this decision, the Tribunal must determine where Dr Mackenzie has demonstrated insight, and if so to what extent.

59. The Tribunal was informed that it should take into account Dr Mackenzie's hitherto good character when making a determination on impairment.

60. The Tribunal was asked to note that part of the determination by the overseas body relates to concerns about maintaining professional boundaries with female colleagues, and part to clinical performance. The Tribunal was reminded that clinical performance may be more easily remediable than concerns about behaviour. Unlike clinical errors, where further practice and/or teaching would likely show a practitioner the correct method of practice, the nature of behaviour goes more to the practitioner's character than learning. Personal mitigation therefore should hold less weight in such cases.

61. Having said that the Tribunal must note that each case should be decided on its own merits. The Tribunal should look at the circumstances of the case, the need to uphold public confidence, and what has been done to remediate.

62. As well as considering the features set out in *Grant,* the Tribunal was informed that it must also consider the overarching objective and determine whether the need to uphold professional standards and maintain public confidence would be undermined if a finding of impairment were not found. The Tribunal was asked to note the principle in the case of *Yeong v GMC* [2009] EWHC 1923 Admin*,* that:

'*There will be occasions where impairment of fitness to practice must be found as a matter of public policy to uphold public confidence in the profession where to make no such finding would have an adverse impact on public confidence in the profession*.'

63. The Tribunal was further advised to have regard to the case of *General Medical Council v Chaudhary [2017] EWHC 2561 (Admin),* which emphasises that remediation alone is not the end of the matter and that the Tribunal must, at all times in its deliberations, have in mind the three limbs of the overarching objective.

The Tribunal's Analysis of the Evidence and Findings

Facts of the Professional Misconduct

64. The Tribunal considered the facts of the professional misconduct that Dr Mackenzie had agreed with Ahpra, which had been accepted by the Board. They were attached to the Board set out in a document entitled 'Annexure A,' which was attached to the determination. From Annexure A, the Tribunal noted that the professional misconduct broadly related to two different areas of concern, namely professional boundaries and clinical performance.

Professional boundaries

65. Annexure A makes it clear that doctors in Australia must conduct themselves professionally in the workplace and maintain professional boundaries with patients and colleagues. This is in order to comply with *Good Medical Practice: a Code of Conduct for doctors in Australia* ('the Australian Code of Conduct'), and to ensure the provision of good care to patients.

66. Contrary to these professional obligations, Dr Mackenzie failed to maintain appropriate professional boundaries with colleagues and patients while working at Practice A.

67. Dr Mackenzie worked at Practice A from 26 February 2019 to 20 August 2019. During this time, Dr Mackenzie made inappropriate sexual comments and jokes to female colleagues on a daily basis. Among other things, these included:

- comments about sexual topics and female bodies,
- comments about female patients,
- occasionally making the comments and jokes while he clutched his groin and made thrusting movements in the manner of an Elvis Presley performance,
- him saying to Nurse G (a nurse) words to the effect that he liked women with nipples large enough that he could hang an umbrella or coat hanger from them,
- making several comments to Nurse G about the bodies of female patients, including comments about the patients' breasts and buttocks and whether he found them to be sexually attractive.
- him saying to Ms H (the practice manager), words to the effects of '*I like my coffee like I like my woman hot and sweet,'*
- saying '*love you'* to Nurse G, and
- persisting after Ms H counselled him to cease making sexual comments to his colleagues.

68. Dr Mackenzie also made repeated unwanted physical contact with his female colleagues at Practice A, which included:

- putting his arms around his female colleagues' shoulders,

- putting his hands on his female colleagues' shoulders or forearm,
- putting his arm around Nurse G's waist, and
- persisting after he was counselled by Ms H to cease making physical contact with his colleagues.

69. Notably, there was a significant power imbalance between Dr Mackenzie and Nurse G. She was a junior nursing colleague and there was an age gap of XXX years between them. However, Dr Mackenzie repeatedly said '*love you'* to her and said that he wanted a *'friend with benefits,'* suggesting *'I guess you will have to do.'* He informed Nurse G that he had drawn a picture of a gingerbread man over a photograph of his penis and attempted to show the photograph to her.

70. There were also concerns raised about the way that Dr Mackenzie interacted with female patients, such as putting his arms round their shoulders while at the practice. A specific example was given where Dr Mackenzie, in relation to a female patient's symptoms for mastitis, said words to the effect that XXX, and that he really liked large breasts.

71. The Tribunal considered this conduct carefully. It noted that Dr Mackenzie 's sexualised behaviour was directed towards both colleagues and some patients. It involved sexual comments, jokes and physical touching on a daily basis over a period of months. The Tribunal also noted the power imbalance between Dr Mackenzie and Nurse G. The Tribunal reminded itself that the behaviour persisted despite Dr Mackenzie being asked to stop.

72. The Tribunal considered that Dr Mackenzie was in a position of trust and that he dealt with a number of vulnerable patients. In making comments about these patients, the Tribunal determined that Dr Mackenzie abused this position of trust. The Tribunal was further concerned that Dr Mackenzie made sexualised comments to patients who may then feel uncomfortable being treated by him.

73. The Tribunal concluded that sexualised behaviour of this nature would be seen as deplorable by fellow practitioners. It decided that Dr Mackenzie's professional conduct engaged limbs *(a) (b),* and *(c)* of the guidance set out in *Grant.* It decided that patient safety could be effected because of the workplace environment that had been created, and because Dr Mackenzie's behaviour toward patients may have curbed their ability to describe symptoms of a personal nature during a consultation. The Tribunal concluded that Dr Mackenzie 's actions could bring the medical profession into disrepute, and by acting in this way, he had breached one of the fundamental tenets of the medical profession.

74. The Tribunal noted that the Board had decided that Dr Mackenzie's behaviour breached the Australian Code of Conduct. The Tribunal concluded that, had the conduct taken place in the UK, it would also have breached a number of paragraphs of GMP 2013 namely:

> *'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to*

date, establish and maintain good relationships with patients and colleagues are honest and trustworthy, and act with integrity and within the law.

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

…

36 You must treat colleagues fairly and with respect.
37 You must be aware of how your behaviour may influence others within and outside the team.

…

46 You must be polite and considerate.
47 You must treat patients as individuals and respect their dignity and privacy.

…

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

75. The Tribunal had regard to the statutory overarching objective and decided that Dr Mackenzie's behaviour toward both colleagues and patients would undermine public confidence in the medical profession, did not promote the health safety and wellbeing of the public, and did not uphold proper professional standards. By having an overseas body make a determination that Dr Mackenzie had engaged in professional misconduct in this way, he had brought the medical profession into disrepute.

Clinical performance

76. Annexure A makes it clear that prescription only medicines and drugs of addiction are restricted by statute in Australia.

77. At Practice C, where Dr Mackenzie had worked from 18 October 2019 to 26 March 2021, he inappropriately prescribed restricted drugs to at least 8 patients. He had on occasion used private scripts, at times did not obtain approval/authority for the prescriptions, concurrently prescribed prescriptions in circumstances were there was no recorded mental state examination, and prescribed excessive quantities of medication. The Tribunal noted the extensive lists of drugs that Dr Mackenzie had prescribed to these patients.

78. Dr Mackenzie did not keep adequate clinical records while at Practice C. Some of his medical notes were very short- comprising one or two words or sentences. Others did not

mention whether an appropriate adult had been present at the appointment if one was required, if the patient had had a mental state examination, or whether referral to a psychiatrist had been considered. In one record, it was not clear if the side effects of medication had been discussed with a patient, and in another why a particular medication had been added to that patient's medication list.

79. The Tribunal noted that Ahpra had sought an independent opinion from an expert, Dr I, about the clinical concerns, and that he produced a report dated 4 April 2022.

80. Dr I considered the case notes for each patient and gave an opinion about Dr Mackenzie's prescribing and record keeping. He described the recommendations in '*Accountable Prescribing'* and the Australian Code of Conduct in relation to the provision of good care which Dr Mackenzie should have been following. He summarised:

> *'Dr Mackenzie on most occasions, under difficult circumstances, did attempt to comply with these recommendations. The main consistent area of deficiency with Dr Mackenzie's medical practice was his poor clinical documentation.'.*
>
> *…*
>
> *'Clearly there are areas of deficiency in Dr Mackenzie's practice that have been outlined in this report, but I believe, overall, that Dr Mackenzie did attempt to provide good clinical care for his patients. I do not believe Dr Mackenzie put the safety of his patients reviewed in this report at any significant risk.'*
>
> *…*
>
> *'I believe, overall, that Dr Mackenzie's care of the patients in this report was adequate and at the level expected from a doctor of his experience and qualifications.'*

81. Dr I described the issues that he felt could have affected Dr Mackenzie's clinical performance. He said that Dr Mackenzie had had to settle in a new practice in a new country and that he had inherited some patients with complex needs. He remarked that, during this period of time, the COVID-19 pandemic was hindering opportunities for GPs to access educational opportunities, such as mental health training, prescribing, managing drug addiction and how to handle the care of the complex patients. He said that this could have made the transition to Australia for Dr Mackenzie's more difficult as he would not have been able to adequately address any deficiencies, he felt he may have had. Dr I felt that most of the deficiencies in Dr Mackenzie's clinical practice could be addressed by accessing relevant educational opportunities.

82. At the end of the report, Dr I stated, '*I believe it has been a difficult journey for Dr Mackenzie settling into General Practice in Australia,'* and answered '*no'* to question that was posed by Ahpra namely:

'Was Dr Mac Kenzie's performance in relation to these patients generally of a lesser standard than reasonably expected of a health practitioner of his level of training and experience?'

83. The Tribunal considered the clinical performance carefully. It noted that Dr Mackenzie had admitted to the concerns about his methods of prescribing of prescribed drugs and drugs of addiction, and his record keeping. The Tribunal reminded itself of Dr Mackenzie's oral evidence in which he acknowledged that he had made *'lapses'* in overprescribing and, seemingly, placed some of the blame for these lapses on the lack of an integrated data system in Australia.

84. The Tribunal acknowledged that Dr Mackenzie saw between 15,000 and 18,000 patients and the allegations referred to only 8. However, the Tribunal reminded itself that, in his own oral evidence Dr Mackenzie accepted that his actions caused risk of harm to patients. The Tribunal is satisfied that the prescribing concerns were serious and that there was potential for patients to be put at risk of significant harm.

85. The Tribunal concluded there was a risk to patient safety both in terms of Dr Mackenize's prescribing, clinical care, and record keeping. Some of Dr Mackenzie's patients were vulnerable, had complex needs, and mis-prescribing could have had a significant impact on them. Also, if records are not kept clearly and accurately, then it risks misunderstandings and confusion among health care professionals, a risk which is heightened when addictive drugs are involved. The Tribunal decided therefore that Dr Mackenzie 's professional conduct in relation to the clinical issues engaged the first limb in *Grant.*

86. The Tribunal noted that the Board had decided that Dr Mackenzie's clinical performance fell below the standards set out in the Australian Code of Conduct. The Tribunal also concluded that Dr Mackenzie 's clinical shortcomings would have breached a number of paragraphs of GMP 2013 had the conduct taken place in the UK, namely:

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

7 You must be competent in all aspects of your work, including management, research and teaching.
…'

11 You must be familiar with guidelines and developments that affect your work.

12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.

…

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs

…

f check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

…
21 Clinical records should include:
a relevant clinical findings
b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c the information given to patients
d any drugs prescribed or other investigation or treatment e who is making the record and when.

87. The Tribunal also concluded that Dr Mackenzie's clinical shortcomings would have breached a number of paragraphs of '*Good practice in prescribing and managing medicines and devices 2013*', namely:

3 You are responsible for the prescriptions you sign and for your decisions and actions when you supply and administer medicines and devices or authorise or instruct others to do so. You must be prepared to explain and justify your decisions and actions when prescribing, administering and managing medicines.
…

9 You must be familiar with the guidance in the British National Formulary (BNF) and British National Formulary for Children (BNFC), which contain essential information to help you prescribe, monitor, supply, and administer medicines.

10 You should follow the advice in the BNF on prescription writing and make sure your prescriptions and orders are clear, in accordance with the relevant statutory requirements and include your name legibly.

2 You should also consider including clinical indications on your prescriptions

11 You should take account of the clinical guidelines published by the:

a NICE (England)
b Scottish Medicines Consortium and Health Improvement Scotland (including the Scottish Intercollegiate Guidelines Network) (Scotland)
c Department for Health, Social Services and Public Safety (Northern Ireland)
d All-Wales Medicines Strategy Group (Wales)
e medical royal colleges and other authoritative sources of specialty specific clinical guidelines.

14 You should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs.

…

55 You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate. You should consider the benefits of prescribing with repeats to reduce the need for repeat prescribing.

…

57 You must be satisfied that procedures for prescribing with repeats and for generating repeat prescriptions are secure and that:

b the correct dose is prescribed, particularly for patients whose dose varies during the course of treatment

Impairment

88. Having considered the facts of the Australian determination carefully, the Tribunal then went onto to consider whether Dr Mackenzie's current fitness to practice is impaired. In doing so, the Tribunal had regard to its overarching objective.

89. In reaching its determination, the Tribunal took into account the written evidence that it had received and the oral evidence that Dr Mackenzie gave. It also considered the submissions of both Ms Widdett and Ms Stock.

90. The Tribunal firstly considered whether the conduct described in the Australian determination was remediable. It took into account the fact that the behavioural concerns about maintaining professional boundaries would be more difficult to remediate than the issues about Dr Mackenzie's clinical performance. Nevertheless, the Tribunal decided that both aspects of the professional misconduct were remediable.

91. The Tribunal therefore considered carefully what steps Dr Mackenzie had taken to remediate his actions.

Insight

92. The Tribunal firstly considered Dr Mackenzie's level of insight in relation to his conduct toward female colleagues and patients.

93. The Tribunal took note of the letter from Every Doctor to the GMC. It said that Dr Mackenzie was going to '*strenuously deny*' and '*vigorously defend*' the allegations. However, the Tribunal did not place much weight on the content of this letter. It amounted to hearsay, and Dr Mackenzie did not recall having seen it. In any event, it was written at a time during the Aphra investigation and before the allegations had been formally put to him by the Board.

94. The Tribunal accepted that Dr Mackenzie admitted professional misconduct when it was put to him by the Board. The Tribunal also acknowledged that Dr Mackenzie had cooperated with the GMC investigation and admitted the UK Allegation at the first opportunity.

95. The Tribunal then went on to consider the evidence of insight he demonstrated when making these admissions.

96. In Annexure A of the Board's determination, there is a section headed *'mitigation'* in which the Board accepted that Dr Mackenzie had shown insight and remorse. As part of the mitigation, Dr Mackenzie explained that there had been no concerns raised after he had left Practice A at either Practice B or Practice C.

97. Dr Mackenzie had also submitted a response to the GMC in an email dated 28 October 2024 ('the Rule 7 response'), which the Tribunal considered carefully. In it, Dr Mackenzie reflected on his behaviour and summarised by saying:

> *'… I accept that while I was practicing at the [Practice A], I was guilty of professional misconduct which I deeply regret. Sadly, I cannot change the unacceptable way I behaved at {Practice A] I let my colleagues down, my patients and my family. My wife has stood by my side as she knows that medicine is a passion and not just an occupation for me. I feel that the level of insight I have has grown tremendously since these events which occurred more than 5 years ago. That being said I am fully and wholeheartedly committed to the necessary steps to be taken if I am fortunate enough to be allowed to return to medicine'.*

98. The Tribunal also noted that Dr Mackenzie acknowledged the upset that he had caused to one of his colleagues. He said:

> *'I was quite upset to learn that I had caused Miss D the level of distress that she clearly had suffered, based on her later submission. I valued Miss D as a colleague and friend and had felt that I had been quite supportive of her in the practice. I valued her professional competence and the support she provided me while I was at [Practice A] When I left [Practice A] I did ask my previous employer if they could facilitate a meeting so that I could apologise to Miss D in person. Unfortunately, I never heard back from them on this request.'*

99. Dr Mackenzie explained in his Rule 7 response that he had wanted to understand why he had behaved in the way he did at Practice A, so when he was at Practice C, he had many conversations with Ms H, that he was working alongside. XXX

100. XXX

101. The Tribunal next considered the reflective statement that Dr Mackenzie had provided, dated 5 July 2025. In relation to the sexual comments and jokes that he made, Dr Mackenzie said:

> *'I have reflected at length as to why I made sexual comments and jokes. I was alone in Australia; XXX I was working at the practice and also working in an out of hours job and so was working a total of 80- 90 hours a week.*
>
> *I had no friends or social life, and the only 'social contact' I had was going to CPD meetings.*
>
> *XXX.*
>
> *XXX. While these factors may help explain why I behaved as I did, I do not use them as an excuse. I accept full responsibility for my conduct, which was unprofessional and unacceptable.*

> *When [Ms H] had asked me to 'tone it down a bit', I thought that I had done so, certainly for a time. Clearly this was not enough, and as already stated, I accept that my behaviour did not meet the standards expected.'*

102. In relation to the physical contact allegations, Dr Mackenzie said:

> *'I do not consciously go out and seek to make physical contact with staff. I am a tactile person by nature, and with hindsight and a lot of soul searching, I have realised that I am inclined to get inside people's personal space. It is now something I am very conscious of, and as a result, I tend to be rather more stand-offish and actively seek to keep my distance in interactions. Looking back, I can see that at times I make physical contact on an arm or hand when trying to attract someone's attention*
>
> *…*
>
> *I now understand that what I considered to be harmless gestures or friendly contact were breaches of personal and professional boundaries. I did not consider at the time how such contact could be experienced as inappropriate or make others feel uncomfortable, especially in a workplace context.*
>
> *With reflection, I recognise a long-standing tendency to at times be physically expressive in interactions, which I now see as problematic in a professional setting. I have taken active steps to change this behaviour.'*

103. The Tribunal accepted that Dr Mackenzie had reflected on his professional misconduct toward female colleagues and patients. It decided that his admissions, both to the Board and this Tribunal, demonstrated a degree of timely insight. The Tribunal concluded that Dr Mackenzie had analysed his behaviour and seemed to have developed an awareness as to what is appropriate behaviour and what is not. He had attempted to apologise to one colleague and generally recognised the impact that it had on others and the wider profession.

104. The Tribunal also accepted that Dr Mackenzie had thought through why he had behaved as he had and had made inroads into recognising potential drivers to his conduct through his meetings with Ms H, XXX.

105. In summary, the Tribunal decided that Dr Mackenzie had worked hard on developing insight. However, it determined that there was more work to be done, especially in relation to understanding the impact of his behaviour on others, team dynamics and the workplace. He did not articulate this understanding in his evidence, accepting only that he was *'trying to engage on a friendly basis, and it went a bit too far.'* He had attempted to apologise to only one colleague, but not the whole team that was subjected to this daily behaviour.

106. XXX

107. The Tribunal concluded that Dr Mackenzie demonstrated timely and developing insight but determined that he had not yet developed full insight.

108. The Tribunal next considered Dr Mackenzie's level of insight in relation to his clinical failings.

109. The Tribunal accepted the findings of the expert, Dr I. However, it recognised that Dr I had drafted his report to assist the Board in Australia, and not this Tribunal. He was applying standards, expectations and guidance for Australia, not those set by the GMC in the UK. He did not attend the Tribunal and was therefore not asked any questions. The Tribunal did not, therefore, give his conclusions as much weight as ordinarily would be the case.

110. Dr Mackenzie explained in his reflective statement that there had been a prescribing review at Practice C, which was when his shortcomings came to light. He accepted that his poor record keeping could have impacted on patient care. He reflected on his methods of prescribing to '*Fly in, fly out'* patients when they did not have access to pharmacies. He thought that some of the deficiencies were due to overbooked surgeries which he would control in future. He adopted the issues raised by Dr I in his expert report (mentioned above), as probable reasons for his clinical performance. He summarised by saying:

> *'While I fully accept that there were some deficiencies in my prescribing, it was never my intention to over-supply any medication, and AHPRA's own auditor was of the opinion that the issues in my prescribing were easily remedied, and that it was clear that I always had the best interests of my patients at heart'.*

111. In his oral evidence, Dr Mackenzie accepted that there was a risk of harm to his patients. He then gave a number of reasons for his poor clinical performance. He said, for example, that in Australia there was not up to date data, so he was sometimes unaware of a patient's records when treating them. He said there were no joined up IT systems, which meant that real time information was not available. He explained that he was treating a number of complex patients who sometimes were obtaining drugs from other services. He said that the system was different from the UK in the way that private scripts are used in Australia.

112. The Tribunal noted that, when asked questions, Dr Mackenzie was aware of some standards in the UK, but not all, and stated that he would be willing to work with a 'prescribing advisor.'

113. In summary, the Tribunal again decided that Dr Mackenzie had worked hard on developing insight. He was now aware of the need to fully document decisions and patient consultations. However, the Tribunal was concerned about Dr Mackenzie's insight into his prescribing errors. While he recognised the seriousness of the errors, and the harm that could have been caused, he did not fully accept responsibility, especially in his oral evidence, when he gave a number of other system related reasons why his performance was deficient.

Remediation

114. The Tribunal next considered the steps that Dr Mackenzie had taken to remediate his actions in relation to his conduct toward female colleagues and patients.

115. In his Rule7 Response, Dr Mackenzie confirmed that he had undertaken some training modules in Australia during 2020, which were all aimed at minimising risk in practice. In his reflective statement, Dr Mackenzie set out more fully the steps he had taken, and also furnished the Tribunal with the detail of a number of courses (related to conduct) that he had attended, namely:

- *Professional Boundaries Course -MMDUS 18 June 2025*
- *An Overview of GP Leadership - RCGP Online CPD Course – 21 May 2025*
- *Professional Virtues in Modern Medicine - RCGP Online CPD Course. Date: 19 February 2025*
- *MIPS of Australia – Employee Relations (Online CPD Course) 29 January 2020*
- *MIPS of Australia – 'Managing Bullying and Harassment' (Online CPD Course) – 29 January 2020*
- *MIPS of Australia – "Contemporary Patient Communications– Are They Safe?" (Online CPD course) Date: 29 January 2020*

116. The Tribunal noted that Dr Mackenzie had described each course, his thoughts on it, and the insight he had gained. He also set out the actions that he had taken as a result of each course or planned to take in the future. He made commitments to how he would act in future.

117. Dr Mackenzie also stated that he been *'Reading and Reflecting'* on GMP, and, since June 2025, has had the benefit of a mentor, Dr F. Dr Mackenzie has shared the details of his conduct with him, and states that their relationship is assisting him in gaining insight about his behaviour. In his reflective statement, he said: '*Dr F …has confirmed my understanding that my previous behaviour may have had on the individuals involved, the Practice where these events took place, as well as the potential negative impact on the Medical Profession.'*

118. The Tribunal read the letter from Dr F dated 24 July 2025. He confirmed that he had conducted three mentoring sessions with Dr Mackenzie during June and July 2025. He described that the first session involved full disclosure of the professional misconduct and the determination by the Board in Australia. The second session involved a discussion about how Dr Mackenzie intends to prepare for a return to and integrate into clinical practice, and the third was an *'emotional check in.'* He explains that Dr Mackenzie has sought professional help and has taken '*great steps to understand himself and his behaviours.'*

119. When considering the steps outlined above, the Tribunal concluded that Dr Mackenzie had made steps to remediate his behaviour. He had attended relevant courses. The Tribunal decided however, that his work with his mentor, Dr F, was limited in both time

and depth. The mentoring arrangement had been in place only since June 2025, with only 3 sessions having taken place.

120. The Tribunal next considered the steps that Dr Mackenzie had taken to remediate his actions in relation to his clinical performance. In his Rule 7 response, Dr Mackenzie accepted he would need to address the way in which GP surgeries now work in the UK. He said:

> '*Having not worked in General Practice (or medicine in general) since June 2018, I fully appreciate (and have always anticipated) that I would need to be reintegrated into UK GP practice to refamiliarize myself with procedures and processes here. Certainly the structure of General Practice, commissioning and PCN's has evolved a lot since I was last in practice in the UK.'*

121. In his reflective statement, Dr Mackenzie confirmed that he had attended a course on 23 May 2025 namely '*GMC Guidance – 'Good Practice in Prescribing and Managing Medicines and Devices'.* Again, he set out what insight he had gained, and actions he has taken or would take in the future. Dr Mackenzie also stated that he has conducted a thorough review of regulatory guidance and professional standards including:

> • *GMC's 'Good Medical Practice' and its supplementary guidance on record keeping and prescribing*
> • *AHPRA's expectations for comprehensive and contemporaneous records*
> • *Principles from the Royal College of General Practitioners (RCGP) and Royal Australian College of General Practitioners (RACGP)*
> • *Key learning from medical defence organisations and documented case studies.*

122. The Tribunal noted that Dr Mackenzie has been trying to keep his general clinical skills up to date while he is not working. He is presently doing a master's course in Public Health and has attended a range of other courses (16 in total), relevant to his potential work as a GP. Dr Mackenzie had also conducted a '*GP Self-Test*' which involves a learning needs assessment to assist a doctor in keeping up to date with any necessary training and has signed an Agreement with NHS England (Midlands) which includes terms aimed at minimising risk if Dr Mackenzie returns to practise in the UK.

123. The Tribunal considered Dr Mackenzie's oral evidence carefully. He demonstrated some awareness of the present Guidelines in the UK, but not all the procedures and guidance that there is.

124. In summary, the Tribunal noted that Dr Mackenzie had taken a number of steps to remediate his clinical short fallings, but that his remediation was a continuing journey.

Risk of repetition

125. The Tribunal then considered whether there is a risk that Dr Mackenzie might repeat his misconduct.

126. In his reflective statement, Dr Mackenzie confirmed that he intends to continue his relationship with Dr F. He said:

> *'…We have known each other for a number of years, and I value his opinion and insights greatly. I feel that his ongoing mentorship will be invaluable in my assimilation back into practice and be very useful in my reflective practice*.'

127. The Tribunal noted that Dr F, from his sessions with Dr Mackenzie has concluded that the risk of repetition is *'vanishingly small,'* and that, in his view, Dr Mackenzie *'is fit to practice without restriction.'*

128. The Tribunal also read a letter from Ms H. She confirmed that she had no concerns about Dr Mackenzie's behaviour toward female's colleagues or patients when he was at that surgery. She said that she and Dr Mackenzie had discussed the allegations that had been made against him at Practice A, along with XXX.' Ms H concluded that;

> *'On the basis of my interactions with him, I do not consider that Dr Mackenzie poses a serious risk to persons, particularly patients with whom Dr Mackenzie might come into contact in his practise as a medical practitioner.'*

129. The Tribunal took into account the fact that Dr Mackenzie had drafted an action plan for himself going forward, which is set out below in full:

> *'Action Plan*
> *• Engage in structured mentorship with a senior clinician for at least 12 months upon resumption of practice.*
> *• Undertake annual CPD specifically focused on professionalism, probity, professional boundaries, and communication skills.*
> *• Commit to quarterly reflective practice sessions, either through peer group discussions or with a clinical supervisor.*
> *• Implement a feedback system including colleague and, where possible, patient feedback every six months.*
> *• XXX*
> *• I intend to commit to regular feedback from staff and colleagues and continue CPD in terms of Professionalism, Probity and Good Medical Practice. I also commit to making more time for myself and family to keep a good work/life balance XXX.*
> *• I will continue to work on communication skills, including the non-verbal skills. I am very conscious of distancing and not invading personal space and need to keep this up.*
> *• Remain conscious of my situation and be more aware of how others perceive me. Get regular feedback from colleagues on 'how I am doing.''*

130. The Tribunal decided therefore that Dr Mackenzie had shown some insight and had taken steps to remediate his actions. Dr Mackenzie had a plan in place for the future, and it concluded, therefore, that the risk of repetition was moderate/low.

131. The Tribunal took into account that Dr Mackenzie was of previous good character, and that there had been no similar incidents before. There had been no complaints about Dr Mackenzie's behaviour at Practice B and Practice C, and he had not worked in the UK because he had accepted the advice that he wait until these issues are resolved. He said:

> *'I strongly feel that I do still have a valuable contribution to make to General Practice largely due to the many years of proven and varied experience, and I sincerely hope that I may have the opportunity to do so again. The feedback from patients on my practice over the years, particularly in the NHS is that I am a kind, generous and skilled family doctor. I am always reading, researching and trying to stay abreast of current medicine and practice as times change.'*

132. The Tribunal then considered the overarching objective. It concluded that Dr Mackenzie 's behaviour toward female colleagues and patients which resulted in a determination in Australia affected the safety of the public, undermined public confidence in the profession and did not uphold proper professional standards. It also concluded that Dr Mackenzie 's clinical performance issues which resulted in a determination in Australia affected the safety of the public and did not uphold proper professional standards.

133. The Tribunal was satisfied that Dr Mackenzie was developing insight, and he had demonstrated the remedial steps he had taken. It had concluded that the risk of repetition of professional misconduct was moderate/low. However, as there is not yet full insight and remediation, and there remains a risk of repetition, the Tribunal decided therefore Dr Mackenzie's current fitness to practise is currently impaired.

134. The Tribunal was also mindful of the seriousness of Dr Mackenzie's behaviour toward female colleagues and patients, and how it affects public confidence. It noted that the behaviour took place daily and involved a number of women. There was physical touching as well as sexual comments and jokes. There was a concerning power imbalance between Dr Mackenzie and Nurse G. His comments were disrespectful and offensive. The Tribunal therefore took into account the case of *Yeong* and decided that, so far as the behaviour is concerned, impairment must also be found as a matter of public policy. It decided that to make no such finding would have an adverse impact on public confidence in the profession.

135. The Tribunal has therefore determined that Dr Mackenzie 's fitness to practise is impaired by reason of the determination by an overseas body.

Determination on Sanction - 01/10/2025

136. This determination will be handed down in private. However, as this matter relates to the determination of an overseas body, a redacted version will be published within 28 days of the hearing.

137. Having determined that Dr Mackenzie's fitness to practise is impaired by reason of an overseas body, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

138. The Tribunal took into account the evidence that it had received during the facts and impairment stages of the hearing, and the submissions made by Ms Widdett and Ms Stock. Dr Mackenzie did not give oral evidence at this stage of the hearing.

139. However, the GMC and Dr Mackenzie jointly produced a document entitled 'Agreed facts document' relating to some new information about his regulatory history. This document revealed that, in December 2014, a complaint had been made by a patient to the GMC that Dr Mackenzie had been inappropriate in his communications with her. XXX.

140. XXX

141. The Tribunal noted that the GMC closed the investigation regarding his previous regulatory history by taking no further action.

Submissions

<u>On behalf of the GMC</u>

142. Ms Widdett reminded the Tribunal that the decision as to the appropriate sanction to impose in this case is a matter for its discretion, exercising its own independent judgement. She stated that the Tribunal must have regard to GMP, the Sanctions Guidance ('SG') and all three limbs of the overarching objective.

143. Ms Widdett then went on to address the Tribunal in relation to the possible sanctions in this case, starting with the least restrictive first. She explained firstly that there were no exceptional circumstances such that taking no action would be justified.

144. Ms Widdett directed the Tribunal's attention to paragraphs 80 and 81 of the SG, and stated that, in relation to the sexual misconduct, conditions would not be appropriate, workable, proportionate or measurable. The GMC considered that a period of retraining and/or supervision is unlikely to be the most appropriate way of addressing this behaviour. She said that the Tribunal had found that Dr Mackenzie had not yet developed full insight and that there was a moderate/low risk of repetition.

145. Ms Widdett submitted therefore that more serious action is required and reminded the Tribunal of its findings at the impairment stage. She stated that sexualising patients deeply undermines public trust in the profession. She pointed out that Dr Mackenzie was in a position of trust, and that there were a number of vulnerable patients he was caring for.

146. Regarding the prescribing and record keeping findings, Ms Widdett submitted that an order of conditions would also not be proportionate, workable nor appropriate. She reminded the Tribunal that it found that there was a potential to put patients at a risk of significant harm, that Dr Mackenzie did not have full insight in relation to the prescribing issues, and he was still on a remediation journey.

147. Ms Widdett submitted that an order of suspension would have a deterrent effect and can be used to send out a signal to the doctor, the profession and the public about what is regarded as behaviour befitting of a registered doctor. She said that suspension is an appropriate response to behaviour that is so serious that action must be taken to protect members of the public. Suspension is also likely to be appropriate in cases of deficient performance where the doctor has the potential to remediate.

On behalf of Dr Mackenzie

148. Ms Stock asked the Tribunal to give due consideration to three important principles when considering sanction. She said that any sanction should be proportionate, balancing the public interest against those of the doctor. She pointed out that sanctions are not intended to punish, but instead ensure the public is protected. She reminded the Tribunal that it is required to start with the least restrictive sanction necessary to meet the overarching objective

149. Ms Stock then submitted that there is a proper and justifiable basis for the Tribunal to consider conditions. She reminded the Tribunal of her previous submissions in which she outlined the aggravating and mitigating factors in this case. She then pointed out some of the mitigating factors that the Tribunal could take into account at this stage and directed the Tribunal to its findings at the impairment stage.

150. Ms Stock firstly pointed out that there is evidence that Dr Mackenzie has demonstrated insight through his early admissions and expressions of remorse, and that he had taken a number of steps to remediate his actions.

151. Ms Stock informed the Tribunal that Dr Mackenzie has no fitness to practice history albeit a single complaint that predates these matters and which was closed with no action being taken.

152. Ms Stock also pointed out that there are some personal extenuating circumstances which the Tribunal could consider, as set out by the expert.

153. Ms Stock further submitted that there was no actual harm done to patients.

154. In terms of risk of repetition, Ms Stock reminded that Tribunal that Dr Mackenzie practised for 18 months without repetition of the inappropriate conduct, and he had an action plan in place for the future.

155. Ms Stock submitted that a sanction of conditions would achieve the overarching objective of public protection and that any more severe sanction would be punitive in the circumstances, particularly as this doctor has already served a disqualification of 12 months in Australia.

156. Ms Stock said that a further period of suspension would have a devastating and lasting impact on this doctor's career and livelihood, and as such would be punitive. Ms Stock submitted that Dr Mackenzie would comply with any retraining, supervision and mentorship. She submitted that the conduct is not such that it is incompatible with continued registration.

The Relevant Legal Principles

157. The LQC gave the Tribunal legal advice. She reminded it that the decision as to the appropriate sanction, if any, is a matter for its own judgement, which must be made independently.

158. The Tribunal was directed to the SG dated 5 February 2024, which, although not statutory, gives it an authoritative steer. It was reminded that it must have regard to the aggravating and mitigating factors, and consider the least restrictive sanction first, and then move on, if needs be, to consider the other available options in ascending severity.

159. The Tribunal was informed that it must bear in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest. The Tribunal should be mindful that this is a balancing exercise - weighing up what is in the public interest, as against the interest of Dr Mackenzie.

160. The Tribunal was reminded that any sanction must be appropriate and proportionate. In the case of *Bolton v Law Society [1994] 1 WLR 512* it was made clear that the reputation of the profession as a whole is more important than the fortunes of any individual member, even if the consequences may be deeply unfortunate for them.

161. The Tribunal should consider the professional misconduct finding in Australia and the facts that lie beneath it. The circumstances of the case must be carefully considered by the Tribunal, and the nature and extent of the conduct and performance must be evaluated on a case-by-case basis.

162. The Tribunal was informed that it can again take into account Dr Mackenzie's hitherto good character and the testimonials when making a determination on sanction.

163. The Tribunal must again take into account the overarching objective of the GMC set out in section 1 of the Medical Act 1983.

The Tribunal's Determination on Sanction

164. The Tribunal accepted the LQC advice, and the submissions from Ms Widdett and Ms Stock, and then moved on to consider what, if any, sanction to impose.

165. The Tribunal first identified what it considered to be the mitigating and aggravating factors in this case. It was mindful that it needed to consider and balance any such factors against the central aim of sanctions, which is to uphold the overarching objective.

Aggravating

166. The Tribunal noted paragraphs 50-59 of the SG, which sets out some of the aggravating factors that are likely to lead a Tribunal to consider more serious action.

167. The Tribunal firstly considered carefully whether the fact that Dr Mackenzie had not developed full insight was an aggravating factor in this case. It was mindful of paragraph 52 (a)-(d) of the SG, which sets out circumstances where a doctor's lack of insight might be demonstrated. However, the Tribunal decided that Dr Mackenzie had developed some insight, accepted his mistakes, attempted to apologise to at least one colleague about his behaviour, and had been open and cooperative during the hearing. It decided therefore that it should not treat his lack of full insight as an aggravating factor.

168. However, the Tribunal was concerned about the lack of insight it had noted in relation to prescribing issues, especially as there was a potential for significant risk of harm to patients. It decided that this was an aggravating factor so far as Dr Mackenzie's clinical performance was concerned.

169. The Tribunal then noted paragraph 54 of the SG which states:

> *'Where the GMC, or another regulator, has previously made findings of impaired fitness to practise and imposed a sanction on the doctor's registration, the tribunal may wish to consider this as an aggravating factor in relation to the case before it.'*

170. While accepting that Dr Mackenzie did not have a previous finding of impairment by the UK regulator, the Tribunal took into account the complaint made by the patient in 2014 as set out in the 'Agreed facts document'. XXX, the Tribunal was concerned that Dr Mackenzie had repeated similar behaviour in Australia five years later. The Tribunal decided therefore that Dr Mackenzie's risk of repetition was 'moderate' and not 'moderate/low' as was decided at the impairment stage. The Tribunal remained of the view that the risk of repetition was not high given the work that he has done to understand the causes of his behaviour. It was further satisfied that Dr Mackenzie has looked at how to manage this

behaviour and has demonstrated maturing insight. Nevertheless, the Tribunal saw the previous complaint as an aggravating factor in this case.

171. The Tribunal next considered the circumstances surrounding the events of this case. It had regards to paragraph 55 of the SG which sets out some examples of aggravating factors that are likely to lead a Tribunal to consider taking more serious action. It was mindful that it should not go behind the decision of the Medical Board of Australia and therefore considered that the Board's determination of professional misconduct engaged the following sub paragraphs of paragraph 55:

> *55*
> *…*
>
> *b a failure to work collaboratively with colleagues*
>
> *…*
>
> *d abuse of professional position*

172. The Tribunal decided that there were a number of concerning features of Dr Mackenzie's behaviour that resulted in the Board's finding of professional misconduct.

173. The Tribunal noted that Dr Mackenzie's behaviour was directed towards female work colleagues. It involved sexual comments, jokes and physical touching on a daily basis over a period of months. The Tribunal also noted the power imbalance between Dr Mackenzie and a young nurse colleague. The Tribunal reminded itself that the behaviour persisted despite Dr Mackenzie being asked to stop. The Tribunal determined that Dr Mackenzie's behaviour would have had a negative impact on the working environment which then could have impacted on the standard of treatment provided to patients. The Tribunal decided that Dr Mackenzie had failed to work collaboratively with these colleagues and abused his professional position.

174. Further, the Tribunal reminded itself that Dr Mackenzie's behaviour was also directed towards patients, discussing them with colleagues in a sexualised and derogatory manner. He did not maintain professional boundaries with patients as he put his arms around them and, on at least one occasion, discussed matters of a personal and sexual nature. The Tribunal determined that Dr Mackenzie was acting in a way that breached the trust of patients and abused his professional position.

175. The Tribunal decided that there were also a number of concerning features of Dr Mackenzie's clinical performance that resulted in the Board's finding of professional misconduct. Dr Mackenzie was dealing with a number of vulnerable and complex patients at Practice C, many of whom had mental health and addiction issues. The Tribunal reminded itself of its finding at the impairment stage that Dr Mackenzie put patients at risk of

significant harm. The Tribunal therefore took into account paragraph 145 of the SG which states:

> *'145 Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:*
>
> *a presence of mental health issues'*

176. The Tribunal therefore decided that there were a number of factors of an aggravating nature relating to the circumstances underlying the decision of professional misconduct by the Medical Board of Australia.

Mitigating

177. The Tribunal then went on to consider the mitigating factors in this case. The Tribunal considered paragraphs 24-49 of the SG, which sets out some of the mitigating factors that the Tribunal may consider, while balancing these against the central aim of sanctions. In particular, the Tribunal noted the examples of mitigating factors listed at paragraph 25 (a)-(g).

178. The Tribunal firstly considered the level of insight that Dr Mackenzie had demonstrated. The Tribunal reminded itself of its findings at the impairment stage. It accepted that Dr Mackenzie has worked hard to develop insight into his behaviour although it is not yet fully developed. It noted that he had admitted the professional misconduct in Australia and the GMC Allegation at the start of this MPTS hearing. It accepted that Dr Mackenzie understands the problem and that he has undertaken steps to address both his behaviour and clinical shortcomings. It noted the CPD courses he has attended and his future action plan. The Tribunal also noted that Dr Mackenzie had expressed regret for his actions.

179. The Tribunal accepted therefore that Dr Mackenzie's insight and his attempts at remediation were mitigating factors in this case.

180. The Tribunal also accepted that Dr Mackenzie did not have any previous regulatory findings against him in the UK, and that, while he is not presently working, he has been keeping up to date with clinical practice. The Tribunal noted that Dr Mackenzie had completed the GP Self-Test certificate in June 2025 and had completed relevant clinical CPD courses. He is presently doing a master's degree in public health.

181. The Tribunal took into account the circumstances described by Dr I that could have affected Dr Mackenzie's clinical performance. He said that Dr Mackenzie had to settle into a new practice in a new country and that he had inherited some patients with complex needs. He remarked that, during this period of time, the COVID-19 pandemic was hindering opportunities for GPs to access educational opportunities.

182. XXX

183. The Tribunal reminded itself that there has now been a substantial lapse of time since the behaviour toward work colleagues and that there had been no repeat of his behaviour at Practice B or Practice C.

184. The Tribunal accepted the testimonial of Ms H, who worked with Dr Mackenzie at Practice C. She wrote,

> *'He has gained insight into his conduct and I have witnessed him making a concerted effort to work on these issues. Dr Mackenzie's patients speak to me of his empathy, his efforts on their behalf, his availability, his sense of humour, and his professionalism in general.'*

185. XXX

186. In summary, the Tribunal concluded that there were a number of aggravating and mitigating factors in Dr Mackenzie's case. The Tribunal then balanced these factors throughout its deliberations and went on to consider each sanction in order of ascending severity, starting with the least restrictive.

The Tribunal's Determination on Sanction

No action

187. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

188. The Tribunal was satisfied that there were no exceptional circumstances in Dr Mackenzie's case which could justify it taking no action. Further the Tribunal considered that concluding the case by taking no action would be insufficient to protect the wider public interest and would not mark the seriousness of the allegations admitted and found proved.

Conditions

189. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Mackenzie's registration. The Tribunal reminded itself that any conditions imposed must be appropriate, workable or measurable.

190. The Tribunal had regard to the following paragraphs of the SG,

> *81 Conditions might be most appropriate in cases:*

…
b involving issues around the doctor's performance
c where there is evidence of shortcomings in a specific area or areas of the doctor's practice
…

82 Conditions are likely to be workable where:

a the doctor has insight
b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
c the tribunal is satisfied the doctor will comply with them
d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.

191. The Tribunal noted that, in relation to Dr Mackenzie's behaviour towards female colleagues and patients, the case did not fit within the examples in paragraph 81 as a type of case where conditions may be most appropriate. The Tribunal decided that there were no conditions that would be workable or measurable to mitigate all the aspects of his misconduct.

192. Although the Tribunal was considering the decision of professional misconduct by the Australian Board, it considered that the behaviour involved abuse of his professional position and misconduct of a sexual nature, which has the potential to seriously undermine public trust in the profession. It decided therefore, that notwithstanding his insight and willingness to remediate, Dr Mackenzie's conduct was so serious that an order of conditions would not be appropriate to maintain public confidence in the profession, nor to promote and maintain proper professional standards and conduct for members of the profession.

193. The Tribunal also considered the findings that related to Dr Mackenzie's clinical performance. The Tribunal decided that conditions would not presently be workable because of the lack of insight that Dr Mackenzie is presently demonstrating in relation to his prescribing errors, which carries a risk of ongoing harm to patients.

Suspension

194. The Tribunal then went on to consider whether a period of suspension would adequately protect the public, maintain public confidence in the profession and uphold proper standards for its members. The Tribunal noted at paragraph 91 of the SG that suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and the public about what behaviour is unbefitting of a registered doctor.

195. The Tribunal considered Paragraph 97 of the SG which indicates circumstances in which suspension may be appropriate. It decided that a number of its sub paragraphs applied in Dr Mackenzie's case, namely:

a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

…

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

196. The Tribunal decided that, had the behaviour and clinical misconduct occurred in the UK, there would have been a serious departure from GMP. It concluded that such a departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

197. The Tribunal decided that, due to Dr Mackenzie's clinical performance, and his lack of insight into his prescribing errors, there remains a risk to patient safety if his registration is not suspended.

198. The Tribunal was satisfied that Dr Mackenzie has made efforts to remediate both his behaviour and his clinical performance and there was no evidence that they cannot be further remediated.

199. The Tribunal accepted that there had been no incidents reported in relation to breaches of professional boundaries by Dr Mackenzie for the 18 months that he was working at Practice B and Practice C and he has not been working in a clinical setting since 2021.

200. The Tribunal had considered the issue of insight carefully at the impairment stage. It concluded that Dr Mackenzie's insight is developing and that the risk of repetition was moderate.

201. The Tribunal decided that the findings of the Australian Board were serious, both in relation to Dr Mackenzie's behaviour and his clinical performance. The Tribunal had, however, found that the underlying conduct could be remediated. It accepted that Dr

Mackenzie had some insight and had made steps to remediate his actions. The Tribunal determined, therefore, that Dr Mackenzie's behaviour was not incompatible with continued registration, and that erasure would be a disproportionate response in this case.

202. The Tribunal determined therefore that a period of suspension would be sufficient to meet the overarching objective to protect patients and the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour.

203. The Tribunal also determined that an order of suspension was sufficient to send a message to the profession and the wider public about the standards of behaviour and performance expected of the profession.

Length of sanction

204. The Tribunal determined to impose an order of suspension for a period of nine months. The Tribunal considered that a suspension of this length was sufficient to mark the seriousness of both the conduct and the clinical performance errors, and to send a message to the profession of the standards expected. In reaching this decision the Tribunal has borne in mind the aggravating and mitigating factors as provided above.

205. In the Tribunal's view, a suspension of nine months is necessary to uphold the overarching objective. The Tribunal also considered that a period of nine months would allow Dr Mackenzie time to further develop his insight and remediation.

206. The Tribunal took into account the impact that this sanction will have upon Dr Mackenzie, especially as his registration was cancelled in Australia in July 2024, with him being disqualified for a period of 12 months before he can reapply there.

207. The Tribunal concluded however, that Dr Mackenzie's interests are outweighed by the need to uphold the overarching objective, and that the reputation of the profession as a whole is more important than the interests of an individual doctor.

208. The Tribunal determined that an order of suspension for a nine-month period takes into account the work that Dr Mackenzie has done since his registration was cancelled in Australia. A suspension for any longer period would be disproportionate.

Review

209. The Tribunal determined to direct a review of Dr Mackenzie's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing the onus will be on Dr Mackenzie to demonstrate how he has remediated and developed further insight.

210. It therefore may assist the reviewing Tribunal if Dr Mackenzie provided;

- XXX,

- any further evidence that Dr Mackenzie has to demonstrate that he recognises the impact of his behaviours on a team workplace and a team environment,

- any further evidence Dr Mackenzie has to demonstrate further insight, reflection, and remediation particularly regarding prescribing, and his understanding of prescribing guidance within the UK,

and

- any other information that Dr Mackenzie considers will assist a reviewing Tribunal.

Determination on Immediate Order - 01/10/2025

211. Having determined to suspend Dr Mackenzie's registration for a period of 9 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

212. Ms Widdett submitted that an immediate order is necessary given the Tribunal's findings that Dr Mackenzie has a moderate risk of repetition of the sexual misconduct and an ongoing moderate risk of a repetition of the prescribing errors. Further, Ms Widdett reminded the Tribunal it had found that a sanction lower than suspension would not be sufficient to protect the public.

213. Ms Widdett submitted that an immediate order is also necessary to maintain public confidence in the profession. In addition, Ms Widdett submitted that Dr Mackenzie has not worked as a GP for five years and to allow him to return to unrestricted practice would present risks in itself.

214. Ms Stock informed the Tribunal that she has no submissions to make on behalf of Dr Mackenzie and this is a matter for the Tribunal exercising its own judgement.

The Tribunal's Determination

215. In reaching its decision the Tribunal reminded itself of its previous findings and the submissions of both parties.

216. The Tribunal took into account paragraph 178 of the SG when deciding whether to impose an immediate order. It considered the seriousness of the matter that led to its

decision to suspend Dr Mackenzie and whether it was, therefore, appropriate for him to continue in unrestricted practice before the suspension takes effect.

217. The Tribunal also considered paragraphs 172 and 173 as set out below:

> *172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*

218. The Tribunal reminded itself of its previous findings. It had decided that Dr Mackenzie posed an ongoing moderate risk of repetition with regards to his behaviour and his clinical errors. It had also found that Dr Mackenzie's insight was not yet fully developed. The Tribunal noted that Dr Mackenzie has been out of clinical practice since 2021. It determined, therefore, that to allow him to return to unrestricted practice would pose a risk to public safety.

219. The Tribunal determined that it was also necessary to impose an immediate order to protect public confidence in the profession.

220. This means that Dr Mackenzie's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

221. The interim order is hereby revoked.

222. This concludes the case.

ANNEX A – 15/08/2025
Application to admit further evidence

223. Prior to the hearing opening, Ms Widdett for the GMC made an application to admit evidence under Rule 34(1) of the Rules, which states:

> *"The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."*

Submissions

224. Ms Widdett advised the Tribunal that the GMC seeks to rely upon a letter from Miss J, from a group called 'Every Doctor', which was dated 27 September 2022. Every Doctor group was, at that time, representing Dr Mackenize in the UK, and wrote to the GMC in relation to his suspension in Australia. In the letter, Miss J states:

> *"Dr Mac Kenzie strenuously denies these allegations which are being defended vigorously by counsel in Australia."*

225. Ms Widdett submitted that this sentence goes to Dr Mackenzie's insight and in particular whether he developed timely insight into his actions. Ms Widdett submitted that there would be no prejudice to the doctor in admitting this evidence as it has been disclosed and Dr Mackenzie had notice that this application would be made some time ago.

226. Ms Stock informed the Tribunal that she opposes the admission of this document in terms of the GMC's reliance on it regarding Dr Mckenzie's insight. Ms Stock reminded the Tribunal that this letter is dated 27 September 2022, and, at this time, Dr Mackenzie approached Every Doctor asking them whether he should be disclosing an investigation by another regulator, namely Aphra. Ms Stock stated that, at this time no finding had been made by the Board in Australia and Dr Mackenzie did not have a duty to disclose it to the GMC.

227. Ms Stock submitted that it would be inappropriate to admit this letter into evidence as Dr Mackenzie has no recollection of this document. Ms Stock submitted that it has never been Dr Mackenzie's stance that he denies the allegations and he never intended to '*vigorously*' defend the allegations in Australia. Ms Stock further submitted that, at the stage the letter was written, the matters remained under investigation and had not been particularised for Dr Mackenzie to either admit or deny them.

228. Ms Stock submitted that Dr Mackenzie had a right to challenge the evidence as per the test in *PSA v Doree (PSA v (1) Health & Care Professions Council (HCPC) (2) Benedict Doree EWCA Civ 319).* Ms Stock submitted that the case in Australia was not contested, and the allegations were admitted. Ms Stock further submitted that to allow the GMC to rely on one line in a legal letter as evidence of the doctor's insight would be inappropriate, would be contrary to the interests of justice and, on that basis, ought not to be admitted into evidence.

Tribunal's Decision

229. The Tribunal had regard to Rule 34(1) of the Rules as quoted above and the submissions of both parties.

230. The Tribunal first considered whether the letter was relevant to the timely development of Dr Mackenzie's insight. The Tribunal reminded itself that the matters underlying this hearing relate to maintaining professional boundaries. The Tribunal further reminded itself that this letter was written at an early point in the Aphra investigation, and that Dr Mckenzie denied the allegation at this time.

231. The Tribunal accepted thar Dr Mackenzie has the right to deny the allegation but considered that whether he has timely insight is something that it should consider. The Tribunal considered that the gap of time between May 2021 when he was suspended, and September 2022 when the letter was written shows a period of time in which Dr Mackenzie could have developed insight. The Tribunal was satisfied therefore that this letter is relevant to the matter of timely development of Dr Mackenzie's insight.

232. When considering whether it is fair to admit the letter into evidence, the Tribunal reminded itself that Dr Mackenzie has been aware of this letter for some time and that it was redacted in the initial GMC hearing bundle that was provided to him prior to this hearing beginning. The Tribunal was satisfied that this letter was served in good time and, therefore, Dr Mackenzie had time to challenge this evidence if he wished to.

233. The Tribunal reminded itself of Ms Stock's submissions that Dr Mackenzie did not recall this letter and that the Aphra investigation had not reached a point where Dr Mackenze could respond to particularised allegations but noted that the letter states that he was denying the allegations.

234. The Tribunal was satisfied that it was fair to admit this evidence, and that it can judge the weight that it will give this evidence in the round with the other evidence provided.

235. The Tribunal determined that it is relevant to these proceedings and fair to all parties to admit this letter into evidence.