Medical Practitioners Disciplinary Tribunal

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DECISION NO: 66/98/34C

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 **TANE ARATAKI TAYLOR** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Mr P Budden, Dr J M McKenzie, Associate Professor Dame N Restieaux, Dr D C Williams (Members)

Ms G J Fraser (Secretary)

Mr B Scott (Stenographer)

Hearing held at Auckland on Wednesday 3 and Thursday 4 March 1999

APPEARANCES: Ms K Davenport for the Complaints Assessment Committee (the CAC)

Ms H D Winkelmann for Dr T A Taylor.

1. THE CHARGE:

1.1 FOLLOWING discussions between counsel Dr Taylor pleaded guilty to a charge of professional misconduct whereby he acknowledged he had failed to exercise the standard of care and skill reasonably to be expected in the circumstances in regard to Ms Mohi's labour and the birth of Hineraukatauri. The particulars of the failure to exercise the standard of care and skill are as follows:

(a) He failed to ensure or to take steps to ensure that a paediatrician was present at the birth of Hineraukatauri Mohi-Rudolph.

(b) He failed to recognise and/or act upon the cumulative risk factors inherent in the labour and delivery of Hineraukatauri Mohi Rudolph. These risk factors were the fetal abdominal circumference identified on the ultrasound scan at the 5th centile and gestational hypertension.

(c) He failed to ensure that Hineraukatauri Mohi-Rudolph was delivered at 0240 hours on 25 May 1996 or shortly thereafter when called upon to review the trace by the midwife.

(d) He failed to recognise and/or act upon the worsening fetal trace and/or act upon the worsening fetal trace expeditiously at his consultations at 1.30 am, 2.40 am or 4.00 am.

(e) He failed to discuss with a consultant the management of Ms Mohi's labour at either 1.30 am, 2.40 am or between 3.50 am - 4.00 am.

(f) He failed to expedite delivery.

2. AGREED STATEMENT OF FACTS:

2.1 **HINEWEHI** Mohi was pregnant with her first child in 1996. Her expected delivery date was about the 16th of June 1996. She was initially under the care of an independent midwife, Helen Bryant. Her pregnancy was uneventful until early May 1996. On 9 May 1996 her independent midwife asked for her to be admitted to National Womens Hospital with vomiting and diarrhoea. She was assessed and discharged on the 10th of May.

2.2 **SHE** was seen again on the 14th of May at the foetal assessment unit. Blood pressure had risen. A tentative diagnosis of gestation hypertension was made. She was admitted again on the 21st of May 1996 as there was concern over her 24-hour urine result, her oedema and previous history of increased blood pressure. At the time of admission her diastolic reading was 96. It had been 60 on booking. The plan was that she would be discharged on the 22nd, that she would be seen in the clinic on Friday, bloods would be done and that she would be given a scan for foetal growth.

2.3 **THE** scan took place on the 24th of May in the morning. At that time the diagnosis was (?) gestational hypertension (see page 99 of the notes).

2.4 **ON** the 24th of May a biophysical profile and ultrasound were carried out (see page 176 of the notes). This indicated that the baby's abdominal circumference was on the fifth percentile. The other measurements were within normal range.

2.5 **ON** the way home from the scan, there was a spontaneous rupture of Ms Mohi's membranes. (SRM)

2.6 **THERE** is some confusion in the notes about the time of the SRM. It seems however that likely sequence of events is that she was assessed by Helen Bryant at approximately 14:00 on the 24th of May (see page 141 of the notes). There was then a discussion with the Registrar on duty in the delivery unit at 15:30 and a decision was made to admit Ms Mohi for augmentation of labour.

2.7 **AT** 15:30 a booking was arranged for delivery unit 2.

2.8 **AT** approximately 19:15 Ms Mohi was admitted. She was reviewed by the Registrar Jacobsen (see page 142 of the notes). She was assigned to the care of midwife Sharon Bailey. She was also under the care of the blue team.

2.9 **AT** 20:15 a syntocin drip was commenced.

2.10 **AT** 01:30 on the 25th of May 1996 Ms Bailey felt some concern over the CTG tracing of the baby and asked Dr Taylor to review the trace. He reassured her about the trace.

2.11 **AT** 02:15 the midwife called the Registrar again. At 02:40 Dr Taylor reviewed the trace then set up for a scalp pH and commenced a vaginal examination. The vaginal examination showed Ms Mohi to be fully dilated. The scalp pH was not carried out as delivery was thought to be imminent. Dr Taylor left the delivery room. At 03:50-04:00 he was called again by the midwife and the CTG reviewed. Delivery had not then occurred.

2.12 **THE** trace had been abnormal for some time prior to 01:30. The trace showed some improvement at about 01:30 when Ms Mohi was moved in to the lateral position. (Pg 205). By 01:50 however the trace deteriorated further with clear decelerations. (Pg 204). It did not improve.

2.13 **DR** Taylor advised that delivery needed to be expedited. He then left the room. At 4:25 delivery was in fact effected. The baby was born and gave sporadic gasps and was floppy. The midwife commenced resuscitation and called for the paediatric crash team. Resuscitation was carried on after approximately 04:28 by the paediatric "crash team". Voluntary respiration was finally established 35 minutes after birth. Her apgar scores were 2 at 1 minutes, 4 at 5 minutes, 5 at 10 minutes and 6 at 35 minutes.

3. EVIDENCE:

3.1 **IT** is understood that it was only following considerable negotiations between counsel that the plea of guilty was entered, and notification to this effect was not received by the Tribunal until the day immediately preceding the hearing.

3.2 **IN** anticipation that there would be a defended hearing briefs of evidence were exchanged in the normal way, and members of the Tribunal read those briefs prior to the hearing. In addition short statements of evidence of Ms Mohi and of her aunt, Ms Vivienne Hinewehi Dallimore, were made available to us during the course of the hearing.

3.3 **FOR** the CAC the witnesses were to have been Lynda Mey Batcheler, an Auckland gynaecologist and obstetrician, and Robert Simon Hearn Rowley, a consultant paediatrician at National Womens Hospital.

3.4 **FOR** Dr Taylor his expert witness was to have been Donald Russell Aicken, Professor and Head of the Department of Obstetrics and Gynaecology at the Christchurch School of Medicine. Given the plea of guilty it was not necessary for the expert witnesses to be called to give their evidence. However it should be noted, at the request of Ms Winkelmann, that Professor Aicken's brief of evidence has been received and treated as evidence for the purposes of a plea in mitigation.

3.5 **ALSO** should be noted a submission made by Ms Winkelmann, with which the Tribunal agrees, that strictly neither Dr Rowley nor Dr Batcheler are independent witnesses. Dr Rowley is a paediatrician who is in charge of Hineraukatauri's care, and Dr Batcheler was the gynaecologist of Ms Mohi before she became pregnant and who saw Ms Mohi when she did become pregnant and referred her to the independent midwife. The Tribunal has been assisted considerably by the balanced and measured approach taken by Professor Aicken in his brief of evidence. Particularly, given Dr Taylor's Registrar status, it is important to note that from 1985 to 1998 Professor Aicken was the Christchurch Regional Training Supervisor for Registrar Specialist Trainees enrolled in the Royal New Zealand College of Obstetrics and Gynaecology programme.

4. DISCUSSION:

4.1 **ALTHOUGH** expressed in a number of particulars the essence of the charge against Dr Taylor is that he failed to recognise or act upon a CTG trace at 0130, 0240 and 0400 on the morning

of 25 May 1996. His failure to recognise the severity of the situation as indicated by the CTG trace was the cause of his failure to expedite delivery, seek assistance from his consultant or to call a paediatrician to the delivery.

4.2 **MS** Winkelmann assisted the Tribunal by providing us with Dr Taylor's explanations for his decisions concerning the events which occurred on 25 May 1996.

4.3 **AT** 0130 he noted an increase in the base line heart rate on the CTG, but that this had settled. Given that Ms Mohi had recently been changed into a lateral position by the midwife, and some improvement appeared to have followed this, he believed the prior abnormality arose from a position of Ms Mohi which had been corrected. With hindsight his comfort in relation to the 2 CTG was misplaced.

4.4 **PROFESSOR** Aicken however notes that it was perhaps beyond Dr Taylor's relatively short obstetric experience to take into account the possibility that the normality of the trace when Dr Taylor saw Ms Mohi was to be only a brief episode. He agrees with Dr Batcheler's comment that an experienced obstetrician may have taken more account of the abnormalities which had occurred over at least two hours, prior to 1.30 am, but is of the view that this may have been too much to expect of a Registrar of Dr Taylor's experience.

4.5 **AT** 0240, Dr Taylor reviewed the CTG again and was concerned. He prepared to do a scalp pH, but on examining Ms Mohi, noted that she was fully dilated and assessed her as about to deliver. Dr Taylor did not progress the scalp pH because he thought she would deliver very shortly. He was reassured that there was movement when the baby's head was stimulated.

When Ms Mohi gave a push the head moved down and there was no meconium. His view was that this was not an emergency situation and that a natural delivery was both imminent and appropriate and therefore that intervention was not warranted.

4.6 **DR** Taylor thought he made it clear to the midwife that she should deliver without delay. It appears that the midwife misunderstood his explanation of his actions, and she failed to appreciate the urgency for delivery, as she then delayed delivery until the epidural wore off sufficiently for Ms Mohi to develop an urge to push.

4.7 **PROFESSOR** Aicken says that Dr Taylor's failing at 0240 hours was not to put in place a back up plan to ensure delivery within 15 to 20 minutes. Essentially Dr Taylor should have said to the midwife that if the baby was not delivered within that period, she should call him back so that he could intervene.

4.8 **PROFESSOR** Aicken says that Dr Taylor had a right to expect the midwife to call him back to review the case in light of the continued adverse fetal trace. Clearly that did not happen, and Dr Taylor therefore was not aware of the failure of his expectation of early delivery. Nor did Dr Taylor make any attempt to find out over the next hour if delivery had taken place.

4.9 **DR** Taylor saw Ms Mohi again at 0350 hours. He was surprised that she had not already delivered, and the midwife explained that she had waited until the epidural had worn off. Dr Taylor examined the CTG and saw that it was normal and appeared to have less reactivity since 0330 hours He believed that delivery had to be progressed quickly, but, in error, he did not evaluate the situation as an emergency. He accepts that he did not appreciate the seriousness of

the CTG and distress on the baby since 0200 hours. He was reassured in his understanding by the apparent confidence of the midwife whom he believed was not concerned and was happy to deliver the baby. He viewed the midwife as experienced and had respect for her professional judgement. He allowed himself to be falsely reassured.

Risk Factors:

Gestational Hypertension

4.10 **THE** symptoms recorded in the summary disclose that Ms Mohi was admitted to National Womens Hospital on 21 and discharged on 22 May. The problem list records *"? gestational hypertension"*. The results of the tests undertaken have an annotation *"insignificant"* and *"no symptoms seen in patient"* marked against them.

4.11 **DR** Rowley lists this as a risk factor but does not comment any further on it. Clearly it was not sufficiently significant for him to elaborate further.

4.12 **DR** Batcheler refers to it as *"mild hypertension"* but does not otherwise state why or to what extent this was significant.

4.13 **PROFESSOR** Aicken says that gestational hypertension is a diagnosis made on interpretation of definitions and criteria which differ between centres, hospitals and practitioners, and that if this was gestational hypertension it was certainly of the lower degree and evidence for it had diminished by the time Ms Mohi was in labour.

Fetal abdominal circumference identified on the ultrasound scan was at the fifth centile:

4.14 **THIS** factor was not mentioned to Dr Taylor at handover. However, Dr Taylor accepts that the reading on the scan of 24 May discloses a fetal abdominal circumference at the fifth centile. As Professor Aicken points out in his statement of evidence, it is arguable whether the foetus could be considered small for dates on one measurement in the presence of three other normal measurements and it certainly could not be assumed that there had been poor fetal growth on the basis of a single scan. Professor Aicken does not accept Dr Batcheler's comment *"she had a small baby who is most likely intrauterine growth retarded"*. He says this is not justified on the facts.

4.15 **ASIDE** from an evaluation of the scan itself, ultimately, the baby's birth weight was within the 30th centile. The birth weight chart shows the baby within the normal weight range. This was not an issue that the paediatrician referred to as a *"problem"* or risk factor when the baby was first assessed.

4.16 **THE** reality is that although these issues were potential risk factors, the mild hypertension was not significant and the ultrasound finding was far from conclusive, and was not borne out by the baby's birth weight.

5. SUBMISSIONS ON PENALTIES:

5.1 **ROBUST** submissions were made by Ms Davenport on behalf of the CAC. She argued it was nonsense to say the midwife was reassuring Dr Taylor. Rather she said the midwife was calling him in and saying I am concerned about this trace. You are the doctor on duty. What do you think about it. She was making a call that she was uneasy and that she was asking for his advice.

However again Ms Davenport pointed to the trace that Dr Taylor saw at 2.40. She said there was absolutely nothing reassuring about that trace. The baby's heartbeat was significantly depressed after each contraction, and was not responding quickly. Dr Taylor recognised that this was a baby showing distress.

5.2 **HAVING** been alerted for the second time by the midwife, Ms Davenport argued that he made a proper decision to do a scalp pH which would have given him information about the welfare of the baby. Then he decided that Ms Mohi was fully dilated and the baby would deliver. Again, Ms Davenport argued that this was probably a very sensible conclusion.

5.3 **BUT** it was at this point that Dr Taylor became culpable, in Ms Davenport's view. He identified Ms Mohi as fully dilated, but he took no steps to ensure that the baby was delivered.

5.4 **MS** Davenport explained that Hineraukatauri cannot walk, she cannot talk, she cannot feed herself and she never will be able to. In Ms Davenport's submission the real tragedy of this case is that it so easily could have been prevented. It is a tragic case and Ms Davenport submitted, in terms of penalties, it highlights the need for Dr Taylor to be dealt with by way of conditions on his right of future practice if he wishes it to include obstetrics.

5.5 **A** number of mitigating factors were identified on Dr Taylor's behalf, which we have been able to take into account in assessing penalties. Among them are his junior status as a Registrar at the time, possible work fatigue given that on completion of the relevant shift Dr Taylor had been on duty for 24 hours, the heavy commitment of cover on the night and unacceptable communication failures which developed between himself and the midwife.

5.6 **A** colleague, Dr Julia Taitz, gave a testimonial on behalf of Dr Taylor in which she concluded, from his patient notes and general feedback, that he is *"a careful, empathetic, compassionate and knowledgeable doctor"*.

5.7 **TE PUNA** Hauora O Te Raki Paewhenua, an incorporated society with charitable status delivering health services to all residents on the Northshore from a Marae-based Maori perspective, spoke highly of Dr Taylor. They explained in their view *"[Dr Taylor] was totally involved with the rest of the team in effecting the restructuring process which has culminated in the success of this programme. As a doctor, [his] clinical skills are outstanding. His ability to relate with clients, their families as well as other team members was appreciated by all"*.

5.8 **MS** Mohi should be aware Dr Taylor wishes her to know that at no time did he deliberately neglect her care. Unfortunately he made serious errors of judgement which he now deeply regrets. Although they are not comparable situations, the consequences for Dr Taylor have also been severe. He has lost his job at National Womens Hospital and with it the opportunity to complete the Specialists Training Programme in obstetrics and gynaecology.

6. PENALTIES:

6.1 **ALL** that said, the consequences for this baby and her mother have been severe. As her mother explained in her brief, if it had been necessary to call her as a witness:

"She cannot walk, talk or sit up and requires constant therapy and care. She also has a tracheotomy to help her breathe and a gastrostomy tube in her stomach for feeding."

6.2 **HAVING** heard the evidence and accepted Dr Taylor's admission the Tribunal orders that he be censured.

6.3 **THE** limit of fine is $1,000.00 under the 1968 legislation, which applies to this case by virtue of the transitional provisions of the 1995 Act. Ms Winkelmann made no submission concerning a fine. On the other hand Ms Davenport argued that a fine should be imposed of between $500.00 and $700.00. The Tribunal orders that a fine of $600.00 be imposed.

6.4 **ON** the question of costs the Tribunal has a discretion to order that Dr Taylor pay part or all of the costs and expenses of and incidental to any or all of the inquiry made by the CAC in relation to the subject matter of the charge, the prosecution of it and the expenses incurred by the Tribunal in hearing it.

6.5 **THE** term "costs and expenses of and incidental to ..." is not defined in the Act. The formulation adopted in this Act is similar to an approach adopted in many Acts. There is simply a basic power to order costs.

6.6 **THE** Medical Practitioners Disciplinary Tribunal is not a Court as such, but consideration of its functions (Section 97) and procedures (Section 102-114, First Schedule, particularly Clause 5(3)) suggest that there are sufficient parallels between the function and procedures of the Tribunal, and a Court, that background assistance can be gained from the processes of a Court in relation to costs. Two general statements regarding costs in Court are therefore of assistance:

(a) "'*Costs' signifies the sum of money which the Court orders one party to pay to another party in respect of the expense of litigation incurred. Except where*

specifically provided by statute or by rule of Court , the costs of proceedings are in the Court's discretion. They normally follow the event so that the successful party will, in the absence of factors justifying some special order, be awarded as costs of suit to be agreed or taxed on a party and party basis. Such costs rarely provide complete reimbursement of expenses, and the principle of restitutio in integrum, which is applicable to damages, does not apply." (12 Halsburys Laws (4th edition) para 1108).

(b) The locus classicus with regard to costs in Civil Proceedings is a judgement of Hardie Boys J which confirms the well established basic principle that party and party costs are to be quantified on the basis of a *"reasonable contribution"* in all the circumstances to the successful parties' costs actually and reasonably incurred (*Morton v Douglas Homes Limited* (No. 2) [1984] 2 NZLR 620, 624-625).

(c) The underlying principle, therefore, is *"What is a reasonable contribution in the particular circumstances?"*.

6.7 **A** distinction should be noted between the provisions contained in the current Act, and those contained in the 1968 Act:

(a) Section 48 of the 1968 Act permitted the Medical Practitioners Disciplinary Committee, or a District Disciplinary Committee, to make *"such order as to the payment of costs as it thinks fit..."*.

(b) Section 58(2)(f), provided that the Medical Council could order:

"... that person to pay any costs of and incidental to the inquiry by the Council and any investigation made the Preliminary Proceedings Committee."

(c) Section 110(1)(f) of the 1995 Act uses a formulation similar to the power previously given to the Medical Council. However, the power appears to have been enlarged, in that the previous power was simply to pay any costs and expenses of and incidental to the inquiry, whereas the current power is to pay *"part or all of the costs and expenses of and incidental to any or all of the following ..."*. Certainly, there is no indication that the power under the current Act is to be used more restrictively than before.

6.8 **IN** the past, the Medical Practitioners Disciplinary Committee and the Medical Council routinely applied a percentage approach, based on a global summary of the costs of prosecution and the costs of the relevant body. The High Court regularly approved this approach. A number of cases illustrating this approach are conveniently gathered in *Cooray v Preliminary Proceedings Committee* (Wellington Registry, AP 23/94, Doogue J, 14/9/95). From page 4 onwards the judgement of the Court summarised dicta in various cases as follows:

O'Connor v The Preliminary Proceedings Committee (unreported, CP 280/89, Wellington Registry, Administrative Division, 23 August 1990, Jeffries J)

"It is a notorious fact that prosecutions in the hands of professional bodies, usually pursuant to statutory powers, are very costly and time consuming to those bodies and such knowledge is widespread within the professions so controlled. So as to alleviate the burden of the costs on the professional members as a whole the legislature had empowered the different bodies to impose orders for costs. They are nearly always substantial when the charges brought are successful and misconduct admitted or found."

"... Tizard v The Preliminary Proceedings Committee (unreported M 2390/91, Auckland Registry, 10 December 1992, Full Court):

"The Court recognises that the disciplinary work of the Council is important, that the Council is not a 'funded tribunal', and that it is appropriate that the medical profession recover, when possible, a reasonable contribution towards the costs of carrying out its work."

6.9 **DOOGUE J** concluded in *Cooray's* case:

"It would appear from the cases before the Court that the Council in other decisions made by it has in a general way taken 50% of total reasonable costs as a guide to a reasonable order for costs and has in individual cases where it has considered it is justified gone beyond that figure. In other cases where it has considered that such an order is not justified because of the circumstances of the case, and counsel has referred me to at least two cases where the practitioner pleaded guilty and lesser orders were made, the Council has made a downwards adjustment. In cases before this Court where an appeal has been allowed to a greater or lesser extent the Court has in reflecting that determination adjusted the costs in a downwards direction. In other cases where there has been no such conclusion the order for costs by the Council has, in general, been upheld."

6.10 **MOST** of the cases under the former Act reviewed the particular percentage applied. In one case (*Guy v Medical Council* [1995] NZAR 67, 90) an attack was mounted against the particulars of the total sum, against which the percentage was to be applied. The sum appealed against was equivalent to 30% of the total costs of $168,000, namely $50,000. Tipping J said:

"In the end the question is whether the total order for costs was unreasonable irrespective of the way in which it was made up. For example, if the total costs were notionally reduced to $100,000.00 the question would then be whether it was reasonable to order Mr Guy to pay 50 percent. Mr Marquet asked me to bear in mind that Mr Guy received the additional sanction of suspension for six months which would have involved a very substantial loss of income. In spite of that submission no evidence was given to me indicating a reasonable estimate of that loss of income. In the various other cases mentioned unsuccessful parties were ordered to pay between 40 percent and 70 percent of the total costs.

I do not propose to examine the schedule setting out all the details of the costs and expenses incurred. Mr Marquet made a heavy attack in open Court on the total but the attack relied more on generality than specifics. It is true that I did not encourage a minute examination of every toll call and other item. I am not satisfied that the total was unreasonable. Nor am I of the view that the amount which Mr Guy was ordered to pay can be characterised as unreasonable or outside a properly exercised discretion. The case took a lot of preparation and extended over six hearing days.

Even if, on a more precise examination of some items, it could be said that some of the costs were open to criticism, the percentage actually awarded was, from the point of view of precedent, quite low. Be all that as it may I am not satisfied that $50,000.00 for a case of this kind, involving the degree of preparation and hearing time which it did, can be regarded as unreasonable."

6.11 **AS** was indicated by Tipping J in *Guy's* case (supra), one starts with the question of whether the total order for costs is unreasonable, irrespective of the way in which it is made up. The Tribunal/Court may then go on to apply a percentage. It is not correct, however, to refine, or tax down the total figure (unless by standing back, it is unreasonable), and then apply a percentage.

6.12 **IN** the Tribunal's view, this two-step approach (Step 1, consideration of whether total costs are reasonable, Step 2, apply an appropriate percentage in the circumstances of the case) remains appropriate and continues to be a sensible method of dealing with the issue of costs, so long as the Tribunal considers it appropriate in a given case. If anything, the statute is now more liberal, and provides provision that all costs and expenses can be ordered as an aspect of penalty (Tribunal's emphasis).

6.13 **SO** that the affected party has the opportunity of commenting on the issue of reasonable costs, detail as to the make up of those costs (Tribunal and CAC) should be provided so as to give opportunity for comment.

6.14 **FINALLY** it should be noted that the statute leaves the exercise of the discretion completely open to the Tribunal. Experience in other cases has suggested that a myriad of factors may be considered in exercising the discretion, such as:

- Length of hearing;
- Importance of issues;
- Legal and factual complexity;
- Urgency, if any;

- Time required for preparation;
- Whether any unnecessary steps were taken;
- Whether there was an admission of guilt;
- Actual costs and expenses incurred;
- Whether any arguments lacked substance;
- Any other relevant factors in the particular case.

6.15 **IN** this case there was some divergence of opinion among the members concerning an appropriate percentage of costs. For this reason the Chair has endeavoured to extract principles from earlier cases in order to provide some guidance when considering the issue in this case and in future cases.

6.16 **IN** this case total costs and expenses amounted to $27,260.99. The costs are high because the hearing extended over two days.

6.17 **COUNSEL** were provided with a breakdown of the costs and expenses in the usual manner.

6.18 **MS** Winkelmann submitted that a level of 15% is an appropriate level in this case given the level of the charge, the withdrawal of certain particulars of the charge following service of evidence, the plea of guilty to the amended charge and the financial and professional penalty already incurred by Dr Taylor arising from this incident.

6.19 **FOR** the CAC Ms Davenport indicated that she thought that the range of costs payable by Dr Taylor should be approximately 35%. Ms Davenport believes 35% would be quite reasonable given the level of fine imposed upon Dr Taylor.

6.20 **TAKING** the two-step approach discussed earlier, we find that the total expenses of $27,260.99 are reasonable. Secondly, given our view that we consider applying a percentage is a sensible method of dealing with costs in this particular case, we determine that the percentage will be 30%. Particularly we consider this percentage affords due recognition of the admission of guilt which came at a late stage after considerable negotiations between counsel.

7. CONDITIONS ON PRACTICE:

7.1 We agree with Ms Winkelmann's submission that any conditions imposed on Dr Taylor's right of practice should be designed to address the issue of competence which has been raised by this case and not to punish. It is clear that there was no deliberate neglect by Dr Taylor, but rather that his knowledge and judgement were in this case deficient.

7.2 **DR** Taylor said in his brief of evidence that as a consequence of the outcome for Hineraukatauri, he decided not to attempt practice in the obstetric and gynaecological primary care area until his case had been resolved. Although Dr Taylor would like to practice in this area again in the future, he recognises that the Tribunal may wish to ensure that he do so only with the appropriate training and supervision to reassure those under his care that their needs are properly met. To that end Ms Winkelmann indicated that Dr Taylor was happy to co-operate with the Tribunal in that process. For the avoidance of doubt it is recorded that Dr Taylor consents to the Tribunal exercising jurisdiction to impose such conditions.

7.3 **DESPITE** our best endeavours, we have not as yet been able to form a consensus as to the appropriate conditions to be imposed, either should Dr Taylor wish to commence practice as a general practitioner obstetrician, or as a specialist obstetrician. The Tribunal therefore proposes to seek the advice of the Royal New Zealand College of Obstetricians and Gynaecologists in that regard. On receipt of that advice counsel will be given an opportunity to comment. Precise conditions of practice will then be formulated and notified in a Supplementary Decision.

DATED at Auckland this 13th day of April 1999

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal