MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 121/00/57D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against J medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Ms S Cole, Dr R S J Gellatly, Dr L Henneveld, Mr M G Laney (Members)

Ms G J Fraser (Secretary)

Ms H Giibbons (Stenographer)

Hearing held at Auckland on Thursday 11 May 2000

APPEARANCES: Mr R Harrison QC and Ms T Davies, Director of Proceedings

Mr H Waalkens for Dr J.

1. THE CHARGE:

1.1 **THE** Director of Proceedings ("the Director") pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 ("the Act") charges:

"On or between 20 April 1997 and 9 July 1999 Dr J was guilty of disgraceful conduct in a professional respect in that:

(1) In the course of treating a patient, the late A at xx Accident and Medical Centre in xx on 20 April 1997 he failed:

(a) to take any or proper steps to investigate, diagnose or treat the cause and symptoms of illness presented by Mr A;

(b) to take any steps to investigate, diagnose or treat the cause or causes of an abnormally low reading of Mr A's blood pressure together with an elevated temperature and general weakness;

(c) to explain adequately or at all to Mr A or his wife or daughter the true nature of his condition or to advise on a course of remedial treatment.

(2) Subsequently for the purposes of misleading the Health and Disability Commissioner when undertaking an investigation into his conduct under Part IV Health and Disability Commissioner Act 1994 Dr J:

(a) prepared and presented to the Commissioner a false handwritten note purporting to record the text of a consultation with a medical registrar at either xx or xx Hospitals either during or immediately following his consultation with Mr A;

(b) advised the Commissioner falsely that he had obtained a second and favourable reading of Mr A's blood pressure before completion of his consultation with him;

(c) advised the Commissioner falsely that at the time of Mr A's departure from xx Accident and Medical Centre his consultation with him had not concluded."

2. FACTUAL BACKGROUND:

2.1 **THE** charge arises in the context of care and treatment given to Mr A (deceased) at the xx Accident and Medical Centre (the Centre) in xx on the night of 20/21 April 1997, and subsequent events. Dr J was on duty at the Centre that night, and carried out the consultation with Mr A after he was brought into the Centre by his wife, Mrs A, and his daughter, Miss A.

2.2 **MR** A died suddenly on the morning of 21 April 1997. An autopsy was carried out and the pathologist, Dr B reported to the Coroner that, in her opinion, death resulted from obscure causes. A complaint to the Health and Disability Commissioner regarding Dr J's care and treatment of Mr A was made by his family in May 1997, and the Commissioner's investigation of that complaint resulted in her referring the matter to the Director.

2.3 **THE** charge against Dr J was laid in February this year, some 2 ½years after the events giving rise to it.

2.4 **THE** detail of the factual background to the charge was presented to the Tribunal by the witnesses for the Director, and Dr J. In essence, the charge against Dr J was that he failed to provide care and treatment of an adequate standard, and that, when he was told of Mr A's death, he retrieved his patient notes and fabricated page 2 of the notes to suggest that his care of Mr A was more thorough than page 1 of notes might suggest.

3. EVIDENCE FOR THE DIRECTOR OF PROCEEDINGS:

3.1 **MRS** A, Miss A, Mr C and Dr Brian King gave evidence on behalf of the Director.

Mrs A

3.2 **MRS** A gave evidence of being awakened by her husband late in the evening of 20 April 1997. Mr A was obviously in distress, and asked his wife to take him to the hospital. Mr A was complaining of feeling very ill, weak and "nauseous". He had been suffering diarrhoea all day and appeared to have also manifested a resumption of influenza, from which he had been suffering over approximately the previous two weeks.

3.3 **MRS** A in turn woke her daughter and they took Mr A by car to the xx Accident and Medical Centre ("the Centre"). Mr A lay on the back seat during the journey to the Centre and, upon arrival, had to be assisted into the Centre and taken directly to a consulting room to be seen by the doctor on duty, Dr J.

3.4 **MRS** A gave evidence that she remained with her husband throughout the time he was at the Clinic. To the best of her recollection, his blood pressure was taken by a nurse on only one occasion. She did not recall details of the other examinations such as pulse and temperature recordings carried out and recorded on Mr A's clinical record.

3.5 **UNDERSTANDABLY**, Mrs A's attention on that evening was focussed on her husband who was clearly unwell. She did not recall who gave Mr A's details to the receptionist when he was admitted, nor did she recall collecting the medication prescribed for her husband; paying for the visit; or that Mr A was told to visit his GP if he was no better in 12 - 15 hours. Mrs A thought it likely that Mr A's admission and discharge were attended to by her daughter. Overall her recollection of the specific details of the consultation with her husband was understandably, imprecise.

3.6 **IT** appears from her evidence that there was very little communication between any of the Centre staff, including Dr J, and her, during the visit to the Centre and that is regrettable. It is clearly something which Mrs A felt most keenly.

3.7 **NEVERTHELESS,** Mrs A was quite sure that her husband's blood pressure was taken only once, and that she did not understand if the consultation was at an end or not when Dr J left the room after examining her husband. In cross-examination, Mrs A recalled sitting with her husband and waiting for her daughter to return to the consultation cubicle. After being told by her daughter that the consultation was ended and that they could go home, she and her daughter assisted Mr A to the car and took him home.

3.8 **AFTER** their return home her daughter attended to Mr A, and Mrs A recounted seeing her husband alive for the last time before she left for work in the morning. Her husband was at that time preparing his breakfast. Mrs A also confirmed that prior to the evening of the 20th of April 1997, her husband had been ill for a week or two and had been prescribed antibiotics by his general practitioner.

3.9 **IN** all other respects she confirmed the information previously provided to the Health and Disability Commissioner by her daughter and herself.

Miss A

3.10 **MISS** A confirmed her mother's account of their taking Mr A to the Centre late in the evening of 20 April 1997, and of taking him directly into a consulting room upon their arrival. Miss A estimated that they waited approximately ½ to 1 hour before being seen by Dr J.

3.11 **MISS** A gave evidence that she left her father's side only once during the time he was at the Centre, and then only very briefly. She did not recall observing her father's blood pressure being taken and assumed this was done only once during the time she was out of the room.

3.12 **MISS** A was present when her father was examined by Dr J. She recalled Dr J asking her father "*if there was one thing we can do for you tonight what would you like us to do*"? Her father replied that he was very "nauseous" and would like something for that,

and also some Dextrose. She also recalled Dr J telling her father that if he was no better by the afternoon, he should visit his GP.

3.13 **DR** J left the room after he examined Mr A and, after waiting a few minutes for him to return, she went out to ascertain whether or not the consultation was ended. She saw Dr J taking another patient into a consultation room and assumed that the consultation with her father had concluded. Miss A went to the receptionist and asked if she could have the anti-nausea medication which Dr J had prescribed for her father. She was given some pills and returned to her parents. Her father took one of the pills, and she and her mother assisted Mr A to the car and took him home.

3.14 **MISS** A gave evidence that her father was still unable to walk unassisted when they left the Centre, and the receptionist had asked if he needed a wheelchair. That was not necessary as Miss A brought the car to the door of the Centre and she and her mother helped him into the car and they returned home. Miss A paid the receptionist for the visit when they left the Centre.

3.15 **MISS** A saw her father in the kitchen in the morning apparently having his breakfast. At about 9.20 am she found her father on his bed, and he appeared to be suffering a seizure. She called the ambulance and was able to obtain assistance for her father, but he died shortly thereafter.

3.16 **MISS** A also accompanied her mother and her uncle when they went to the Centre after Mr A's death to ask for a copy of his notes. They were given one page only of notes (Ref: Tab 1, Agreed Bundle of Documents). It was Miss A's evidence that she did not see the second page of the notes produced at the hearing until it was shown to her and her mother by the Health and Disability Commissioner some months after her complaint was made.

3.17 **PAGE** 2 of the notes purports to contain a record of Dr J's telephone discussion with a Registrar about Mr A's symptoms in the early morning of 20 April 2000, and additional blood pressure recordings which Dr J says were obtained when he asked for Mr A's initial low blood pressure recording to be checked.

Mr C

3.18 **MR C** was the nurse on duty with Dr J on the night of 20/21 April 1997. Mr C did not recall any details of Mr A's attendance and consultation. However, he was able to provide the Tribunal with very helpful evidence regarding his own customary practice; Dr J's usual practice, demeanour and reputation; and the routines and practices generally followed at the Centre.

3.19 **MOST** relevantly, he recalled that the night of 20/21 April 1997 was very busy. From time to time if the Centre is busy, the staff on evening shift may stay behind for a short time after the 'changeover' at 11.00 pm, to complete records, or to assist the staff coming on duty, generally just one nurse and one doctor.

3.20 **IT** is possible therefore that although only himself and Dr J were rostered for the night shift, there could have been other staff members present when Mr A was brought into the Centre. These staff members could have attended to Mr A's admission and admission recordings.

3.21 **IN** relation to patients' records, Mr C gave evidence that patients' charts are kept on a trolley at the reception desk and taken to the consulting room when patients are examined, or recordings taken. The charts are then returned to the trolley. If Mr C, or another staff member, had reported a very low blood pressure recording for Mr A (as was recorded on admission), and Dr J had asked for it to be checked, this might have been done without the chart being present; it could have been retained by Dr J if he was going directly to examine Mr A after completing another examination, or it could have been returned to the trolley.

3.22 **IT** was possible therefore, for any subsequent blood pressure recordings made at Dr J's request to have been relayed to him orally, or to have been recorded on a separate piece of paper given to Dr J, and entered into Mr A's record later by Dr J.

3.23 **MR** C also gave evidence that the pages used for patients' notes at the Centre are double sided; and the stamping of the notes "COMPLETED" is a reference to the entering of the diagnostic coding into the Centre's computer records, and not a reference to the completion of the consultation or any other event.

3.24 **MR** C was also questioned about the practices around the printing and disposal of patient labels at the Centre. He gave evidence that five labels are printed on admission. The time

on the label approximates the time of arrival, but this is more significant in terms of the time of arrival in relation to other patients (so that patients are seen in order of arrival), rather than recording the exact time of arrival at the Centre.

3.25 **THE** patient record sheets are self-carboning; one of the printed labels is affixed to the first page of the patient record and one on the 'self-carbon' page. Three are left spare on the chart and detached and put on the prescription pad and the continuation sheet if needed. Labels which are not used are disposed of into a rubbish bin kept at reception for rubbish to be disposed of into a secure document disposal wheelie bin and taken away for shredding.

3.26 **THESE** bins are emptied every morning, and possibly also in the afternoons. According to Mr C, it would be "*impossible*" for a bin of rubbish to be left for more than a day. Patient record pads are available around the Clinic, in consultation rooms and at reception, and if there was a need to make a patient record on another page (if the page was full or if the doctor did not have the patient's chart with him) then the doctor could use a another, separate, sheet which would generally be stapled together with the 'original' page prepared on admission.

3.27 **"HOPEFULLY"**, said Mr C, *"by the end of the shift you've located all the notes and normal practice is to have found the notes before the person has left the Clinic so they can be given their carbon copy and so that the receipt or method of payment is entered on the back of the page"*.

3.28 **MR** C also gave evidence that:

(a) on a busy evening, all of the consultation rooms may be full and the doctor might be seeing several patients simultaneously;

(b) it was forbidden for medications to be dispensed by a receptionist, and, if he, or any other of the nurses, had dispensed medication then that would have been recorded on the patient's chart;

(c) Dr J may have dispensed a 'starter' dose of the medication he prescribed for Mr A;

(d) Dr J would often make telephone calls to hospital registrars to get second opinions about patients whom he was seeing at the Clinic;

(e) the diagnostic coding was usually entered on the patient's chart by the doctor but was also done by himself and other nurses;

(f) the diagnostic coding was entered into the computer by the receptionist, or nurse if no receptionist was on duty (on night duty for example).

Dr Brian King

3.29 **DR** King is a medical practitioner currently practising in Wellington. He also works at the Wellington After Hours Medical Centre on a rostered basis. In summary, it was Dr King's opinion that, if the consultation was reviewed on the basis of the information contained on page 1 of the notes only, then he would consider that Dr J did not provide Mr A with adequate care because he failed to adequately assess Mr A's abnormally low blood pressure recorded on admission. However, if the notes were considered on the basis that they comprised both pages 1 and 2 presented in evidence, then his view was that Dr J did provide Mr A with medical treatment to an appropriate standard of care.

4. EVIDENCE FOR THE RESPONDENT:

4.1 **DR** J gave evidence on his own behalf. Written statements of evidence on behalf of Dr J were provided by Dr D, a medical practitioner of xx who has practised in Accident and Medical centre-type work for approximately the last 11 years; and Mrs E, a registered nurse of xx, who has worked with Dr J at the Centre between 1995 and 1998.

4.2 **A** number of references as to Dr J's character and reputation provided by medical practitioners and registered nurses who have worked with Dr J were also presented to the Tribunal.

Dr J's evidence

4.3 **DR** J gave evidence that he recalled Mr A being admitted to the Centre, and that when his notes were given to Dr J a comment regarding Mr A's low blood pressure recording was made to him. At that time he was attending to another patient, and he asked for Mr A's blood pressure to be re-checked in the lying and sitting positions.

4.4 **HE** recalled that the re-checked blood pressure recordings were handed to him on a separate piece of paper - not on the patient notes. He later recorded this information into Mr A's chart either when or shortly after he had spoken to a hospital Registrar about Mr A's symptoms. Dr J gave evidence about his consultation with Mr A, and of his uncertainty as to what was wrong with Mr A.

4.5 **IT** was Dr J's evidence that he left the consultation with the intention of telephoning a registrar at the hospital for a second opinion and, after that, to return and conclude the

examination. There may have been a delay in contacting a registrar, and he may have decided to see another patient and to try to telephone a registrar afterwards.

4.6 **HE** did not recall which registrar he spoke to, or which hospital he contacted. Dr J apparently usually contacts registrars at xx Hospital, but also from time to time, at xx Hospital. He did not recall the gender of the registrar he spoke to.

4.7 **HE** made a note of his discussion with the registrar, and that is the record which appears on page 2 of Mr A's notes. It is likely this record was made after the telephone call, but certainly on the night of 20/21 April 1997. The record includes a note that "… *needs CBC, Mycoplasma titres*", being the blood tests recommended by the registrar. The note concludes with the plan which the registrar agreed with Dr J i.e. review in 12 hours if not improved. It is simply impossible now for Dr J to recall why page 1 and page 2 of the notes became separated.

4.8 **AFTER** speaking to the registrar, Dr J returned to the cubicle to discover that the A's had left the Centre. He could not recall if he had asked where they had gone, but he did recall being puzzled that they had left. In any event, he did not attempt to telephone Mr A or to follow up the initial consultation because he considered that he had gathered sufficient information about his symptoms; he had explained to him the basis of his treatment, and the need for review if there was no improvement.

4.9 **THE** registrar had essentially agreed with his diagnosis and treatment plan, and Dr J thought that the blood tests recommended could be done if Mr A returned for review. Dr J

had intended to re-check Mr A's blood pressure again, and would have concluded the consultation by ensuring that Mr A understood his advice, and asking him if he had any questions. Also, he had not given Mr A any prescription for medication, and there was no record of the dispensation of any medication.

4.10 **AFTER** he was told of Mr A's death several days later, he obtained Mr A's notes and photocopied them to review them. Both pages were with the notes at that time and Dr J is unable to explain what became of page 2. He did not recall if he had photocopied the notes himself, or if he had asked a staff member to do this. He denied fabricating the blood pressure readings or other information contained on page 2 of the notes.

Dr D

4.11 **DR** D gave evidence of the general nature of Accident and Medical Centre practice, and his opinion as to the standard of care provided by Dr J to Mr A. It was his view that Mr A's case was "*rather complex*" and that it was unreasonable to be critical of Dr J's clinical care. That view would seem to be borne out by the subsequent findings of the pathologist (Dr B) on post-mortem examination. Dr B records that, in her opinion, "*death resulted from obscure causes.*"

4.12 **DR** D believed that it was reasonable of Dr J to have sought a second opinion, and that it would have been difficult to be certain about what was wrong with Mr A when he presented at the Centre.

E

4.13 **STAFF** Nurse E gave evidence as to her regard for Dr J having worked with him at the Centre for three years, and of the operation and general practices at the Centre. It was her opinion that Dr J was "*meticulous"* about prescribing drugs, and that he often gave drugs to patients himself, and documented any such prescriptions, instructions or medication given.

4.14 **STAFF** Nurse E had also observed that Dr J would often re-check recordings, and she had observed him checking recordings a number of times during an examination. She regarded Dr J as being *"a very thorough doctor*." He was very thorough also in the explanations he gave to patients and their families, and he often did not send patients home if he was concerned about them but left them in the consultation rooms under his observation.

4.15 **IT** was Nurse E's experience that Dr J often telephoned the registrars for a second opinion, and that he was much more inclined to do this than other doctors she worked with. He was very cautious where there was any doubt as to the severity of the patient's condition.

5. THE DECISION:

5.1 **HAVING** carefully considered all of the evidence presented to it, and submissions made by both counsel, and, most importantly, having had the opportunity to assess the credibility of the witnesses, the Tribunal is satisfied that the charge as particularised is not established and that Dr J is accordingly **not guilty** of disgraceful conduct in a professional respect.

6. REASONS:

The Standard of Proof:

6.1 **IT** is well-established that the standard of proof in disciplinary proceedings is the civil standard, the balance of probabilities. It is equally well-established that the standard of proof will vary according to the gravity of the allegations and the level of the charge. In this present case, the charge is laid at the most serious level of the hierarchy of charges available; thus the standard of proof is correspondingly high.

6.2 **THE** standard of proof may also vary within a single case, such as this, where an allegation that a doctor might have reconstructed medical records some time after the events at issue occurred is made fairly requires a more rigorous standard of proof than allegations of clinical shortcomings or error. However, all elements of the charge must be proved to a standard commensurate with the gravity of the facts to be proved: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375 - 376.

6.3 **THIS** present charge as particularised essentially contains two parts; the first, that Dr J's treatment of Mr A was inadequate in clinical terms; the second, the factual allegations that Dr J fabricated page 2 of the patient record for the purposes of misleading the Health and Disability Commissioner in her investigation of the complaint made against him by Mr A's wife and daughter.

6.4 **IN** relation to the first part of the charge, the approach adopted in *Ongley v Medical Council of New Zealand* (supra), is appropriate. In that case, Jefferies J held that:

"The structure of the disciplinary processes set up by the Act which rely in large part upon the judgment of a practitioner's peers, emphasises that the best guide to what

is acceptable professional conduct is the standards applied by competent, ethical and responsible practitioners."

6.5 **THAT** is not to say that the Tribunal unhesitatingly applied the opinions expressed by those practitioners who gave evidence as 'experts'. The test is objective; that is, the conduct under review is measured against the judgment of the practitioner's professional peers of acknowledged good repute and competency, "*bearing in mind the composition of the tribunals which examine the conduct; Ongley v Medical Council (supra).*"

6.6 **THUS,** while the evidence of what other doctors would have done, or as to how they assessed Dr J's management and conduct of Mr A's care, or of acceptable practice generally in the context of care given in the circumstances which presented in this case, i.e. a busy Accident and Medical Centre, is a useful guide, perhaps even the best guide, it will never be more than that. All of that evidence is weighed against the judgment of the trial judge, or in this case, a specialist Tribunal comprising both medical practitioners and lay members.

6.7 **SIMILARLY**, the issue as to whether or not the outcome might have been different had Dr J's management of Mr A's care been different, will not determine whether or not a charge is proven. The central issue for the Tribunal's inquiry is to ascertain whether or not the practitioner's conduct and management of the subject case (at the relevant time) constituted an acceptable discharge of his professional and clinical obligations. Only if the Tribunal identifies any such shortcomings or errors may it go on to determine if those shortcomings or errors are culpable, and warrant the sanction of a finding against the practitioner.

6.8 **THEREFORE**, a practitioner may be found guilty of a professional disciplinary charge notwithstanding that any actions, failures or omissions on his or her part did not affect the outcome for the patient.

The Burden of Proof:

6.9 **THE** burden of proof is borne by the Director of Proceedings.

Findings:

6.10 **THE** Tribunal's finding in relation to the first part of the charge largely depended upon it's finding as to the veracity of page 2 of Mr A's patient notes. In this regard, it applied a standard of proof commensurate with the gravity of the charge, i.e. disgraceful conduct. On that basis, it was not satisfied that the allegations that Dr J fabricated page 2 only after he was told of Mr A's death were proven.

6.11 **THE** Tribunal was satisfied that Dr J was a truthful witness, and, on the basis of the weight of evidence in this regard, that any such conduct on his part would be out of character. The result of the finding by the Tribunal that it is satisfied that page 2 of the notes is genuine, is that the assessment as to the adequacy of the care and treatment given by Dr J to Mr A is made on the basis of the record contained in pages 1 and 2 of Mr A's notes. Both Dr King, for the Director of Proceedings, and Dr D, for Dr J, accepted that if both pages of notes correctly recorded the consultation, then Dr J's care was of an acceptable standard.

6.12 **THE** Tribunal accepts that evidence. The notes record Mr A's vital signs on admission, details of Dr J's initial examination and inquiries regarding symptoms, a treatment plan, advice to the patient to return to his general practitioner later in the day if symptoms persisted, a request for a second opinion in the presence of uncertainty, and details of Dr J's discussion with the registrar.

6.13 **IN** closing, Mr Harrison conceded that the case against Dr J was largely circumstantial. He submitted that the Tribunal would only find Dr J's account plausible if it accepted that each of a large number of events implausible in themselves occurred in combination.

6.14 **HOWEVER**, the Tribunal was not satisfied that several of the events, or facts, relied upon by the Director, were, as a matter of fact, as implausible as was suggested. For example, the fact that Dr J did not recall the gender or identity of the registrar he consulted, or even which hospital he might have contacted.

6.15 **THERE** was written evidence presented from a number of witnesses who had worked with Dr J that he was a doctor who was relatively more inclined than other doctors to seek the assistance of hospital registrars from time to time. Given that hospital registrars work both on rosters and rotation, it is not surprising that the specific identity of the registrar spoken to in the course of any particular duty cannot be recalled some time later. Nor does the Tribunal find it improbable or implausible, on the basis of it's collective clinical experience, that a practitioner might simply contact the hospital and ask to speak to "*the registrar*", and engage in some brief discussion with him or her, without making further inquiry as to his or her identity.

6.16 **THE** Tribunal also accepts that Mrs A was adamant that she did not leave here husband's side throughout the time they were at the Centre, and that she is sure that only one blood pressure recording was made. However, Mrs A very honestly and understandably also conceded that she was distressed and worried for her husband. The Centre was busy; they had to wait some time to be seen after admission; and it was the middle of the night, and the first time this issue was raised with Mrs A was several months after the event.

6.17 **NO** evidence was given about Mr A's actual admission to the Centre. Mrs A and Miss A told the Tribunal that they took Mr A directly into an examining room upon their arrival at approximately 11.24 pm. However, the evidence given by Mr C was that the arrival time recorded on the admission label is relative to the arrival of other patients, rather than being an exact record of the time of arrival.

6.18 **THE** possibility that Mr A's admission, and blood pressure recordings, were attended to by someone other than Mr C could not be excluded.

6.19 **SIMILARLY**, the evidence given regarding the stamped "COMPLETED" notation on the record was that this refers to the entry of the diagnostic classification into the computer, rather than recording that the consultation was completed.

6.20 **THERE** was also evidence that it was not unusual for Dr J to leave patients in the consulting rooms and to return to check on them from time to time if they were very ill; and that it was also not unusual for the doctor on duty to be attending to more than one patient at a time if the clinic was busy and all of the consulting rooms were occupied.

6.21 **THE** Tribunal is satisfied, on the balance of probabilities, that the A's left the Centre mistakenly believing that the consultation was over. Some time later, after he had spoken to the registrar, Dr J discovered that they had left, but did nothing further because, he was satisfied that there was nothing to add to the treatment plan he had already put in place, and that Mr A's condition would be reviewed later that day if he had not improved.

6.22 **THE** Tribunal is satisfied that it is more likely than not that the series of events under scrutiny involve nothing more than a series of simple, but nonetheless unfortunate, miscommunications and misunderstandings.

6.23 **TO** find the charge established, either in part or entirely, the Tribunal would have to be satisfied that Dr J fabricated page 2 of the notes some time after the night of 20 April 1997. Both Mr Harrison and Mr Waalkens submitted that the charge called for an *"all or nothing*" approach by the Tribunal.

6.24 **BOTH** counsel agreed that it was not open to the Tribunal to find Dr J guilty on part of the charge only, nor could it find him guilty at a lesser level of the charges available to the Tribunal because any finding that Dr J had falsified patient records as alleged could not be regarded as anything but the most serious wrongdoing on the part of any practitioner.

6.25 **THE** Tribunal is satisfied that those submissions are correct, and it's deliberations on the charge proceeded accordingly. Having determined that the factual allegations upon which the charge is based are not proven to the requisite standard of proof, the Tribunal determined that the charge should be dismissed.

7. CONCLUSION:

7.1 **IN** conclusion, the Tribunal is not satisfied that Dr J made any errors of clinical judgment in his treatment of Mr A, or that he acted to mislead the Health and Disability Commissioner in her inquiry by falsifying Mr A's patient records. Dr J is therefore not guilty of disgraceful conduct in a professional respect.

7.2 **THE** Tribunal came to this conclusion on the basis of all of the oral and written evidence presented to it, and after careful consideration of each of the particulars of the charge, and the charge in its totality.

7.3 **THE** Tribunal's decision is unanimous.

8. COSTS:

8.1 **AS** a result of the Tribunals' decision there are no issues as to penalty or costs.

9. ORDERS:

9.1 **THE** interim orders made by the Tribunal on 28 April prohibiting the publication of Dr J's name and details of his identity, including the name of his employers, are made permanent.

DATED at Auckland this 19th day of June 2000

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal