Medical Practitioners Disciplinary Tribunal

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DECISION NO: 69/98/36C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **JULIAN MEREDITH CLIVE WHITE** medical practitioner of Cambridge

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr F E Bennett, Professor B D Evans, Dr R S J Gellatly,

Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Hamilton on Tuesday 16 March 1999

APPEARANCES: Mr M F McClelland for the Complaints Assessment Committee ("the CAC")

Mr A J Knowsley for Dr J M C White.

1. INTRODUCTION:

1.1 **DR** White, through his solicitor, was provided with copies of all briefs of evidence of the CAC witnesses (and one affidavit) on 23 February 1999.

1.2 By letter dated 26 February 1999 Mr Knowsley advised the Tribunal that Dr White would plead guilty to all charges; and that Dr White would not be filing any affidavits, and nor would he require any of the CAC's witnesses for cross examination.

1.3 **IN** order to clarify matters the CAC requested confirmation from Mr Knowsley that Dr White would admit each particular of each charge, and that that particular amounts to either conduct unbecoming a medical practitioner (as statutorily qualified), or professional misconduct.

1.4 **BY** letter dated 26 February 1999 Mr Knowsley confirmed that Dr White admitted each particular and that that particular amounted either to conduct unbecoming or professional misconduct.

1.5 **AS** a result of the admissions made by Dr White, through Mr Knowsley, the CAC did not call any oral evidence. Rather, it relied entirely on the evidence from the briefs and one affidavit filed with the Tribunal on 12 March 1999.

1.6 **ALTHOUGH** Dr White admits the facts and that the particulars amount to either conduct unbecoming or professional misconduct, it is nonetheless the role of the Tribunal to determine first that the facts have been established to the required standard; secondly, that the facts establish the particulars of the charge; and thirdly that the established particulars amount either to conduct unbecoming or professional misconduct. At its option it is open to the Tribunal to determine that one or more of the established particulars amount to disgraceful conduct.

1.7 **THE** burden of proof is on the CAC to establish that Dr White is guilty of the charges and to produce the evidence that proves the facts upon which the charges are based.

1.8 **IT** is well established in professional disciplinary cases that the civil, rather than the criminal, standard of proof is required, namely proof to the satisfaction of the Tribunal, in this case the Medical Practitioners Disciplinary Tribunal, on the balance of probabilities. At the same time, however, the cases recognise that the degree of satisfaction which is called for will vary according to the gravity of the allegation.

2. CHARGE A: Conduct unbecoming a medical practitioner and that conduct reflects adversely on that practitioner's fitness to practise medicine.

Particulars of Charge A: Failed to exercise and show due care when prescribing or ordering drug treatments in that he:

1. Treated xx at various places in Cambridge during the months of November and December 1997 by changing his heart medication without proper clinical examinations.

2.1 **THE** evidence for this particular is found in the statements from xx who is the son of xx, and from xx who is xx's wife.

2.2 **MR** xx had suffered from heart problems from the early 1990's and until February 1998 had been a patient of Dr White.

2.3 **DR** White prescribed Mr xx Fusemide, Renitec and Digoxin.

2.4 **BECAUSE** Mr xx was often too weak to go to the Medical Centre for consultations Dr White used to visit him at home. Over all the occasions that Dr White visited Mr xx at home he never brought a stethoscope, he never took his blood pressure and he never checked his breathing. Despite this failure to carry out any form of physical check up Dr White increased the dosages so that by late 1997/early 1998 his medication was 3 Frusemide per day and 30 mg of Renitec per day. At about this time Mr xx suffered a series of minor strokes and heart attacks for which Dr White prescribed Warfarin.

2.5 **ON** 10 February 1998 Mr xx was admitted to Waikato Hospital. This resulted in his medication being significantly reduced to one Frusemide per day, one Imdur tablet per day and one Digoxin per day. He was taken off Warfarin.

2.6 **MR** xx' condition has improved significantly since his medication was reduced.

2.7 AMENDMENT:

On the evidence the particularity of specifying that Mr xx was treated during *"the months of November and December"* has not been established to our satisfaction. Accordingly this first particular of Charge A is amended by deletion of the words in italics and in their place substitution of the word *"late"*. In consequence the first particular of Charge A will now read *"Treated xx at various places in Cambridge during late 1997 by changing his heart medication without proper clinical examinations."*

2. During the years of 1993 to 1997 treated xx on a regular basis during which time he caused to be administered the prescription drug Kenacort in excess of acceptable clinical practice without appropriate warnings as to the possibility of adverse side affects.

2.8 XX is a xx employed by xx. She was a patient of Dr White for some five and a half years.

2.9 BETWEEN 1993 and 1997 Dr White treated Ms xx with Kenacort. Each time Ms xx had sinus problems Dr White would either inject or arrange for her to be injected with Kenacort. At no stage over this period did Dr White tell her of the side affects of the drug.

2.10 OFTEN the injections would leave large dents in Ms xx's buttocks which looked as though the flesh was eaten away. She drew this to Dr White's attention several times but he always said there was no need to worry.

2.11 IN 1994 because she was so concerned about the large indents she questioned the blood nurse xx. Ms xx told Ms xx that she knew it was not good to have too many Kenacort injections and when Ms xx explained how many injections she had had Ms xx pointed out that these could

cause the indents Ms xx was suffering from.

2.12 **MS** xx estimates that she received approximately five or six Kenacort injections per year; at no time did she realise that she was receiving the maximum dose.

2.13 **AMENDMENT:**

In our view the evidence has failed to settle just exactly what is *"established clinical practice"* for administration of the prescription drug Kenacort. Accordingly this second particular of Charge A is amended by deletion of the words *"in excess of acceptable clinical practice"*. Consequently the second particular of Charge A will now read: *"During the years of 1993 to 1997 treated xx on a regular basis during which time he caused to be administered the prescription drug Kenacort without appropriate warnings as to the possibility of adverse side affects."*

3. On one occasion between the years of 1993 and 1997 at Cambridge prescribed to xx sixty tablets of the prescription drug Halcion without warning her as to its addictive potential.

2.14 **BECAUSE** Ms xx visited xx as part of her job she mentioned to Dr White that perhaps she needed something to help her sleep. Dr White never told her that sleeping pills were addictive but he did say that if she took them for two or three nights in a row then she should have a night without them.

2.15 **ON** one occasion Ms xx mentioned to Dr White that she was having marriage problems. Dr White without prompting prescribed 60 tablets of Halcion; she did not request these. Dr White did not tell Ms xx about the drug and nor did he warn her of its addictive potential. Because she

was upset she started taking the tablets every night; Dr White never questioned the fact that she had taken so many tablets each time she went to see him to get more, he simply continued prescribing them.

4. Between the years 1996 to 1998 at Duke Street, Medical Centre, Cambridge, failed to maintain or adequately maintain a record of narcotic use in accordance with accepted clinical practice.

2.16 THE evidence in respect of this particular is provided by Dr xx and xx, registered nurse. It is considered desirable that General Practitioners keep a narcotics or controlled substances record book. When Dr xx first joined the practice he was concerned that Dr White kept no record book for narcotics and as a result arranged for the implementation of a controlled drug register.

2.17 ONLY Dr White, Mr xx and Dr xx had access to the safe box containing the drugs required to be recorded in the book but Mr xx and Dr xx had continuous difficulties balancing the record book because Dr White was removing ampoules from the store without recording the fact.

2.18 DR White never recorded any details of his use of controlled drugs in the record book. This meant that Mr xx had to write *"doctor neglect"* in the balance column in the record book in order to reconcile it.

2.19 AS a result Dr xx decided to keep his drug register totally separate to that of Dr White's.

5. During 1997 at Duke Street, Medical Centre, Cambridge, altered the existing treatment regime of patients of the Centre attended to by Dr xx without consultation or proper clinical examination.

2.20 **DR** xx provides evidence of occasions when Dr White altered the existing treatment regimes of several of Dr xx's patients without consulting him or without properly clinically examining the patients concerned.

2.21 **ONE** example is Mrs xx who was seen by Dr xx on 7 January 1997. He diagnosed her as having bronchitis and prescribed Amoxil. Mrs xx saw Dr White two days later and on her notes for 9 January 1997 Dr White has changed her medication from Amoxil to Ciproxin which is a much more potent antibiotic which should be reserved for severe infections.

2.22 **DR** xx saw Mrs xx on 21 September 1997 and, after clinically examining her for a bladder infection started her on Augmentin which is a broad spectrum penicillin based anti-biotic which is effective for treating urinary tract infection.

2.23 **ON** 23 September 1997 Dr White saw Mrs xx and changed her treatment to Ciproxin. Dr xx only found out about the change in antibiotics when he followed Mrs xx up a few days later.

DETERMINATION:

2.24 **SUBJECT** to the amendments made by the Tribunal to Particulars 1 and 2 of Charge A, it determines that:

(a) The facts have been established to the required standard;

(b) The facts establish the particulars of the charge;

(c) The established particulars amount to conduct unbecoming a medical practitioner and that conduct reflects adversely on that practitioner's fitness to practise medicine.

2.25 **THIS** determination was made unanimously with the exception only of Particular 4. Dr Gellatly expressed a reservation that general practitioners are required by law to keep a narcotics or controlled substances record book.

3. CHARGE B: Professional misconduct.

Particulars of Charge B: Failed to observe the acceptable standards required of a medical practitioner in clinical procedures in that he:

1. During the year of 1997 at Duke Street, Medical Centre, Cambridge inadequately or inaccurately labeled pathological specimens.

3.1 **THE** evidence for this particular is provided by xx, xx, over the years 1995 to 1997, Ms xx, xx and Mr xx.

3.2 **IN** her statement of evidence Ms xx details instances of Dr White failing to properly label pathological specimens. One incident was on 6 January 1997 when Ms xx found an unlabelled histology pot in the treatment room at the Medical Centre. The pot contained a specimen but the label had not been filled out. Dr White said he could not remember whose specimen it was and told Ms xx to put it in a safe place as he might remember whose it was.

3.3 **ON** 9 January 1997 Ms xx asked Dr White whether he had recalled whose specimen it was; by this time the specimen needed to be sent to the laboratory for analysis. Dr White said he still could not remember the name of the patient but that Ms xx should put his own name on the histology pot as he wanted to know the result of the test. Ms xx did this and when the results came back she entered them on the computer under Dr White's personal files.

3.4 **ON** several other occasions Ms xx had to ask Dr White who certain specimens belonged to because he failed to label the histology pots, or if he did label the pots he wrote only the surname of the patient and in hand writing which was very difficult to read.

3.5 **IN** his statement of evidence Mr xx described several occasions when Dr White would cut more than one mole off a patient but not remember which site each mole had been taken from. Also on one occasion Dr White left a cervical smear slide floating in formalin in his surgery; the slide did not have the patient's name on it.

2. During the years of 1993 to 1998 at Cambridge failed to evaluate and follow up cervical smear results in respect of a patient xx.

3.6 **MS** xx is a registered nurse who first became a patient of Dr White in November 1988.

3.7 **MS** xx had a smear on 24 April 1991; this was taken by Dr White.

3.8 **ON** 3 May 1993 she had a further smear but there were difficulties with the result in that there were no endocervical cells in the specimen taken. Dr White advised her that she needed a review smear in six months. This she did and the results were similar and Ms xx was told that she needed a further review smear in five months.

3.9 **ON** 31 March 1994 Ms xx had a further smear and was duly advised that there were no problems and that she would not require a smear for another three years.

3.10 **ON** 29 November 1995, because of the difficulties with smears in the past, Ms xx asked Dr White for a further smear. Dr White arranged for his nurse, Mrs xx, to take the smear. Ms xx never received the results of that smear and understood that because she was not contacted the results were normal.

3.11 **BETWEEN** November 1995 and January 1997 Ms xx had a number of appointments with Dr White but he never mentioned to her about the results of the smear on 29 November 1995.

3.12 **OUT** of caution Ms xx requested another smear on 7 February 1997 but for various reasons this was not carried out until after Ms xx transferred from Dr White to Dr xx. She had transferred because she was concerned that Dr White had become unprofessional.

3.13 **ON** 21 April 1998 Dr xx took a smear and a week or so later advised Ms xx that there were abnormal cells present and that a repeat smear was required. Dr xx referred Ms xx to Dr Hastie at the Angelsea Clinic in Hamilton. Dr Hastie completed the necessary treatment.

3.14 **ON** 24 June 1998 Ms xx asked Dr xx to give her the results of the smear which Dr White had arranged on 29 November 1995. The results were not documented in her notes and Dr xx had to telephone the laboratory in Hamilton for a copy of the report. That report indicated that the evaluation of the specimen taken from Ms xx on 29 November 1995 was limited by the absence of endocervical and metaplastic cells; the report recommended that a repeat smear be carried out in twelve months. Dr White had not informed Ms xx in November/December 1995 or at all that she needed a repeat smear in twelve months.

3. During the years of 1996 and 1997 in Cambridge failed to adequately monitor and respond to abnormal INR results.

3.15 EVIDENCE in respect of this particular is provided by Mr xx, Ms xx and Dr xx.

3.16 IN 1996 Dr White started working from the Medical Centre in the mornings only; he worked at Central A & E in Hamilton each afternoon. INR and other blood test results were always made available to the medical centre each afternoon. Ms xx received the results by facsimile or telephone each afternoon and she would show them to the doctor who was ultimately responsible for the results.

3.17 HOWEVER on a number of occasions Ms xx would telephone Dr White but was unable to contact him; staff at the Central A & E would say that they did not know where Dr White was or when he would be returning. This worried Ms xx considerably because some of the results were abnormal and would need immediate attention. When she could not contact Dr White she would ask Dr xx what should be done. This meant that Dr xx ended up making decisions about a number of Dr White's patients on a regular basis because no one had been able to contact Dr White.

3.18 MS xx provides a number of specific incidences where Dr White's failure to monitor abnormal results have created problems.

4. During 1987 at Cambridge re-used hypodermic needles on different patients.

3.19 MR xx and Mr xx, address this particular.

3.20 **MR** xx had suspected for some time that Dr White re-used hypodermic needles when his stock became low. On 9 January 1998 Mr xx noticed Dr White only had one needle left and so marked the syringe lid of the last needle with a pen. Dr White used the last needle on a patient prior to carrying out an incision. After the procedure Mr xx noticed Dr White had left the needle on the syringe that he had marked. Mr xx then marked the levels of the cartridge containing the Xylocaine and the needle with a vivid marker pen. Mr xx did not remove the needle because Dr White had told him not to do so. Mr xx told Mr xx what he had done. Mr xx then placed the used needle in Dr White's used tray in his surgery.

3.21 **ON** 14 January 1998 another patient came into the surgery to have stitches; he was given a local anaesthetic. After the procedure Mr xx noted that the same needle had been used and that the level of medication in the cartridge and the position of the needle had changed considerably. Mr xx removed the needle to ensure that Dr White did not use it again.

3.22 **AMENDMENT:**

In our view the evidence has established it would be more accurate to include the year *"1998"* in this fourth particular of Charge B. Accordingly it is amended to read *"During 1997 and 1998 at Cambridge re-used hypodermic needles on different patients"*.

5. During the year of 1997 at Cambridge in the course of his clinical practice used un-sterile instruments and procedures.

3.23 **MS** xx, Mr xx, Ms xx, Ms xx and Mr xx all address and provide examples of Dr White's consistent use of un-sterile instruments and procedures.

3.24 **DR** White removed five moles from Ms xx's back and shoulders. He was extremely rough and unhygienic when doing this. Dr White did not wear gloves, some of the stitches came undone and on several occasions he left the treatment room during the procedure. Dr White placed each mole into a separate jar but did not label the jars.

3.25 **DR** White also removed Ms xx's IUD on one occasion but when doing so did not ask Ms xx whether she wanted a nurse or someone else present in the room. Throughout this procedure Dr White went in and out of the room leaving Ms xx lying on the bed feeling most uncomfortable. Even after she had told him she was ready for the IUD to be removed Dr White left the room with his glove on. When he returned Ms xx asked him to put a new glove on as she did not know what Dr White had done once he had left the room.

3.26 **BOTH** Mr xx and Ms xx gave evidence that Dr White very rarely washed his hands before or between patients or before surgical procedures. On several occasions Mr xx said he saw Dr White perform a procedure and then, with blood on his hands from that ungloved procedure, move on to perform a procedure on another patient.

3.27 **SIMILARLY** Ms xx recounted occasions when she saw Dr White go from one patient to another during surgical procedures without washing his hands, even when he had dried blood on them.

3.28 **MS** xx also commented on Dr White's poor standard of hygiene. On numerous occasions she said she saw Dr White remove moles without wearing gloves and not wash his hands before or after the procedure. Ms xx described as a common occurrence Dr White suturing a patient and

then treating another patient in the treatment room without washing his hands between the two treatments respectively.

3.29 IN so doing clearly Dr White was exposing his patient to significant risk of cross infection.

3.30 AMENDMENT:

Likewise in respect of this fifth particular of Charge B the Tribunal considers, from a careful re-evaluation of the evidence, that the year *"1998"* should be added. Additionally, again after a careful re-evaluation of the evidence, the Tribunal concluded that the contention of use of unsterile instruments and procedures would be more accurately encapsulated by reference to use of *"unsafe techniques thus exposing his patients to the risk of cross infection"*. Accordingly the fifth particular of Charge B is amended to read *"During the years of 1997 and 1998 at Cambridge in the course of his clinical practice used unsafe techniques thus exposing his patients to the risk of cross infection."*

DETERMINATION:

3.31 SUBJECT to the amendments made by the Tribunal to particulars 4 and 5 of Charge B, it determines that:

(a) The facts have been established to the required standard;

(b) The facts establish the particulars of the charge;

(c) The established particulars of particulars 1, 2 and 3 are confirmed as amounting to professional misconduct. However in respect of the fourth and fifth particulars of Charge B, the Tribunal determines that they amount to disgraceful conduct.

REASONS FOR DETERMINATION:

3.32 **THE** test for disgraceful conduct was considered by the full Court in *Brake v Preliminary Proceedings Committee* (Full Court, Auckland) HC169/95, 8 August 1996 at page 7:

"The test for "disgraceful conduct in a professional respect" was said by the Privy Council in ***Allison v The General Council of medical Education Registration*** *to be met:*

> *If it is shown that a medical man in the pursuit of his profession has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency.*

It is apparent from this test, and from the later cases in which it has been adopted, that it is an objective test to be judged by the standards of the profession at the relevant time ...

In considering whether conduct falls within that category, regard should be had to the three levels of misconduct referred to in the Act, namely disgraceful conduct in a professional respect, s58(1)(b); professional misconduct, s43(2); and unbecoming conduct, s42B(2). Obviously, for conduct to be disgraceful, it must be considered significantly more culpable than professional misconduct, that is, conduct that would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct, or as it was put in ***Pillau v Messiter****, a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

3.33 **IT** is necessary for the Tribunal to explain why it has elevated the level of misconduct from professional misconduct to disgraceful conduct in respect of particulars 4 and 5 of Charge B.

CHARGE B (4):

3.34 **THE** prevention of infection and cross infection is fundamental to basic medical practice. Patients have a right to be confident, during examinations and other medical and surgical procedures, that they are not unnecessarily exposed to the risk of infection. For any medical person trained in sterile techniques and aware of the problems of transmission of infection, to deliberately disregard this training and information, is, in our view, simply repugnant. Regard must be had for a patient's safety and wellbeing. This is fundamental to the contract between a patient and a doctor. That

relationship must be based on the patient's expectation that the doctor will try to do his or her best for the patient under all circumstances.

3.35 **IT** is well established that certain, extremely dangerous infections, such as hepatitis B, hepatitis C and HIV can be spread by needles contaminated with the blood/body fluids of an infected individual. In the present environment hepatitis B is not uncommon in any community in New Zealand. Hepatitis B infection carries the possible risk of the complication of liver cancer developing, let alone the morbidity and mortality of the initial hepatic infection.

3.36 **AS** well there is the possibility of transmitting the AIDS virus to another person. The actual incidence of AIDS is probably low in Cambridge, and the possibility of successful transmission of the virus has been stated to be 1/400 when using hollow needles, so the actual risk is possibly quite low, but to ignore this is unacceptable.

3.37 **BASIC** practice requires that a doctor does not expose his patients to a risk of infection by using a dirty needle. A doctor using a dirty needle deliberately and knowingly injecting a patient with a needle contaminated with the body fluids of another patient, is deliberately putting the patient at the risk of death or tremendous suffering. Such behaviour is contrary to the basic philosophy of medical practice and totally undermines the trust that the patient puts in the doctor. Even if a patient does not become infected but knows about the events which have occurred, then tremendous stress and anxiety may result.

CHARGE B (5):

3.38 **AS** has already been explained, doctors have a duty to minimise the risk of infection and cross-infection to patients. Dr White has clearly deliberately ignored the basic rules which have been

put into place over a great many years to protect patients from cross-infection. Dr White should know, as all doctors do, that infections can be transferred from one patient to another. It is standard practice to wash one's hands following one surgical procedure before embarking on another. This standard practice has been ignored by Dr White who, with blood on his hands, has gone from one patient to perform a surgical procedure on another. Again such conduct is disgraceful. He has deliberately and knowingly exposed his patients to the risk of life-threatening infections. He has ignored the basic rules of hygiene and as a result of this he has put his patients at risk. His standard of practice has fallen to an appalling level, and the Tribunal has no hesitation in finding him guilty of disgraceful conduct on this fifth particular of Charge B.

4. CHARGE C: Conduct unbecoming a medical practitioner, and that conduct reflects adversely on that practitioners fitness to practice medicine.

Particulars of Charge C: Failed to observe patient privacy and confidentiality in breach of the Code of Ethics:

1. During the year 1997 allowed an unqualified person namely xx to be present during consultations and surgical procedures.

4.1 MR xx and Ms xx describe numerous instances when xx, Dr White's partner, who is not a qualified nurse, was present during patient consultations and surgical procedures. In his evidence Mr xx describes an occasion when he and Dr White were removing a mole from a patient's neck. Without the patient's consent, Dr White allowed Ms xx into the treatment room to watch the procedure during which time Ms xx made inappropriate comments particularly as to how the mole looked cancerous and how she was going to be sick because it looked so ugly.

2. During the years 1996 to 1998 in waiting/reception area in Duke Street, Medical Centre, Cambridge made statements about personal and medical matters concerning his patients in hearing of other patients and members of the public.

4.2 **MR** xx described in his statement of evidence how Dr White would give him instructions in a loud voice on what to do for certain patients when Mr xx was working on the computer in the reception area/waiting room.

4.3 **IN** her statement of evidence xx also provides evidence of this. On one occasion on 8 August 1997 Dr White came to the reception area where Ms xx was, holding in his left hand a used speculum and in the other a cervical smear glass. Two former patients were present at this time. He then wrote the name of the woman concerned on the used smear glass simultaneously saying the patient's name out aloud in front of the other patients.

4.4 **IN** her statement of evidence Ms xx provides instances of Dr White's persistent breaches of patient confidentiality. One instance was when the staff of the surgery went out for dinner. Dr White mentioned a patient by name and said that the patient was *"always in and out of the surgery for [a particular drug]"* which Dr White named. Dr White spoke very loudly and was in clear hearing of other people dining at the restaurant.

5. CHARGE D: Conduct unbecoming a medical practitioner, and that conduct reflects adversely on that practitioner's fitness to practise medicine.

Particulars of Charge D: Failed to conduct himself in a professional and ethical manner in dealings with other medical practitioners, staff and patients.

1. During the years 1993 to 1997 at Cambridge used offensive language in consultation with patients and in public areas of the centre.

5.1 **VIRTUALLY** all of the witnesses who have filed statements in respect of the charges before the Tribunal have provided evidence of Dr White's constant use of offensive language to his patients and in public areas. The instances are too numerous to detail but it is quite clear from the evidence that the use of such language was the norm for Dr White.

2. During the years of 1997 and 1998 impugned the reputations of other health professionals, namely Dr xx, Mr xx, Mr xx and Mrs xx.

5.2 **THE** instances of such conduct are too numerous to need detailing. Suffice to say the statements of Mr xx, Mr xx, Ms xx, Mrs xx and Dr xx all provide many instances of such conduct.

3. During the months of August and September during 1997 at Cambridge applied undue pressure to his former patient Mr xx and his wife to return as patients to his practice.

5.3 **THE** evidence for this particular is provided by Mr and Mrs xx. Mr xx suffers from cordite damage to his lungs. Up until mid 1997 he had been a patient of Dr White for a number of years.

5.4 **ON** 21 August 1997 Mr xx caught his leg on a piece of wood and cut a vein. He bled very heavily. Mrs xx tried to contact Dr White but could not reach him at any of the numbers he had given them. Accordingly she rang Dr xx who sent his nurse Mr xx. Mr xx was taken by ambulance to Waikato Hospital and discharged the next day. He was required to have the wound dressed every day until it healed.

5.5 **MR** and Mrs xx made an appointment to see Dr xx to have the wound dressed, as he had dealt with the incident from the start.

5.6 **SHORTLY** after seeing Dr xx for the first dressing, Mrs xx received a telephone call from Dr White asking whether he could call around to the house that afternoon. Mrs xx agreed. When Dr White arrived he became very angry with her and shouted and abused her for taking Mr xx to Dr xx. Mrs xx attempted to explain that it was an emergency, and that she had tried to get hold of Dr White, but Dr White would not accept this.

5.7 **THE** next day Dr White arrived at the xx's home unannounced and with Ms xx. He started giving Mrs xx a series of excuses as to why he had been unavailable to attend; he pressured Mrs xx to assure him that they would continue to use Dr White as their doctor. He started swearing and shouting and saying that he had had enough of Dr xx taking all his patients and he would *"get that bastard xx, I'm going to prosecute that bastard xx ... he is taking all my patients"*. He was extremely abusive and Mrs xx became very upset.

5.8 **AT** 10pm the following evening Dr White rang the xx's at home. Mr xx got out of bed and answered the phone. Dr White started swearing at him for going to see Dr xx; he spoke in a very abusive tone telling Mr xx that he should remain a patient of his.

5.9 **AT** approximately 8.30pm the following night Dr White again came to the xx's home. Mrs xx did not want to see Dr White so she went to her bedroom. Mr xx met Dr White at the door. Dr White wanted to know why Mr xx and his wife had been ignoring him and told him that he would take Dr xx to Court for taking his patients.

5.10 **AS** a result of Dr White's behaviour Mr and Mrs xx have transferred to Dr xx.

4. During the months of April and May 1988 at Cambridge in his capacity as a designated doctor for Income Support solicited patients seen pursuant to that scheme to return to him for ongoing care.

5.11 **DR** xx deals with this particular in paragraphs 30-31 of his statement. xx deals with the particular in paragraph 27 of her statement.

5.12 **IN** April and May 1998 Dr White solicited at least three patients seen pursuant to the Income Support Scheme to return to him for ongoing tests. For example xx, who was a patient of Dr xx, told Dr xx that he felt terrible that he was no longer allowed to see him any more. Dr White had told Mr xx that as he was his designated doctor for Income Support purposes, he had to see Dr White permanently.

6. CHARGE E: Professional misconduct

Particulars of Charge E: Failed to ensure that medical care was available to patients

That on the 19th and 22nd days of December 1997 at Cambridge he intentionally interfered with the after hours emergency medical phone service of the Duke Street Medical Centre in such a manner it prevented patients from accessing emergency medical care.

6.1 **DR** xx deals with this particular in his statement.

6.2 **IN** December 1997 the reception at the Medical Centre was split into two so that Dr xx could have things as he wanted them at the reception desk; his own receptionist, privacy of records, and the like. When Dr White first discovered that Dr xx wanted to split the reception area, he told him that he could not do that because it was not his (Dr xx's) building. Dr xx said he told Dr White, that in fact, he now owned a half share in the building. Dr White was not happy.

6.3 **ON** the evening of 21 December 1997, the day Dr xx first told Dr White that he was now a part-owner of the building, Dr White added immense problems to his practice by tampering with the telephone system at the Medical Centre. As Dr xx was the only doctor who does after-hours work at the Medical Centre, Dr White tried to damage his practice by placing a message on the telephone with xx speaking, and giving incorrect hours of practice and interfering with the after-

hours set-up which had been used for the past few months. Dr xx's hours were until 7 pm and Dr White was aware of this. He arranged for the message to be put on the Telecom answering machine which automatically stated that the surgery closed at 5 pm and that people should contact the after-hours doctor. Telecom confirmed with Dr xx subsequently that only Dr White had the authority to change the message. Dr xx was unable to alter the message because Dr White had installed a password which he did not know.

6.4 **THE** next day, 22 December 1997, Dr White changed the message on the telephone to cater for after-hours calls to state that *"All our lines are busy at the moment, please call back in a minute"*. The message played on continuously all through the night and resulted in no patients being able to contact the duty doctor at all when dialing the Medical Centre in the event of an emergency. The message gave the patients in dire need of assistance the impression that by re-dialing they would eventually be attended to.

6.5 **THIS** behaviour demonstrates that Dr White deliberately left a message on his answer phone which at worst might prevent patients getting adequate emergency help, and at best might delay them getting appropriate assistance and cause them a great deal of unnecessary anguish. In our view this act can only be described as appalling, and it is for this reason that we have detailed Dr xx's evidence so as to illustrate the seriousness of the situation which we believe might have developed at the times in question.

6.6 **ALSO** relevant is Dr xx's affidavit in support of an application for an interim injunction dated 23 December 1997 and the Court Order of the same date restraining Dr White from interfering or dealing with the Duke Street Health and Medical Centre telephone number and from placing any message on the telephone without the message first having been approved in writing by Dr xx.

6.7 AMENDMENT:

THE Tribunal determines that the level of misconduct in respect of Charge E should be elevated from professional misconduct to disgraceful conduct in a professional respect.

REASONS FOR AMENDMENT DETERMINATION IN RESPECT OF CHARGE E:

6.8 AGAIN this charge illustrates disregard for patient safety which we can only describe as callous. An important principle that guides medical practitioners in their dealings with patients is summarised in the pithy Latin phrase *"Primum non nocere"*. This is translated as *"firstly do no harm"* and is often quoted when trying to balance the possible gains from a therapeutic intervention against possible harm to the patient. It is particularly relevant in the invasive interventional world of surgery, but applies to every intervention and is as true in general practice as in any other area of medical practice.

6.9 DOCTORS have an enormous capacity to harm if their skills and position of authority are abused. It is hard to interpret Dr White's actions in any other way than an abuse of his position. His actions were a willful and deliberate disregard for the safety of other people who were dependent on him for therapy or access to therapy.

6.10 DR White was a general practitioner in Cambridge. He was a doctor providing care to a great many people living in Cambridge. It is unbelievable that such a person should deliberately take steps, which could prevent his, and other patients in Cambridge, getting urgent medical attention at night. He left a message on an answer phone deliberately designed to mislead his patients. This meant that they might not receive urgent treatment which they required or alternatively such

treatment might have been delayed. For a doctor to do this knowingly and in a premeditated fashion is absolutely disgraceful. Such conduct can only be judged by Dr White's medical peers as disgraceful, and the charge was amended for this reason.

7. INTERIM RULINGS:

7.1 **AN** order is made prohibiting publication of the name and any particulars of all patients and complainants in this case.

7.2 **PENALTIES** are reserved.

7.3 **IT** is noted that Dr White has voluntarily surrendered his practising certificate to the Medical Council. Mr Knowsley produced a medical certificate to the effect that Dr White is medically unfit to practise as from 27.2.99.

7.4 **HAVING** regard to the need to protect the health and safety of members of the public, the Tribunal orders that Dr White's registration as a medical practitioner be suspended pending determination of these proceedings, pursuant to Section 104(1)(a) of the Act.

7.5 **IT** is to be noted that under Section 105 of the Act a medical practitioner in respect of whom an order is made under Section 104 of the Act may at any time apply to the Tribunal for the revocation of that order.

7.6 **EVERY** application under Section 105 of the Act should be in writing and delivered to the Secretary. An application made under Section 105 of the Act shall be heard within 10 working

days after it is received by the Secretary, and the Tribunal may grant or refuse the application as it thinks fit.

7.7 **THE** Secretary shall give notice of the Decision of the Tribunal under Section 105 of the Act to the medical practitioner concerned as soon as reasonably practicable.

7.8 **IN** the event the Tribunal may at any time, of its own motion, revoke an order made under Section 104 of the Act.

7.9 **WITH** the consent of Dr White the Tribunal has arranged for him to undergo psychiatric, psychological, and physical medicine examinations. Counsel have been supplied with copies of the Tribunal's letters of referral to these specialists.

7.10 **ON** receipt of the reports from the specialists counsel will be supplied with copies and invited to make submissions in response, with timetable directions to be made at that time.

7.11 **LEAVE** is reserved for counsel to apply for further directions at any time.

DATED at Auckland this 30th day of April 1999

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal