Medical Practitioners Disciplinary Tribunal

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DECISION NO: 87/98/36C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by 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)

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

Mr A J Knowsley for Dr J M C White.

Date of substantive hearing:	16 March 1999
Date of substantive Decision:	30 April 1999
Date of penalties hearing:	30 July 1999 (teleconference)
Date of penalties supplementary Decision	20 August 1999

SUPPLEMENTARY DECISION:

1.1 **THIS** supplementary Decision should be read in conjunction with the substantive Decision which was delivered on 30 April 1999 under Decision No. 69/98/36C.

2. SUBMISSIONS MADE AT HEARING:

2.1 **FOR** the CAC Mr McClelland submitted that the conduct which is the subject of the charges is in a number of instances serious where patient safety was compromised through improper procedures or bad management. Dr White's attitude and approach to patients, staff and members of the public alike cannot be condoned by the Tribunal.

2.2 **IT** was explained by Mr Knowsley on behalf of Dr White that he had voluntarily sent back his practising certificate to the Medical Council as an acknowledgement that he was unfit to practice medicine at that time.

2.3 **ALSO** Mr Knowsley asked for it to be noted that Dr White had voluntarily submitted himself to the Medical Council's Health Committee under Part VII of the Act.

2.4 **ADDITIONALLY** Mr Knowsley indicated that Dr White would also voluntarily submit himself to the competence provisions established under Part V of the Act.

2.5 **GIVEN** these voluntary initiatives taken by Dr White, it was submitted by Mr Knowsley that it would be inappropriate to either fine or censure him, and that he should simply be permitted to go through the Medical Council procedures with the objective of returning to medical practice when properly fit and competent to do so.

3. THE MEDICAL REPORTS:

3.1 **AT** the conclusion of the substantive hearing, because the Tribunal believed that Dr White might be unfit to continue practising medicine because of some mental or physical condition, arrangements were made for him to be examined by a consultant physician, a consultant psychiatrist and by a psychologist. These arrangements were made with the approval of counsel and with the consent of Dr White.

3.2 **TO** assist in their reporting, each specialist was provided with a copy of the charges to which Dr White had pleaded guilty, together with copies of the statements of evidence of the witnesses for the CAC.

3.3 **DR** Robin Briant, an Auckland specialist physician and clinical pharmacologist, examined Dr White on 26 April 1999, and submitted a report to the Tribunal which is dated 5 May 1999.

Dr Briant concluded her three page report with these impressions:

"Dr White present himself somewhat late for the appointment, having been stuck in Auckland traffic, and he was appropriately a little anxious but generally presented himself well, calmly and coherently. I found Dr White to be medically normal. There was no history of significant symptomatology other than what I would expect with the stressful circumstances of his life in the last few years. On clinical examination apart from his mild overweight there were no abnormalities and in particular nothing to suggest a cerebral or cerbrovascular abnormality.

My impression was that this was a man who has functioned well and probably at quite a high level in the past, who has experienced both work and domestic stressors which have adversely affected his function in both domains and resulted in depression. The allegations sound like lack of control and slackness, both of which would appear to have a behavioural rather than medical basis, but I have to say that he did not acknowledge them to me at all despite his having pleaded guilty, for what he says were pragmatic reasons.

***In summary** this is a 37 year old doctor who has had a minimal past medical illness and in whom I can find no current organic abnormality. I am not in a position to judge the truth or otherwise of the allegations but note his spirited denial of them to me. I can find no evidence of any organic medical basis for the matters by the tribunal."*

3.4 **IN** a supplementary report dated 1 June 1999 Dr Briant presented the results of basic biochemistry and haematology tests ordered by her, to give her further confidence in her statement that organic disease was not at the basis of Dr White's apparent failures in practice.

3.5 **DR** Briant confirmed there were no abnormalities in Dr White's general blood screen test, which included a full blood count, liver enzymes, proteins, calcium and phosphate creatinine and electrolytes, thyroid function, glucose, iron studies, vitamin B12 and folate.

3.6 **DR** D G Chaplow, a specialist in general and forensic psychiatry, reported to the Tribunal on 14 May 1999. He interviewed Dr White on 14 and 19 April 1999 for a total of three hours

and again interviewed him on 25 April 1999 by telephone for just under one hour. Dr Chaplow's comprehensive report is some 15 pages in length.

3.7 **PAGE 1** of Dr Chaplow's report particularises the documents to which he had access in writing his report. Pages 2 and 3 detail the charges considered by the Tribunal. Page 4 contains a list of the questions Dr Chaplow was asked by the Tribunal to address. Page 5 gives relevant background personal information concerning Dr White. Pages 6-7 discuss the several professional conflicts which began to emerge between Dr White and Dr xx. Page 8 lists what Dr Chaplow describes as *"a barrage of complaints"* made by various persons in respect of various matters which Dr White faced between mid 1997 and December 1998. Pages 9-10 contain a summary of each charge faced by Dr White and his response to each allegation. Page 11 contains other personal history pertaining to Dr White. Page 12, in referring to the details of the charges and the findings of the Disciplinary Tribunal, Dr Chaplow said he was in no position to evaluate the verity of what Dr White said, "*though the possibility of minimisation and distortion was there"*, but not to a psychotic extent. Continuing at Page 12 Dr Chaplow discussed Dr White's cognitive parameters of personality function as being:

"... within normal limits. By this I mean that he was orientated to time, place and person, that he had a reasonable short and long term memory and that he was able to attend and concentrate during the quite lengthy interview. His general knowledge was also good and he had good insight into the fact that he was before the Council and had pleaded guilty to quite serious charges and was awaiting the Tribunal's findings in their respect."

Pages 12-14 address a number of questions which were posed by the Tribunal.

3.8 **DR** Chaplow concludes his report with the following summary:

"Dr White is a thirty eight year old medical practitioner who is before the Disciplinary Tribunal on a number of serious complaints to which he has pleaded guilty to. These

complaints which arose during the approximate years of 1993 and 1998 did so in the context of over work, a collapsing marriage, intense conflict with his medical partner and deteriorating health which all of the signs and symptoms of a major clinical depression reaching its peak toward the end of 1998. At this time Dr White was barely functioning being unable to sleep properly, losing weight, unable to concentrate or remember and appearing to function rather chaotically in his practice. He commenced anti-depressant medication (Fluoxetine) in November 1998 and this was changed in March 1999 to Paroxetine with apparent benefit to his mental status.
In March 1999 the charges against him were heard. He pleaded guilty to all of them, apparently without close attention to the charges such was the state of his depression and unconcern about his future. He acknowledged that he indeed pleaded guilty and accepts responsibility for this state of affairs.

He was seen by me on two occasions in April and had a lengthy interview per phone. He was found to be in near normal mental health with residual depressive symptoms on examination and had the emerging enthusiasm to consider practising again sometime in the future clearly at the Medical Tribunal's and the Council's decision. It appears that he is more settled socially and has a more healthy perspective on his life and his future.

In my considered opinion Dr. White will be medically fit to practice again in the future, but must do so in close consultation with collegial support, personal and medical and psychiatric support, paying attention to workload and supervision.*"*

3.9 **THE** thirteen page report of Ms Suzanne Blackwell, a registered psychologist, is dated 26 May 1999. Noted early in this report is Dr White's consent for Ms Blackwell to have discussions with a former nanny, and a former business partner, Dr xx. By reference to data derived by Ms Blackwell from interview and observation of Dr White, interview of Dr xx and psychometric assessment, she said these sources indicated a pre-morbid style of thinking that was extroverted, sociable and optimistic. Ms Blackwell continued:

"Dr xx, who has known Dr White since 1988, saw him as a "blustering", somewhat "eccentric" character, with an easygoing nature. Whilst they were associates, their practices were independent. He described Dr White as having "a lot of things whizzing around in his mind" and being a "good salesman" and entrepreneurial. He saw Dr White as having an "easygoing nature" which at times bordered on being "slap happy". He described Dr White as being not neat and tidy, and if under stress that could get worse. He described him as being volatile under stress. He described a casual attitude to language on the part of Dr White which resulted in him using low grade swearing such as "bloody", but not with the intent of offending someone, rather in an "off the cuff" fashion. He was reported as calling patients "love" and "dear" in a way that denoted thoughtlessness rather than inappropriate boundaries. It would appear that Dr White was self motivated and Dr xx indicated that it was "diabolical" "trying to get him to fit

into our way of thinking and pinning him to the mundane". He described Dr White as a "driven person" whose nature it was to "ride rough shod" and be "rough and ready" and motivated by self interest. He did not consider that there had been any personality changes in Dr White since his first knowledge of him in 1988, except for those in the last two years, which he considered were stress imposed."

3.10 **MS** Blackwell explained that Dr White's scores obtained by psychometric assessment confirmed collateral and clinical assessment of his pre-morbid functioning as *"an exploratory, curious, impulsive, enthusiastic, driven, materialistic and somewhat disorderly person"*.

3.11 **DR** White was psychometrically assessed by Ms Blackwell using the Temperament and Character Inventory (the TCI), the Beck Depression Inventory (the BDI) and the Wechsler Adult Intelligence Scale (the WAIS-R). The TCI results indicated it was unlikely that Dr White had a personality disorder. Dr White's response on the BDI indicated a severe degree of depression that was chronic and ongoing but without psychotic features. Dr White's scores on the WAIS-R reflected his <u>current</u> (Tribunal's emphasis) cognitive impairment, notably poor memory, psychomotor slowing, perceptual slowing and some expressive aphasia.

3.12 **IN** Ms Blackwell's opinion Dr White's condition is treatable. She explained crucial treatment variables will include medication, rest from work-related activities, resolution of outstanding Tribunal matters, cognitive behavioural therapy, stress management psychotherapy to develop a style of function that has appropriate boundaries, and strategies to preclude future burn-out and relationship difficulties. Ms Blackwell also noted *"Dr White continues to suffer from severe depression which associated cognitive impairment"*.

4. SUBMISSIONS IN RELATION TO THE MEDICAL REPORTS AND IN RELATION TO PENALTY:

4.1 **ADDITIONAL** submissions were made by counsel following receipt of the medical reports.

4.2 **FOR** the CAC Ms Elliott submitted it may well be that the public interest would be best served by removing Dr White's name from the Register.

4.3 **THE** following is a summary of the principal submissions made by Mr Knowsley:

1. In relation to the levels of findings made by the Tribunal it is important to note that Dr White did not plead guilty to charges of disgraceful conduct. He pleaded guilty to charges which the CAC (which was in possession of both sides of the story) considered amounted to professional misconduct and conduct unbecoming;
2. Dr White entered pleas of guilty to all charges because he was not medically fit to defend them. He could not survive the strain of a hearing;
3. The Tribunal is asked to take into account that all the serious breaches occurred during the period of Dr White's tremendous stressors as outlined and during the period of his significant depression as detailed in the medical reports;
4. What is clear is that Dr White is sick and needs treatment not retribution. He has voluntarily surrendered his practising certificate and there is no danger to the public which requires him to be struck off. A suspension with a requirement to receive treatment is the appropriate penalty to be imposed in the circumstances;
5. Striking Dr White's name from the Register of medical practitioners would be a grave injustice given the circumstances surrounding the non-defence of the charges;

6. The Tribunal should do what is right and just in this case and not let its judgment be swayed by a perceived public response which might be generated by the adverse publicity which has surrounded this case. Judges when deciding on the appropriate penalty are regularly faced with this situation and must always make the penalty fit the circumstances. The Tribunal is urged to do likewise.

5. DETERMINATION:

5.1 **WHILE** not included in the summary of principal submissions made by Mr Knowsley, noted is his final submission that the Tribunal should give Dr White credit for his guilty plea at an early stage, which saved witnesses the trauma and disruption of being subjected to cross-examination. We agree that Dr White should be commended for this, although as was also noted in the summary of submissions, Dr White pleaded guilty to all charges because he was not medically fit to defend them. It was said he could not survive the strain of a hearing. Consequently the degree of real altruism inherent in the guilty pleas, may be questionable.

5.2 **IT** is acknowledged that Dr White did not plead guilty to charges of disgraceful conduct. By noting that he pleaded guilty to lesser charges in respect of which the CAC was in possession of both sides of the story, is Mr Knowsley inferring that the CAC was in a better position than the Tribunal to assess levels of misconduct? Is this the inference which Mr Knowsley is inviting us to take from this submission? If so, then it behoves us to observe, that we consider the initial prosecution of the charges against Dr White was characterised by a lack of vigour on the part of the CAC which we consider the seriousness of Dr White commissions and omissions warranted.

5.3 **SOME** two weeks in advance of the hearing the CAC was informed that Dr White would be pleading guilty to the charges. Despite this period of notice we are very surprised, to say the least, that the CAC did not suggest at the hearing, in the public interest, that Dr White be suspended from practice.

5.4 **THE** remainder of Mr Knowsley's submissions focus on Dr White, his sickness and his need for treatment rather than retribution. Mr Knowsley should be reminded that the Tribunal is not in the business of meting out vengeance.

5.5 **IT** is significant that the principal purpose of the Medical Practitioners Act 1995 is stated in Section 3 as being *"... to protect the health and safety of members of the public ..."*. In part the principal purpose of the Act is achieved by the disciplining of medical practitioners.

5.6 **ALTHOUGH** he was dealing with the predecessor 1968 Act, the comments made by Tipping J in *Guy v Medical Council of New Zealand* [1995] NZAR 67 at 77 are no less relevant:

> *"proceedings before the Medical Council are not criminal or even quasi criminal in character. They are designed primarily to protect the public from incompetent and improper conduct on the part of medical practitioners. The powers given to the Medical Council are exercised primarily in the interests of the public and the profession itself and are only incidentally penal in nature."*

5.7 **IT** is well settled that the Tribunal is entitled to exercise its disciplinary functions only in the public interest. While any Decision of the Tribunal will inevitably have a punitive effect, it does not have jurisdiction to impose or enforce punitive sanctions against members of the medical profession where there has been no impact on the public interest. In *Re a Medical Practitioner* [1959] NZLR 784 at 802 Gresson P said:

"... Though the imposition of a monetary penalty, or a suspension, or a striking off, viewed realistically, is a punishment, nonetheless the primary purpose of such domestic tribunals and the powers given to them is to ensure that no person unfitted because of his conduct should be allowed to continue to practice the particular profession or to follow the particular calling ..."

5.8 **AND** in the same case North & Cleary JJ said at p 814:

"When [the Council] becomes concerned with conduct which constitutes an offence, it is not for the purpose of punishing that conduct as an offence against the public, which is the purpose of the criminal law, but because it is conduct which may show that the practitioner concerned is no longer fit to continue to practise the profession."

5.9 **THE** statement of Eichelbaum CJ in *Dentice & Anor v the Valuers' Registration Board* (Wellington CP 406/89 unreported decision 27 August 1991) about the purposes of professional disciplinary procedures has relevance here:

"Such provisions exist to enforce a high standard of propriety and professional conduct; to ensure that no person unfitted because of his or her conduct should be allowed to practise the profession in question; to protect both the public, and the profession itself against persons unfit to practise; and to enable the profession or calling, as a body, to ensure that the conduct of members conforms to the standard generally expected of them ... Obviously and distinctly, it is in the public interest that in respect of such professions and callings, high standards of conduct should be maintained."

5.10 **RECENT** Decisions of the New South Wales Court of Appeal in *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 and *Zaidi v Health Care Complaints Commission* (1998) 44 NSWLR 82 have again emphasised the fundamental distinction between professional disciplinary proceedings and criminal prosecutions. It is well established that whilst findings of professional misconduct against members of a profession can have serious consequences for the persons so disciplined, that is not the purpose of such proceedings in the eye of the law. That purpose is the protection of the public and no element of punishment is intended to be involved. *In New South Wales Bar Association v Evatt* (1968) 117 CLR 177 at 183-4 the Court said:

"... The power of the Court to discipline a barrister is ... entirely protective and notwithstanding that its exercise may involve a great deprivation to the person disciplined, there is no element of punishment involved."

5.11 **IN** *Litchfield* (supra) the Court cited with approval comments made by the Court in *Clyne v New South Wales Bar Association* (1960) 104 CLR 186 at 201-202:

"... Although it is sometimes referred to as 'the penalty of disbarment' it must be emphasised that a disbarring order is in no sense punitive in character. When such an order is made, it is made, from the public point of view, for the protection of those who require protection, and from the professional point of view, In order that abuse of privilege may not lead to loss of privilege."

5.12 **AT** the hearing will be recalled the difficulty we experienced in Mr Knowsley refusing to allow Dr White to be questioned. Subsequently Mr Knowsley has indicated to the Tribunal that Dr White is willing to answer questions from the Tribunal in relation to penalty. The Tribunal is satisfied that sufficient information is contained in the expert reports.

5.13 **WE** have researched the question of whether it was open to Dr White to refuse to answer questions at the hearing. The entirely protective purpose of professional disciplinary proceedings has led us to conclude that principles which are accepted as fundamental to the criminal law do not apply in disciplinary proceedings of the nature brought against Dr White. For example, in *Bowen-James v Walton* (New South Wales Court of Appeal, unreported, 5/8/91), it was held that there is no right to silence or privilege against self incrimination upon which a medical practitioner answering a complaint before the Medical Tribunal is entitled to rely. The reasoning of the Court in this regard was based, at least in part, upon the existence of:

"... a public interest in the proper discharge by medical practitioners of the privileges which the community accords to them, and in the due accounting for the exercise of the influence which the nature of the occupation permits them, and indeed requires them, to exert over their patients." (at p 14).

5.14 **SIMILARLY**, it is now well established that the civil standard of proof applies in disciplinary proceedings and not the criminal standard of beyond reasonable doubt. The Full Federal Court of Australia in *The Queen v Davis*, unreported, 19/6/95 expressed the opinion that the difference in the standard of proof:

"... reflects a view that it may be acceptable, as an act of public protection, to exclude from practice a person against whom it is impossible to prove the facts beyond reasonable doubt."

5.15 **THE** decision in *Litchfield* together with a later decision of the New South Wales Court of Appeal in *Law Society of New South Wales v Walsh*, unreported, 15/12/97, has emphasised that considerations which may be of importance in the criminal sentencing process have no relevance to the determination of appropriate orders by a professional disciplinary tribunal unless such considerations have a protective purpose. Beazley JA in *Walsh* (supra) at 9-12 explained the very limited relevance of subjective factors in this way:

"The subjective considerations which might compel a different course (to deregistration) are ones which themselves are relevant to and enhance the essential nature of the Court's jurisdiction, which is the protection of the public. An example is where the legal practitioner has reported the subject conduct to the Law Society or Bar Association. The relevance of mitigating conduct of that type is that it encourages practitioners guilty of misconduct promptly to report it;

In general, mitigating factors, such as evidence of a respected reputation, no previously found misconduct, or service to the profession "are of considerably less significance than in the criminal sentencing process": Law Society of New South Wales v Bannister at 13 ..... In my opinion, the solicitor's conduct was of such a serious nature as to require that his name be removed from the Roll of Solicitors, unless there are mitigating factors sufficient to warrant some other course. The mitigating factors in this case are the solicitor's long period in and service to the profession and the absence of any earlier or other finding of what I will generally describe as misconduct. Those factors are not of the kind which support or enhance the Court's protective jurisdiction and do not generally carry great weight as matters of mitigation."

5.16 **THE** Tribunal has adopted the above statements from a number of judgments, both in New Zealand and in Australia, as accurately representing the principles to be applied.

5.17 **MR** Knowsley's advocacy on behalf of Dr White, while understood as perhaps being in his best interests, is totally unconvincing when considered in context of the public interest, the protection of the public, in the several discussions undertaken by Courts in the judgments cited earlier in this Decision.

5.18 **WITHOUT** reservation we reject Mr Knowsley's submission that striking Dr White's name from the Register would be a grave injustice given the circumstances surrounding the non-defence of the charges. Mr Knowsley can be assured that the Tribunal will do what is right and just in this case, but certainly not by reference to the subjective factors argued by him on behalf of Dr White, which we consider, in law, have very limited relevance.

5.19 **IT** does seem to us from the information obtained by the three experts who assessed Dr White at our request, a general physician, a psychiatrist and a psychologist, that he still does not really accept the validity of the charges against him, and seeks to diminish their impact.

5.20 **PART** of the problem confronting the Tribunal is that Dr White's offending is of a considerable magnitude and over a considerable period of time. It is not a single incident of offending, but rather many incidents with multiple factors to consider. A further part of the problem is that there is no firm guarantee that Dr White will not re-offend. Dr Chaplow, although he is of the opinion that Dr White will be medically fit to practise again in the future, does not even attempt to approximate just when this might be.

5.21 **LIKEWISE** Ms Blackwell's recommendation was guarded. She explained that Dr White's future fitness to practise would depend on his continued response to medication and therapy.

She concluded that Dr White's safe future practice would be more likely assured if he became involved in ongoing general practitioner education, professional development, clinical supervision and/or mentoring, attention to workload and the seeking of psychological intervention to assist in stress management and relationship difficulties. The sum total of all these factors is a very tall order. The Tribunal would need the wisdom of Solomon to tailor conditions of practice to meet all these variable requirements. The Tribunal simply has no confidence that it could formulate conditions of practice at this time which would protect the health and safety of members of the public to the extent necessary. We consider that Dr White's style of practice could be dangerous were he to return to that style. We do not feel confident that any conditions on practice would make Dr White change his ways. The specialist medical evidence concludes that Dr White's miserable performance as a doctor over a number of years, is due to negative interactions with colleagues, employees, patients, friends and family, together with a depressive illness provoked by stress. There seems to us to be absolutely no reason why this situation could not recur. We are obliged to conclude that Dr White's rehabilitation cannot be our responsibility.

5.22 **DESPITE** expressions of support from some former patients in letters to the Tribunal, we are firmly of the opinion that Dr White should be formally removed from the Register.

5.23 **WHERE** the Tribunal makes such an order, it may in that order, exercise either or both of the following powers pursuant to Section 111(1) of the Act:

a) Fix a time after which that person may apply to have his name restored to the Register:

b) Impose one or more conditions that must be satisfied by the person before he may apply to have his name restored to the Register, which conditions may (without limitation) consist of, or include, -

i) A requirement that the person undertake a specified course of education or training:

ii) A requirement that the person undergo any specified medical examination and treatment or any specified psychological or psychiatric examination, counselling and therapy:

iii) A requirement that the person attend any course of treatment or therapy for alcohol or drug abuse:

iv) Any other requirement designed to address the matter that gave rise to the persons removal from the Register.

5.24 **THE** Tribunal is not permitted to impose any condition under (b) (ii) above requiring a person to undergo any medical, psychiatric, or psychological examination or treatment, or any psychological or psychiatric counselling or therapy, unless the person consents to the examination, treatment, counselling or therapy.

5.25 **THE** Tribunal expressly refrains from exercising either or both of the powers given to it under Section 111(1) of the Act. The psychological and psychiatric reports outline clearly the steps which Dr White will need to take to rehabilitate himself and effect a return to unimpaired mental health. The Tribunal recommends that the Medical Council exercise extreme care and caution in considering any application by Dr White for re-instatement to the Register. The Tribunal also recommends that if in the future the Medical Council decides that Dr White should be reinstated to the Medical Register, mechanisms to ensure patient safety must be put into place.

The Tribunal feels that there should be an ongoing mechanism for monitoring both Dr White's psychiatric state and also his medical competence so that patient safety is protected.

6. NAME SUPPRESSION:

6.1 **MR** Knowsley seeks an order prohibiting publication of Dr White's name and all identifying details. In support of this application Mr Knowsley has explained:

1) The medical reports obtained by the Tribunal make clear that Dr White is currently suffering from major depression;

2) The publicity since the findings has seriously affected Dr White and further publicity as to the penalties imposed has the serious potential to be very damaging to his recovery;

3) The publicity that has already taken place is sufficient to convey any necessary warning to the public and nothing further would be gained by publicity at this point.

6.2 **THE** Tribunal is unable to accede to the request for suppression of Dr White's name. We find that the public interest in knowing the outcome of the proceedings outweighs the effect any further publicity may have on Dr White.

6.3 **ALSO** it is in the interests of the medical profession that there be publication of Dr White's name.

6.4 **DR** White's misconduct is squarely in the public arena. There have been a number of reports published in newspapers, including an editorial in the Waikato Times on 31 March 1999 which described the events leading up to Dr White's appearance before the Tribunal as *"… a modern day horror story"*.

6.5 **IN** consequence of Dr White pleading guilty to several charges of misconduct on medical grounds, it was necessary for the Medical Officer of Health to send a circular letter to all medical practitioners in the Waikato. This letter identified a number of issues which have the potential of long term implications for the health of former patients.

6.6 **WE** note that it will be appropriate to make final an interim order prohibiting publication of the name and particulars of all patients and complainants which was made in Decision No. 69/98/36C.

7. COSTS:

7.1 **PURSUANT** to Section 110 of the Act the Tribunal has the power to order Dr White to pay part or all of the costs and expenses of and incidental to the inquiry and hearing.

7.2 **MR** McClelland invited the Tribunal to take into account the fact Dr White indicated that he would admit the charges shortly after receiving the CAC's evidence. This indication certainly meant that significant costs associated with a defended hearing were avoided at an early stage.

7.3 **THE** costs of the hearing, as advised to counsel, amounted to $47,133.24 apportioned:

Tribunal Expenses	$15,416.83
CAC Costs	$31,716.41
TOTAL	**$47,133.24**

7.4 **INCLUDED** in the Tribunal's expenses is $5,102.25 for the three specialist medical reports.

7.5 **ON** the subject of costs Mr Knowsley submitted:

1) The total costs are very high for a matter where there was not a defended hearing.

2) Dr White pleaded guilty to all the charges and advised the CAC and Tribunal at the earliest opportunity of that plea. He should be given a substantial credit for that , and for the large savings that were made by not having a lengthy hearing.

3) He should also be given credit for not requiring the witnesses to be cross-examined thereby saving them that experience.

4) Dr White pleaded guilty due to medical reasons (he not being mentally fit to go through a defended hearing) and this should be recognised in the costs which are imposed.

5) Dr White is still in the process of recovering from his major depression and the Tribunal is asked to take that factor into account along with the fact that Dr White is suspended and has not been working since early in the year which affects his ability to meet any costs award.

6) It is a well recognised principle that costs awards should not be so high as to dissuade practitioners from defending charges. Dr White did not defend these charges and it is submitted that any costs award should not be so high that even his guilty plea brings him no credit. There is usually a significant reduction in costs even when a practitioner defends charges so as to give a true credit for an early guilty plea. The reduction in costs should be a significantly greater one than would normally occur in defended matters.

7) Rather than a percentage of the overall costs the Tribunal is asked to consider what actual dollar figure would be reasonable and to then set the costs from that mark taking into account the particular circumstances of this case in Dr White's favour.

7.6 **LITTLE** needs to be said about the costs. We do not necessarily agree that the total costs are very high for a matter where there was not a defended hearing. 99% of the CAC costs related to the fees of legal counsel, CAC members and the legal assessor. Obviously the multiplicity and range of matters investigated by the CAC is reflected in its costs. So far as the Tribunal is concerned, the average cost of a one day hearing in Hamilton is $10,000. The cost of the medical reports brings the Tribunal expenses up to $15,000.

7.7 **THE** principles which applied to the exercise of the Medical Council's powers to make orders as to costs pursuant to the 1968 Act are equally applicable to the Tribunal's powers under the 1995 Act. This principle was established by the Tribunal in Decision No. 14/97/3C.

7.8 **IN** *Gurusinghe v Medical Council of New Zealand* [1989] NZLR 139 the appellant medical practitioner had been ordered to pay costs amounting to $20,000. This sum was approximately half of the actual expenses incurred. The Full Court of the High Court held that such a sum was not excessive and noted that the ordering of payment of costs was not in the nature of a penalty, but rather to enable the recovery of costs and expenses of the hearing.

7.9 **IN** *O'Connor v Preliminary Proceedings Committee* (High Court, Administrative Division, Wellington, 23 August 1990, Jeffries J, CP 280/89) an order for costs of $50,000 being two-thirds of the actual costs incurred, was upheld. (In that case, as with *Gurusinghe*, the orders made against the doctor prevented him from practising). Jeffries J acknowledged that orders for costs in this type of proceeding will be substantial and commented that this will be known to any doctor to be so.

7.10 **SIMILAR** comments were made by Jeffries J in *Vasan v Medical Council of New Zealand* (Full High Court, Administrative Division, Wellington, 18 December 1991, Jeffries J, AP No. 43/91).

8. ORDERS:

FOR the reasons given the Tribunal makes the following orders:

8.1 **THAT** suspension of Dr White's registration as a medical practitioner pending determination of these proceedings, an order which was made in Decision No. 69/98/36C, be vacated.

8.2 **IN** place of the suspension order is made a further order, that Dr White's name be removed from the Register pursuant to Section 110(a) of the Act.

8.3 **THAT** Dr White be censured.

8.4 **THAT** Dr White contribute $23,000.00 towards the costs and expenses of the inquiry and hearing.

8.5 **MADE** final is the interim order made in Decision No. 69/98/36C prohibiting publication of the name and particulars of all patients and complainants.

8.6 **FINALLY** the Tribunal orders publication of the above orders in the New Zealand Medical Journal pursuant to Section 138 of the Act.

DATED at Auckland this 20th day of August 1999

.....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal