Medical Practitioners Disciplinary Tribunal

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DECISION NO: 39/98/19D

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 93(1)(b) of the Act against **BELLANAVIDANELAGE ELMO STANLEY JAYASINHA** medical practitioner of Shannon

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Professor B D Evans, Dr A M C McCoy, Dr J M McKenzie,

Ms S Cole (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Date of hearing: 27 May 1998

Date of reserved Decision: 30 June 1998

APPEARANCES: Ms K G Davenport, for the Director of Proceedings.

Mrs A Lombard for Dr Jayasinha ("the respondent").

1. RESERVED DECISION:

THE hearing of the charge against Dr Jayasinha concluded with the Tribunal indicating that its Decision would be reserved and would issue in writing with reasons at a later date.

2. PARTICULARS OF THE CHARGE:

"THE Director of Proceedings pursuant to section 102 of the Medical Practitioners Act charges Dr Stanley Jayasinha of Shannon, Medical Practitioner, that on or about 18 October 1996 his management and treatment of his patient Mr A was inadequate.

1. ......

[in that]

2. His overall management of Mr A was not carried out with reasonable skill and care.

In Particular: (but without limiting the totality of the charge)

A. About 18 October 1996 he incorrectly, (in the face of contrary symptoms being described by Mr A) diagnosed a urinary tract infection.

B. He failed to arrange for an immediate urine specimen.

C. He failed to obtain any laboratory tests to confirm the diagnosis.

D. When contacted and advised that Mr A's condition was worsening he failed to arrange for a review of Mr A and or his diagnosis.

E. He inappropriately arranged for a follow up urine test on the last day of the dose of antibiotics.

Such conduct reflects adversely upon the practitioners fitness to practise medicine being professional misconduct."

3. PRIVACY ORDER:

IN Decision Number 33/98/19D which issued on 24 April 1998 the Tribunal made an order (following application from Dr Jayasinha) that publication of his name be prohibited pending outcome of the proceedings against him.

4. EVIDENTIAL RULINGS:

4.1 **AT** the commencement of the hearing Mrs Lombard formally objected to inclusion in the bundle of documents compiled by Ms Davenport of:

4.1.1 Opinion of the Health and Disability Commissioner;

4.1.2 Reference in the Commissioner's opinion to peer review by a General Practitioner;

4.1.3 Hospital records and patient notes.

4.2 **MRS** Lombard explained her objection was based on unavailability of the parties for cross examination, lack of transparency and breach of the rules of natural justice.

4.3 **IN** responding to the objection Ms Davenport explained production of records and medical notes is a legal requirement of both the Health and Disability and Medical Practitioners legislation. In upholding that submission the Tribunal explained it would be impossible to inquire properly into the charge without production of these primary source documents.

4.4 **BY** reference to mention of peer review by a GP, given Ms Davenport's explanation that the peer reviewer was Dr King (who was being called to give evidence at the hearing) the Tribunal ruled, in this instance, that there was no prejudice to Dr Jayasinha.

4.5 **IN** ruling that the opinion of the Health and Disability Commissioner would remain part of the record, the Tribunal referred Mrs Lombard to the final 10 pages of its recent Decision concerning Dr Nealie. The Chair explained to Mrs Lombard that that Decision sought to explain the interface between the Medical Practitioners Act 1995 and the Health and Disability Commissioner Act 1994.

5. BACKGROUND:

5.1 **MR** A visited Dr Jayasinha on the morning of the 18th of October 1996 with a history of abdominal pain and vomiting from the previous day. He was examined by Dr Jayasinha who found the abdomen to be distended and tender in the left lower quadrant and suprapubic region. A diagnosis of urinary tract infection was made by Dr Jayasinha who prescribed Maxalon for nausea and vomiting, and Triprim for the infection.

5.2 **MR** A's urine was not tested with a dipstick by Dr Jayasinha, and no microscopic urine examination was requested that day. It is understood, however, that Mr A was given a specimen bottle to take back a urine sample on Tuesday 22 October 1996.

5.3 **AT** about 4.45 pm the same day, 18 October, Mr A telephoned Dr Jayasinha to tell him that he was feeling worse, his symptoms being further vomiting, increased abdominal pain, an elevated temperature and bad stomach cramping. Apparently Dr Jayasinha told Mr A to take Panadol, another antibiotic and to give the medication time to work.

5.4 **ON** Sunday 20 October 1996 Mr A's condition deteriorated with stomach cramps, elevated temperature, rapid pulse and sore testicles. He consulted xx After Hours service and was referred to xx Hospital with suspected appendicitis or peritonitis. Mr A was operated on that day. The operation record states: *"It was obvious that there was gross intraperitoneal soiling with purulent material throughout the whole peritoneal cavity. This procedure had obviously been going on for a number of days"*. The appendix was described in the notes as *"grossly gangrenous and perforated"*.

6. EVIDENCE:

6.1 **FOR** the Director of Proceedings evidence was given by Mr A and Dr Brian Donald King, a general practitioner of Wellington. Dr King is currently in private practice in Wellington as a general practitioner and has been a general practitioner since 1988.

6.2 **DR** Jayasinha gave evidence on his own behalf and as well Dr Allan Wilfred Hull gave evidence on behalf of Dr Jayasinha. Dr Hull graduated MB ChB from the University of Otago in 1968 and has been practising medicine for 30 years. At present Dr Hull is a general practitioner working as a partner in a medical centre in Levin.

7. OUTLINE OF DECISION:

ESSENTIALLY it is the task of the Tribunal to assess the adequacy, skill and care of Dr Jayasinha's overall management and treatment of Mr A. In so doing reference will be made to each of the particulars of the charge, as benchmarks in the assessment process, but without limiting the totality of the charge.

8. INCORRECTLY DIAGNOSED A URINARY TRACT INFECTION:

8.1 **DR** King explained that urinary tract infections in men are not common, usual symptoms including some discomfort when passing urine (dysuria), bladder irritability and haematuria (blood in the urine). On the information recorded in Dr Jayasinha's notes Dr King described the diagnosis of a urinary tract infection as *"fairly tentative"*. In Dr King's experience vomiting would be a fairly rare presenting symptom. With the information before him Dr King was of the opinion that the diagnosis of a urinary tract infection, given the presenting symptoms, could only at the best have been tentative.

8.2 **ALTHOUGH** Dr Jayasinha could not remember specific details of the consultation on 18 October 1996, he said he felt confident of a diagnosis of urinary tract infection, in preference to appendicitis which he said *"was unlikely"*.

8.3 **IN** light of the presenting symptoms, they being abdominal pain and vomiting, it was Dr Hull's view that a urinary tract infection was not incorrectly diagnosed.

8.4 **FINDING:**

8.4.1 **THERE** can be little doubt that Dr Jayasinha diagnosed a urinary tract infection, when it transpired the condition was appendicitis which developed complications.

8.4.2 **HOWEVER** it is not possible for the Tribunal to find that the initial diagnosis of a urinary tract infection was made without reasonable skill and care.

8.4.3 **DR** Jayasinha was confident of his own diagnosis at the time. He has practised medicine for over 40 years. Although Dr King placed the possibility of a urinary tract infection well down on his list of possible diagnoses, in view of his extensive experience, and Dr Hull's support, Dr Jayasinha is entitled to the benefit of any doubt that a urinary tract infection was the problem. In this conclusion the Tribunal is reinforced by the evidence of Mr A. In answer to questions from the members, Mr A took pains to explain that, if anything, he would have down played to Dr Jayasinha the intensity of the stomach pain he was experiencing at the time.

9. FAILED TO ARRANGE FOR AN IMMEDIATE URINE SPECIMEN:

9.1 **DR** King said most GP's have on-the-spot *"dipstick"* technology for testing urine. Although not infallible Dr King explained that use of it could have given some information to help confirm the diagnosis. Dr King explained to Professor Evans that the dipstick test *"usually provides some evidence of a urinary tract infection"*.

9.2 **PRIOR** to making the diagnosis of a urinary tract infection Dr Jayasinha explained *"I would have required a sample of urine for labstix testing and referral to the laboratory. This is my usual practice/protocol which I have developed over the years. It is possible that Mr A was not able to give me a sample at the time, as many patients are not able to provide a sample at the time of examination"*.

9.3 **DR** Hull gave similar evidence of labstix practice and his experience of patient inability to supply a specimen.

9.4 **FINDING:**

9.4.1 **ON** the evidence it is clear that the provision of a specimen and labstix testing is common practice in helping to make a diagnosis of a urinary tract infection.

9.4.2 **THE** Tribunal is unable to make any finding on this aspect of the matter. Although on the evidence there was consensus, that a urine sample should be obtained and tested in an ante-room, unfortunately neither Dr Jayasinha nor Mr A could recall if Mr A was asked to give a specimen or alternatively that he was asked but was unable to comply with the request.

10. FAILED TO OBTAIN ANY LABORATORY TESTS TO CONFIRM THE DIAGNOSIS:

10.1 **WHILE** having no information about Dr Jayasinha's ability to access recognised laboratory investigations, Dr King felt he should have asked for an urgent microscopic urine examination which possibly could have given a result by the end of surgery that day.

10.2 **GENERALLY** Dr Jayasinha said he would have insisted on a urine sample being sent to the laboratory. In Mr A's case Dr Jayasinha explained this was not done because:

"The procedure is that the bus leaves Shannon daily at 12.00 noon and all samples have got to be packed in a container by 11.00 am and delivered to the bus stop. Mr A saw me on a Friday after 11.00 am and there was no time to forward a urine sample to the laboratory. This is, unfortunately, one of the frustrating aspects that a rural G.P. has to contend with. We do not have laboratory facilities at our immediate disposal."

10.3 **DR** Hull confirmed the unavailability of access to a 24-hour laboratory.

10.4 **FINDING:**

THE evidence has satisfied us that non-access to 24-hour laboratory services precluded Dr Jayasinha from obtaining lab tests to confirm the diagnosis of a urinary tract infection. Receipt of tests four days later would have rendered them irrelevant.

11. FAILED TO ARRANGE FOR A REVIEW OF MR A AND/OR HIS DIAGNOSIS (WHEN CONTACTED AND ADVISED THAT HIS CONDITION WAS WORSENING)

11.1 **BY** reference to this particular of the charge it was Mr A's evidence:

"I went home, took the medication and went to bed. About 3 p.m. only about 4 hours later, I vomited again and had further cramping in my stomach which had intensified. At 4.15 p.m. my temperature was 100 degrees. I telephoned Dr Jayasinha around 4.45 p.m. to let him know I was feeling much worse.

I said to him I have vomited up the pills and have aching testicles, a temperature of 101 degrees and bad stomach cramping. Dr Jayasinha told me the antibiotics took time to work. I then said because I had vomited up the last lot of pills should I take more and could I have something for the pain? Dr Jayasinha told me to take panadol, another antibiotic and to give the medication time to work. I said are you sure there is nothing else I can do? Dr Jayasinha reassured me I would be feeling better by Sunday and said you will be a new man on Sunday.

I was very concerned about my condition and sought reassurance about what he had said."

11.2 **WHEN** Mr A telephoned later in the day Dr King said the diagnosis should have been reconsidered, especially given that the symptoms on which Dr Jayasinha made the diagnosis of urinary tract infection were atypical. If the condition was a urinary tract infection then Dr King said he would have expected the patient's symptoms to have started improving quite

quickly, within 4-6 hours, and not to have deteriorated with increasing abdominal pain and further vomiting.

11.3 **DR** Jayasinha remembered receiving a telephone call from Mr A or his wife. He explained: *"I was of the opinion that the antibiotic should be given a little more time to take effect. Mr A was my patient and he knew I would have been willing to see him any time during the night had his situation worsened, or at least the next day. I would like to mention that if he had requested to see me at the time (he or his wife phoned) I would certainly have seen him. If I was told his situation was worsening I would have immediately wanted to see him. ……….. At the time of the phone call I WOULD NOT HAVE BEEN TOLD HIS CONDITION WAS WORSENING. I cannot recall specifically the words of Mr A or his wife, but I know that it is my usual practice to encourage patients to see me immediately when they inform me their condition is worsening. I must make it clear that I would have still been in my rooms until at least 6.00 pm when Mr A phoned and could have easily reviewed him had I the impression his condition was getting worse."*

11.4 **BECAUSE** Mr A telephoned Dr Jayasinha only a few hours after commencing treatment, the opinion of Dr Hull (as per his brief of evidence), was that in these circumstances it was not necessary to review the diagnosis. Dr Hull explained it was not known what time Mr A took his medication, and in any event, the symptoms could, in his opinion, persist for much longer than the reaction time estimate of 4-6 hours given by Dr King.

11.5 FINDING:

11.5.1 **IT** is the Tribunal's view that this is the most serious particular of the charge.

11.5.2 **IT** is important to record what was elicited of Dr Hull in cross-examination by Ms Davenport. He conceded, as a close acquaintance of Dr Jayasinha of several years standing, that he could not be entirely impartial in giving his evidence. Dr Hull also conceded, on receipt of the telephone call, that Dr Jayasinha should have made it his business to re-examine Mr A. It was also conceded by Dr Hull, having made an uncommon diagnosis, on the presenting symptoms, that Dr Jayasinha should have questioned his patient closely as to the symptoms at the time of the call and the degree of their severity. If there was increasing pain, Dr Hull's preference would have been to see his patient at that stage.

11.5.3 **IT** is the Tribunal's conclusion that there are two facts which are critical in making a finding with respect to this particular of the charge. Having made a diagnosis on somewhat tentative grounds, and when dealing with a patient whose history suggested it was most unlikely that he would contact his GP over trivial matters (no contact between 1990 and 1996), Dr Jayasinha should have taken the telephone call in itself as a sign that all was not right. In this situation the Tribunal considers he should have made sure that he elicited the reason for the telephone call and acted appropriately on it. The Tribunal believes Dr Jayasinha should have reconsidered his own diagnosis and offered to see Mr A again that evening. At the very least the Tribunal considers that Dr Jayasinha should have made contact with Mr A the next morning. In evidence Dr Jayasinha conceded *"I obviously did not think at the time of the phone call that it was necessary to review my diagnosis"*.

11.5.4 **THE** Tribunal accepts the evidence of Dr King, when Mr A telephoned later in the day, that Dr Jayasinha should have been concerned to re-evaluate the situation, instead of simply advising Mr A to wait for the antibiotics to work.

11.5.5 **A** secondary conclusion reached by the Tribunal is that any conflict between the evidence given by Dr Jayasinha and Mr A should be resolved in favour of the latter. We say this because we prefer the quite clear recollection of Mr A that he told Dr Jayasinha his condition was worsening. This recollection is corroborated by Mr A's complaint to the Health and Disability Commissioner which is recorded on 11 November 1996 that he telephoned Dr Jayasinha around 4.45 pm on 18 October to let him know that he was feeling worse. Dr Jayasinha reassured him he would be feeling better and *"... a new man on Sunday"*, or words to similar effect.

11.5.6 **FOR** the record the Tribunal notes one of the closing submissions made most forcefully by Mrs Lombard, that Mr A was a vengeful complainant with a mental history, and thus his evidence should be approached with caution. As evidence of her perception of Mr A's mental state Mrs Lombard referred the Tribunal to a number of references in the hospital records to the effect that Mr A appeared confused, was hallucinating at times and made a request to read his notes and be supplied with a copy. The Tribunal rejects as being relevant to Mr A's complaint Ms Lombard's portrayal of him as having a mental history. The references quoted by Mrs Lombard are from nurses only. There is simply no evidence from a doctor or a psychiatrist to justify this submission. Furthermore there is no

evidence in the notes that Mr A required any treatment other than for his appendicitis and subsequent peritonitis. There is no evidence that Mr A's mental state was in any way affecting his judgement. The Tribunal also rejects Mrs Lombard's portrayal of Mr A as wanting to take revenge. Mr A's request to read his notes and concern about the earlier diagnosis does not, in the Tribunal's view, reveal any evidence of vengeance. Consequently the Tribunal considers it was quite inappropriate and totally unacceptable for Mrs Lombard, during the period the Tribunal was deliberating, and prior to adjourning, to communicate with Mr A in a manner which resulted in him apologising to Mrs Jayasinha for all the distress he has caused her family.

11.5.7 **UNFORTUNATELY**, but understandably so far as Dr Jayasinha is concerned, he was unable to recollect very much either of the initial consultation or of the subsequent telephone call. In consequence the evidence of Dr Jayasinha primarily was not his recollection, rather that of his invariable practice speaking from the experience of past occasions. Mr A impressed as a sincere and genuine person who, if anything, was self-effacing in his desire to present his evidence as absolutely truthful testimony.

11.5.8 **THE** Tribunal is obliged to find, when contacted and advised Mr A's condition was worsening, that Dr Jayasinha failed to arrange for a review of him and or his diagnosis, with the degree of reasonable skill and care appropriate in the circumstances. Essentially this finding is confirmed by reference to letters from Dr

Jayasinha to the Health and Disability Commissioner dated the 7th and 15th of April 1997 in which he explained:

"That night I was contacted by telephone and informed that his condition had not improved. Sine [sic] a diagnosis of a urinary tract infection had been made, He was told that it would take somewhat longer for the condition to subside and that he should continue with the medication, including Panadol for the pain."

12. INAPPROPRIATELY ARRANGED FOR A FOLLOW UP URINE TEST (ON THE LAST DAY OF THE DOSE OF ANTIBIOTICS)

12.1 **IT** was Mr A's evidence that Dr Jayasinha gave him a specimen bottle and told him to bring back a urine sample the following Tuesday 22nd October.

12.2 **DR** Jayasinha said he could not believe it was inappropriate to have a follow-up urine test, one which would serve the purpose of at least confirming that the medication prescribed had cleared the condition or otherwise.

12.3 **DR** Hull was of a similar opinion.

12.4 **FINDING:**

12.4.1 **THE** Tribunal sees no need to make any finding in respect of this particular of the charge. Suffice for it to be said that events quickly overtook any expediency implicit in this precaution.

13. DETERMINATION:

13.1 **THE** Tribunal is satisfied to the required standard, the civil standard, being the balance of probabilities, that Dr Jayasinha's overall management and treatment of Mr A was inadequate and was not carried out with reasonable skill and care. Specifically and primarily this finding has been made on the basis that when contacted and advised that Mr A's condition was worsening, Dr Jayasinha failed to arrange for a review of his patient and or his diagnosis.

13.2 **THERE** are other aspects of Dr Jayasinha's management and treatment of Mr A which, in the Tribunal's view, were questionable. The Tribunal resiles from making formal findings against Dr Jayasinha in respect of the remaining particulars of the charge. Overall, however, we are of the view that Dr Jayasinha's management and treatment of Mr A on the occasion in question, as has been explained, in some respects fell short of a reasonably competent general practitioner.

13.3 **GIVEN** the wording of the charge, not formulated to follow either (1)(b) or (1)(c) of Section 109 of the Act, the Tribunal considers that some discussion of professional misconduct/conduct unbecoming may be desirable. In noting Section 109(1)(c) of the 1995 Act requires the alleged conduct unbecoming also to *"reflect adversely on the practitioners fitness to practise medicine"*, this gloss will not be overlooked in the discussion which follows.

13.4 **A** recent judgement of the High Court, *Lake v The Medical Council of New Zealand*, 23/1/98, Smellie J, HC 123/96, examined professional misconduct and conduct unbecoming under the predecessor 1968 Act. For present purposes that examination remains relevant.

13.5 **THE** judgement is significant for the authorities it cites and principles emerging from those authorities which have contributed to the development of medical disciplinary jurisprudence in New Zealand. The judgement facilitates re-statement of the following propositions:

13.5.1 **THE** penalties for conduct unbecoming and professional misconduct are the same. In law it follows that the professional misconduct offence could be of equal or lesser gravity than the "conduct unbecoming" offence: *Cullen v the Preliminary Proceedings Committee* (Wellington Registry AP225/92).

13.5.2 **THERE** is little authority for what comprises "conduct unbecoming". It must be conduct which departs so significantly from acceptable professional standards as to attract sanction for the purposes of protecting the public. A finding of conduct unbecoming is not required in every case where error is shown. The question is not whether error was made, but whether the practitioner's conduct was an acceptable discharge of his or her obligations: *B v The Medical Council* (HC 11/96, Auckland Registry 8/7/96, Elias J).

13.5.3 **USUAL** professional practice, while significant, may not always be determinative of whether there should be a finding of "conduct unbecoming": *Cullen* (supra).

13.5.4 **A** dictionary definition of "professional misconduct" would be unhelpful. The test for professional misconduct (and it must be the same for conduct unbecoming) could be formulated as a question: *"Has the practitioner so behaved in a professional capacity that the established facts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? …… The test is objective"*: *Ongley v Medical Council of New Zealand* (1984) 4 NZAR, 369, 374-375.

13.5.5 **THE** Tribunal is to be regarded as a representative body. In fixing standards the members of the Tribunal must bear in mind that they act in a representative capacity and must endeavour to formulate standards which are themselves seen as representative, rather than an expression of their own personal views: *Faris v Medical Practitioners Disciplinary Committee* [1993] 1 NZLR 60.

13.5.6 **DISCIPLINARY** Tribunal's may not disregard the expert evidence in favour of their own views. However, having accepted the expert evidence called, the Tribunal is entitled to reach a conclusion that the level of care indicated by the evidence fell below protection of the public and maintenance of standards within the profession required: *Lake* (supra).

13.6 **ANY** perception that the former "conduct unbecoming" offence under the 1968 Act was at the lower end of culpability has been dispelled by attachment of the additional words "and that conduct reflects adversely on the practitioners fitness to practise medicine".

13.7 **THE** Tribunal is only entitled to make orders as to penalty when the conduct in question reflects adversely on the practitioner's fitness to practise medicine (Section 109(1)(c) of the Act). It is considered that the words have been added to ensure that the Tribunal does not take steps against a practitioner unless the offending has a bearing on his or her fitness to practice. Plainly Parliament intended to raise the threshold before a practitioner is found guilty of "conduct unbecoming". Quite clearly references in *Cullen* to such areas as *"merely administrative"* and *"personal life and behaviour outside the conduct of the profession"* will have less influence in the framing of "conduct unbecoming"-type charges against medical practitioners in the future.

13.8 **HAVING** determined that some of the facts alleged in the charge have been proved to the required standard, the Tribunal must go on to determine whether the conduct established by the proven facts amounts to professional misconduct or to conduct unbecoming which reflects adversely on fitness to practise medicine.

13.9 **THE** Tribunal is satisfied that Dr Jayasinha's conduct does not warrant a finding of professional misconduct. No evidence was placed before us which would indicate that the default in question was other than simple neglect. We would not categorise the default as wilful neglect. On the evidence the default was not recurring, and fortunately it did not extend over a significant period of time. This was not a case of a patient repeatedly telling his doctor of certain symptoms, and of the latter ignoring repeated opportunities to re-diagnose.

13.10 **IT** is clear to the Tribunal that a failure to recognise worsening symptoms, and to act appropriately on them, reflects adversely on fitness to practise medicine. Dr Jayasinha's failure in this regard, was an unacceptable discharge of his obligations to Mr A. In the Tribunal's view Dr Jayasinha's conduct extended beyond just simple error in failing to recognise worsening symptoms. This finding is not an expression of the personal views of the members of the Tribunal. It is based on a careful assessment of all the evidence, particularly the evidence of Dr King and cross-examination of Dr Hull.

13.11 **ACCORDINGLY** the Tribunal considers, and so holds, that Dr Jayasinha has acted in a manner which would be reasonably regarded by his colleagues as constituting conduct unbecoming which reflects adversely on fitness to practise medicine. When such conduct is considered objectively and measured against the judgement of Dr Jayasinha's professional

brethren of acknowledged good repute and competency, then the Tribunal must conclude that the charge of conduct unbecoming, as statutorily qualified, has been established.

14. PENALTY:

14.1 **A** charge having been upheld, the Tribunal invites submissions from counsel as to penalties. The timetable for making submissions will be as follows:

14.1.1 **MS** Davenport should file submissions with the Secretary of the Tribunal and serve a copy on counsel for Dr Jayasinha not later than 10 working days from the date of receipt of this Decision.

14.1.2 **IN** turn counsel for Dr Jayasinha should file submissions in reply with the Secretary and serve a copy on the Director of Proceedings not later than 10 working days from receipt of the submissions made by Ms Davenport.

14.2 **THE** Tribunal reminds counsel of the privacy order affecting Dr Jayasinha which was made prior to the hearing. The Tribunal invites counsel to address whether or not that order ought to remain in place, or be discharged, in their further submissions.

DATED at Auckland this 30th day of June 1998

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal