Medical Practitioners Disciplinary Tribunal

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DECISION NO: 24/97/13C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **PAUL GILLESPIE COOKE** medical practitioner of New Plymouth

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr I D S Civil, Dr A M C McCoy, Dr B J Trenwith,

Mrs H White (Members)

Ms G J Fraser (Secretary)

Ms K G Davenport (Legal Assessor)

Mrs E Huse (Stenographer)

Hearing held at New Plymouth on Thursday 11 December 1997

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

Mr C J Hodson for Dr Cooke ("the respondent").

DECISION:

1. THE CHARGE:

The respondent is charge by the CAC, pursuant to Section 93(1)(b) of the Medical Practitioners Act 1995 that his management and treatment of A was inadequate in that he failed to perform an adequate pre-operative diagnostic assessment prior to removing the right kidney and ureter of his patient A.

AND IN PARTICULAR BUT WITHOUT DETRACTING FROM THE TOTALITY OF THE CHARGE

1. The respondent in assuming the right kidney of his patient A contained a malignancy when he knew or believed that the local cytology expertise was then of a standard which he [the respondent] did not consider to be reliable, relied too heavily on the results of a urinary cytology report.
2. He failed to arrange further radiological or other investigations, especially when the Intravenous Urogram report on his patient suggested that that was appropriate.

being professional misconduct.

2. THE BACKGROUND:

2.1 **AT** the time of her consultations with and the operation by the respondent in July and August 1994, Mrs A was aged 66 years. In about June 1994, because there was a history in the family of bowel cancer, she went for a check-up to her GP, Dr B. Generally she was in good health at the time and did not have any symptoms causing her concern.

2.2 **AS** part of the check-up, Dr B arranged for a laboratory urinalysis which showed microscopic haematuria. Two further urinalyses were arranged by Dr B. These also showed microscopic haematuria. Dr B then arranged an Abdominal Ultrasound.

2.3 **ON** 8 July 1994 Mrs A underwent an Intravenous Pyelogram x-ray (urogram) and Dr D reported:

"....

On the right side, the calcyces appear normal, but there appears to be a filling defect laterally in the renal pelvis. .... The appearances are suspicious of a transitional cell carcinoma, and an urgent urological referral is recommended with a view to cystoscopy and a right retrograde ureterogram."

2.4 **DR** B referred Mrs A to the respondent who first saw her on 14 July 1994. He arranged for further urine cytology and a cystoscopy to be carried out, and recorded in his notes that after these investigations *"a final decision"* would be made.

2.5 **THE** first urine cytology specimen of 14 July 1994 noted transitional cells as being present with the comment:

"No malignant cells are seen. The atypia is worrisome but morphology is obscured by marked degeneration. A repeat specimen is advised.

Diagnosis: Urine Cytology - Moderate Atypia. Degenerate."

The second urine cytology specimen performed on 18 July 1994 noted the presence of:

".... one well preserved intact cell with a hyperchromatic nucleus and prominant nucleola. This is suspicious but not in itself diagnostic.

The features seen are inconclusive, the cellularity of the specimen is unusual and the presence of one atypical cell gives reason for suspicion.

Repeat specimen and other investigations are recommended."

2.6 **THE** respondent carried out the cystoscopy on 21 July when no abnormality was noted.

2.7 **IN** his notes and his reporting letter to Dr B of 21 July 1994, the respondent described the two urine cytologies as being *"equivocal"*.

2.8 **AT** the consultation on 21 July 1994 the respondent told Mrs A that she had cancer of the right kidney and that she would have to have it removed. Mrs A, who was feeling perfectly fit and healthy, asked whether it could be anything else other than cancer, but he advised her that cancer was the only thing that it could be. She questioned whether she could have a biopsy, but the respondent advised her that biopsies were not reliable. Mrs A agreed to the removal of her kidney because she trusted the respondent's diagnosis and because he had explained to her that if the cancerous kidney was not removed, it would spread to other parts of her body.

2.9 **IN** his notes the respondent recorded that Mrs A *"agrees reluctantly (difficulty in general with decision)"*.

2.10 **A** further urine specimen taken on 21 July 1994 was reported as normal with no malignant cells or other suspicious elements.

2.11 **THE** respondent also arranged for a chest x-ray and bone scan and both of these were normal.

2.12 **ON** 19 August 1994 the respondent performed a right nephroureterectomy at xx Hospital. The histology report on the kidney and ureter showed no evidence of malignancy or diagnostic abnormality.

3. EVIDENCE FOR THE CAC:

A:

3.1 **THE** respondent informed her that the x-rays showed a dark patch on her kidney and that the dark patch was the carcinoma. She was devastated.

3.2 **THE** three weeks she spent prior to admission since being *"diagnosed"* she was in a terrible state. The anguish caused to her and her family by this diagnosis was dreadful. All concerned were terribly upset by the news.

3.3 **AFTER** the operation she recalled the respondent coming in to see her whilst she was in hospital. He simply told her that *"it wasn't cancer"*. Telling her this seemed to nearly choke him. It was as though he couldn't believe he could have got it wrong. Although she felt very relieved by the

news, her next thought was *"what was wrong with my kidney then?"* She was not told the answer to this question and nor did she ask it.

3.4 **SHE** was discharged from hospital about a week after the operation on the 25th of August. At this point she still did not know what was wrong with the kidney that had been removed.

3.5 **FOLLOWING** surgery she went to see the respondent twice at his rooms. On her first visit the respondent told her that there had been *"nothing wrong"* with the kidney that had been removed. She was terribly shocked by this. She could not believe that she had had a perfectly good kidney removed. She couldn't help but think *"what would happen if something was wrong with my other kidney"* because she knew that at her age she would not be eligible to receive a transplant organ.

3.6 **SHE** recalled that following one of her visits to the respondent, she believed it was the last, he gave her a form to take to the xx Med Lab for another urine test. She did not follow up on this test as she had really had enough. She figured that if there was something wrong with her other kidney, not much could be done about it. At this time she found it difficult to put thoughts about her other kidney out of her mind, and lay awake worrying about what would happen to her should there be something wrong with it.

3.7 **IN** about July 1995 she had occasion to attend on Dr B again. He suggested she have a number of tests, one of which was a urine test. This test showed up that the minuscule bleeding problem was still there. This was a huge shock to her, and it confirmed her worst suspicions, that there

was something wrong with her other kidney, and that nothing could be done about it. Hardly a night goes by when she doesn't wake up for the worry it causes her.

3.8 **THIS** whole episode has been very difficult for her. She has had no counselling about it and has been offered no explanation as to how such a mistake could happen. She finds that she is simply unable to put this behind her. She worries about it constantly. Because of the anxiety and stress this has caused her, her marriage has been affected and her quality of life has diminished.

3.9 **SHE** also has a number of concerns over her long term care should something go wrong with her remaining kidney. She would not be able to see the respondent as she has lost complete faith in him and would have to travel out of xx for any treatment that is needed. This would be both inconvenient and costly.

ROBIN SMART:

3.10 **MR** Smart, a Specialist Urologist in private practice in Palmerston North, was called by Mr McClelland as an independent expert on behalf of the CAC. Mr Smart graduated from the University of Otago with the degree MB ChB in 1969 and is a FRCS Edin 1974, FRCS Eng 1975, and FRACS 1978.

3.11 **THE** evidence given by Mr Smart was based on information contained in copies of medical reports and correspondence, hospital records and investigation reports considered by the CAC and a Medical Misadventure Advisory Committee of the ACC.

3.12 **HAVING** reviewed Mrs A's case, Mr Smart was of the opinion that the respondent failed to carry out sufficient investigation to establish a diagnosis of transitional cell carcinoma of the right kidney to a degree of certainty that would justify advising Mrs A to undergo nephroureterectomy.

3.13 **IN** Mr Smart's opinion, Intravenous Urograms are not a sufficiently reliable examination. Further imaging is always required in the evaluation of collecting system filling defects as these may be due to a wide variety of causes aside from carcinoma. Additional investigation would not only establish the diagnosis but also enable assessment of the nature and extent of cancer if found.

3.14 **MR** Smart viewed the respondent's failure to perform both a bladder biopsy at cystoscopy (which is a standard procedure) and a retrograde ureterogram as being significant omissions. He explained a retrograde ureterogram is a standard conventional and old-fashioned approach which the radiologist reporting the IVU noted as being an appropriate further investigation to be carried out.

3.15 **IN** Mr Smart's opinion the most serious omission regarding imaging was the respondent's failure to perform computerised tomography scanning aided by intravenous contrast to outline the renal collecting system. He explained this is a standard investigation for lesions detected at ultrasound or IVU where there is suspicion of cancer; it has a number of advantages over retrograde studies.

3.16 **IN** a letter of 23 November to ACC mention was made by the respondent that CT Scanning was not considered because of the consistency of the filling defect seen on IVU and also that the size of the filling defect suggested that further information would not be available from a CT Scan. Acknowledging that small transitional cell carcinomas in the renal pelvis can be difficult to

visualise on CT Scanning, Mr Smart explained the problem is much less significant now than it used to be with modern spiral type scans using computerised techniques. In his opinion the existence of this problem was not sufficient reason to preclude a CT Scan being performed in cases such as Mrs A.

3.17 **MR** Smart was also concerned that the respondent did not contact or consult the radiologist for further advice regarding appropriate imaging to establish the certainty of diagnosis.

3.18 **NOTED** by Mr Smart was a request by the CAC, of Dr E, radiologist, to provide a further report on the IVU without having seen the original report. Mr Smart explained Dr E's report, although considerably more detailed, was essentially similar to the original report and recommended further evaluation using Ultrasound and/or CT as being useful additional imaging modalities.

3.19 **IN** Mr Smart's opinion the urine cytology available to the respondent considerably influenced him in reaching his diagnosis of a transitional cell carcinoma. However from the material available the respondent did not appear to have taken into account the fact that the third cytology report was normal and thereby raised suspicions as to whether or not cancer was in fact present.

3.20 **THE** interpretation of urine cytology is a difficult area requiring expertise. Despite the respondent's interpretation of the urine cytology as being significantly positive, Mr Smart noted that he did not have much apparent faith in the xx Urine Cytology Service.

3.21 **MR** Smart noted the CAC's request of Dr Clinton Teague from the Medical Laboratory, Wellington, to carry out a second opinion on the urine cytology. Also noted by Mr Smart was Dr Teague's conclusion that the urine cytology from Mrs A (i.e. the three specimens), was normal.

3.22 **IN** Mr Smart's opinion, in the circumstances and given the difficulty of interpreting the first two urine cytology results, a second opinion should have been obtained from a unit specialising in urine cytology. Furthermore, in his view the omission of further urine cytology examination by selective ureteric catheterisation, cytological brushing of the ureters, bladder quadrant biopsies and additional urine cytology specimen to be significant.

3.23 **FINALLY** Mr Smart explained there are additional investigations available to assess filling defects in situations where there is still uncertainty after those outlined by him had been performed. Ureteroscopy with either a Flexible or a Rigid Ureteroscope may be useful. In Mrs A's case, he said, it would seem the site of the filling defect would probably have been visible at ureteroscopy. Biopsy can be performed ureteroscopically. Ureteroscopy also evaluates the ureter very well. MRI scanning is another modality which Mr Smart explained has its advocates and is considered by some to be superior to CT Scanning in imaging lesions.

4. EVIDENCE FOR THE RESPONDENT:

PAUL GILLESPIE COOKE:

4.1 **AFTER** graduating MB ChB from the University of Otago in 1962, he went to the United Kingdom and was elected to a Fellowship in the Royal College of Surgeons in Edinburgh in 1967. He did his post-graduate training in the United Kingdom from 1967 to 1972.

4.2 **RETURNING** to New Zealand he took up a position as specialist at New Plymouth Base Hospital in 1972. He had the desire and intention to do mostly urology. With the co-operation of the other five surgeons from 1972 to 1992 he did 85% urology and 15% general surgery. For the last five years from 1992 he has practised only in urology. However he is not the holder of urological vocational registration with the Medical Council.

4.3 **MRS** A presented as a person very concerned about cancer. Repeatedly she stated that her father and grandfather had had cancer of the colon.

4.4 **HE** had a very considerable surprise when he read the report which showed there had been no lesion. His initial feeling about the matter was that he was disappointed in himself, but in a way very pleased for Mrs A.

4.5 **FOLLOWING** various post-operative checkups, her final call being on 15 December 1994 when she was discharged from routine care, the next time he heard of the matter was in September 1995 when ACC asked for a report. He has found the subsequent interval trying. Having given the matter much thought, and influenced considerably by this case, his practice has changed in so far as he sends more x-rays off and seeks further advice.

4.6 **THE** essence of the case is that he put weight on the two urine cytology reports plus the x-ray. No one of these reports alone would have been enough. Despite reference to the quality of cytology reporting, he does not think that this was very important. The reporter was in fact the one person on whose opinion he would put the most weight. He now accepts that it would have been appropriate to conduct further investigations.

5. SUBMISSIONS:

5.1 **IN** summary it was Mr McClelland's principal submission on behalf of the CAC, that the evidence establishes in relation to the charge, that the respondent's conduct would be reasonably regarded by his colleagues as constituting professional misconduct. Mr McClelland argued that the respondent's conduct fell well short of what could be regarded as an acceptable discharge of his professional obligations to Mrs A. In Mr McClelland's view what occurred cannot be described as an error of clinical judgement. Exercising judgement presupposes that there is reliable information on which to base such judgement. Mr McClelland explained that the respondent was never in a position to exercise reasonable clinical judgement because at no time did he have sufficient information before him which would allow any reasonable diagnosis to be made. As the charge alleges, Mr McClelland argued that the respondent failed to perform an adequate pre-diagnostic assessment of Mrs A with the result that he never had sufficient information available to him.

5.2 **IN** summary it was Mr Hodson's principal submission on behalf of the respondent that in this case a misdiagnosis was made, albeit in good faith. Mr Hodson argued that Particular 2 is all that matters, that Particular 1 is not so consequential, and that the Tribunal needs to make but only one finding. In recording formally the respondent's acknowledgment that he should have gone further in terms of carrying out a pre-diagnostic assessment prior to removing the right kidney and ureter of Mrs A, Mr Hodson argued that the outcome is only one aspect of the matter, and that bad luck was at least one factor in a very unfortunate outcome. In seeking a finding of professional misconduct, Mr Hodson argued that the CAC had over-stated its case against the respondent.

6. FINDING:

6.1 **FIRST** the Tribunal must determine whether the facts alleged in the charge have been proved to the required standard. If the facts are found to have been established to the required standard, then the second task of the Tribunal is to go on to determine whether the conduct established amounts to professional misconduct.

6.2 **IN** this case the Tribunal had little difficulty in concluding that the facts alleged in the charge had been proved to the required standard. Mr Hodson as much as acknowledged this was so.

6.3 **MR** Smart discussed in his evidence what standard procedures would have been available to the respondent and which should have been carried out to reach the necessary degree of certainty in making a diagnosis. As was observed by Mr McClelland, Mr Smart's evidence does not describe the gold standard or a standard of perfection. It simply describes the standard reasonably to be expected of a practitioner having experience, training and knowledge similar to that of the respondent. Mr Smart characterised that experience as *"the working standards adopted by urologists practising in New Zealand generally, certainly not a gold standard"*. Although the respondent is not the holder of vocational registration as a urologist, it must be accepted that he could satisfy the Medical Council that he holds general registration, and appropriate qualifications, training, experience and competence to practise in that branch of medicine.

6.4 **AS** was concluded by Mr Smart, the respondent was incorrect in considering that sufficient investigation had occurred to establish a diagnosis of transitional cell carcinoma of the right kidney to a degree of certainty that would justify advising Mrs A to undergo nephroureterectomy. The

omission of computerised tomography scanning was particularly to be regretted. The failure to perform the retrograde studies recommended by the radiologist was inadequate in the circumstances. The omission of correct evaluation of the source of the apparently positive cytology was inadequate.

6.5 **THE** Tribunal finds that the respondent's management and treatment of Mrs A was inadequate in that he failed to perform an adequate pre-operative diagnostic assessment prior to removing her right kidney and ureter. The Tribunal holds that it is not necessary to make further findings by reference to either of Particulars 1 or 2 of the charge.

6.6 **AS** earlier explained, the Tribunal must determine whether the conduct established amounts to professional misconduct. 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 allegations.

6.7 **THE** definition of professional misconduct is well established. In *Ongley v Medical Practitioners Disciplinary Committee* [1984] 4 NZAR 369, at 374-5, Jeffries J stated in the context of the 1968 Act:

"To return to the words "professional misconduct" in this Act. .....

In a practical application of the words it is customary to establish a general test by which to measure the fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with a medical practitioner could be formulated as a question. Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."

6.8 **IN** *Tizard v Medical Council of New Zealand* (Full Court, Auckland, M 2390/91, 10 December 1992) the Full Court stated:

"'Professional misconduct' is behaviour in a professional capacity which would be reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct. It, too, is an objective test judged by the standards of the profession: ***Ongley v Medical Council of New Zealand*** *[1984] 4 NZAR, 369, 374."* (p16).

6.9 **AS** was indicated at the conclusion of the hearing, the Tribunal is unanimous in its finding that the respondent's behaviour did not amount to professional misconduct. To a considerable extent this

finding is based on Mr Smart's evidence, that he considered that the Radiologist's report of the IVP contributed to the problem encountered in this case. Unfortunately this report, although possessing the virtue of brevity, did not indicate other possible causes of the appearance. The opinion that a cystoscopy and right retrograde ureterogram would be the best option for further investigation was stated, with no mention of other alternatives. There is no evidence that a discussion of the case took place between Dr D and the respondent. The report was therefore the only communication of importance. Its content is in marked contrast to that offered by Dr E as discussed earlier. These omissions may have contributed to the respondent forming the opinion he did.

6.10 **DR** F's reports on the urine cytology specimens of 14 July 1994 and 18 July 1994, while not describing definite malignancy, did describe suspicious changes, such as hyperchromatic nucleus, large pleomorphic nuclei, prominent nucleola and atypia. These features were dismissed by the report of Dr Teague. If the respondent had had a clearly normal report regarding these two urines, as furnished by Dr Teague, his decision may have been different.

6.11 **IN** the Tribunal's judgement the conduct of the respondent in this case, although failing to meet the objective test of professional misconduct by measurement against acknowledged standards of repute and competence, nevertheless fell below acceptable standards. In this regard the Tribunal's conclusion is that the respondent is guilty of conduct unbecoming a medical practitioner, to the extent that the conduct in question reflects adversely on his fitness to practise medicine (Section 109(c) of the Act).

6.12 **THE** Tribunal's view should be explained, by addition of the rider in Section 109(c), of the conduct in question having to reflect adversely on the respondent's fitness to practise medicine, that Parliament clearly intended to raise the threshold of offending or error in respect of such conduct.

6.13 **TO** satisfy the lower or lesser test of "conduct unbecoming", what is required is conduct which departs from acceptable professional standards, such departure being significant enough to warrant sanction in the interests of the public generally. In the Tribunal's judgement the respondent's failure to perform an adequate pre-operative diagnostic assessment prior to removing Mrs A's right kidney and ureter, amounts to conduct unbecoming to the extent that it reflects adversely on his fitness to practise medicine. The Tribunal finds accordingly.

7. PENALTY

7.1 **THE** respondent denied one charge of professional misconduct which had been framed against him. In the event the Tribunal found that the established facts amounted to conduct unbecoming which reflected adversely on his fitness to practise medicine.

7.2 **UNDER** the Medical Practitioners Act 1995 the Tribunal has a range of penalties which it can impose in respect of a finding of conduct unbecoming. These include a fine, censure and imposition of conditions of practice for a period not exceeding three years. The Tribunal also has the power to order the respondent to pay part or all of the costs of the inquiry and hearing.

7.3 CENSURE AND FINE:

7.3.1 IN submissions received following the hearing Mr Hodson referred to the medico-legal consequences suffered by the respondent for over two years which in his evidence he said he had found "trying". The day following the hearing a report of the finding appeared on the front page of the New Plymouth Daily News. Explaining the extent to which the respondent will have a New Plymouth practice remains to be seen, in these circumstances Mr Hodson submitted that the respondent has already been sufficiently punished. Mr Hodson argued that neither censure nor fine would have any particular meaning in the context of what has already occurred.

7.3.2 THE Tribunal prefers the submission made by Mr McClelland on behalf of the CAC, that an order that the respondent be censured is justified in the circumstances of this case. It is ordered accordingly.

7.3.3 A fine is also appropriate although pursuant to the transitional provisions of Section 154 of the 1995 Act, because the respondent's conduct took place before 1 July 1996, the maximum cannot exceed $1,000.00. It is ordered that a fine of $750.00 be paid by the respondent.

7.4 CONDITIONS OF PRACTICE:

7.4.1 GIVEN the nature of the conduct giving rise to the finding of conduct unbecoming, Mr McClelland submitted that conditions should be imposed on the respondent's practice. He said these could include conditions requiring:

- Mr Cooke to attend regular weekly meetings with the radiologists and pathologists in New Plymouth to enable and encourage discussion of issues relevant to his practice.
- Mr Cooke to maintain contact with urologists practising in Hamilton and/or Palmerston North by regularly attending audit and associated meetings. The CAC notes that attendance at such meetings is a compulsory requirement of the Royal Australasian College of Surgeons.

7.4.2 **FOR** the respondent Mr Hodson argued that the finding made against the respondent does not justify the imposition of conditions on his practice. Mr Hodson sought to reiterate that the finding made by the Tribunal against his client is a unique event in his practice and that in all the circumstances it is fair to submit that there is no likelihood of its recurring. As to the two conditions proposed by Mr McClelland on behalf of the CAC, it was submitted by Mr Hodson:

"• The first presupposes that there are regular weekly meetings of radiologists and pathologists in New Plymouth. In fact the radiologists meet all the surgeons weekly. It further presupposes that the participants would be interested in weekly discussions of issues relative to Mr Cooke. In fact a wide range of topics arise. This proposed condition is impracticable and inappropriate. The important result of this matter is that Mr Cooke is, as he said, making a more frequent practice of discussion with his colleagues or referral to others in specific cases.

- Mr Cooke gave evidence that it is his practice to attend appropriate meetings of the College; as attendance is a compulsory requirement of the College there can be no purpose in the Tribunal making an order to the same effect."

7.4.3 **AGAIN** the Tribunal considers it is obliged to uphold the submission made by Mr McClelland, that some conditions should be imposed on the respondent's right to practise. Implicit in the Tribunal's finding is the view that there should have been further investigation before the procedure was undertaken on Mrs A. From this position followed activation of the statutory qualification, that the default in question reflects adversely on the respondent's fitness to practise medicine. Not to impose some conditions on the respondent's practice could be seen to be paying no more than lip service to the finding which has been made. The Tribunal makes an order that the following conditions be imposed on the respondent's practice over the next three years:

7.4.4 **THE** Medical Council of New Zealand in association with the appropriate post graduate organisation should appoint a mentor to supervise the respondent's practice for the next three years, such supervision arrangement to include someone to act in the absence of the mentor for any reason.

7.4.5 **IN** any surgical case involving a partial or total resection of the ureter or kidney, the respondent is required to consult with a view to having his proposed course of action approved by his mentor. Such consultation and outcome must be documented in the patient's notes by the respondent. Additionally the respondent is required to send a copy of the pathology report of the resected specimen to his mentor. The provisions of

this clause shall not derogate from the obligation of the respondent to respect privacy considerations at all times.

7.4.6 **THE** mentor should provide an annual report with recommendations on the respondent's practice to the Medical Council.

7.5 COSTS:

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

7.5.2 **UPHELD** is Mr McClelland's submission, that 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. Consequently guidance is available from a range of judgements of the High Court which have considered the appropriateness of costs orders made by the Medical Council under the 1968 Act from time to time.

7.5.3 **OF** the cases cited by counsel it seems to be common ground that *Cooray v Preliminary Proceedings Committee* is helpful in the context of these proceedings. In that case (unreported, AP23/94, Wellington Registry, 14 September 1995, Doogue J) Justice Doogue reviewed the recent authorities and concluded at page 9:

"Whilst I accept that the proportion of costs awarded in other cases cannot be a final determinator of what is a reasonable order for costs in the present case,

nothing has been put forward which would justify a proportion of costs in the present case considerably in excess of the highest proportion of costs awarded in any other case brought to the attention of the Court or upheld in earlier cases before this Court. 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."

7.5.4 **IN** this case a full hearing took place with cross examination of witnesses and opening and closing submissions by counsel. In these circumstances the Tribunal agrees with Mr McClelland that a downward adjustment of costs cannot be warranted. It has always been the case that costs follow the result. In Mr Hodson's assessment the prosecution in this case was at best 50% successful. Consequently he submitted, having regard to the result of this case and the principles enunciated by Doogue J, that the starting point is one-half of 50%.

7.5.5 **THE** Tribunal does not accept this submission. Whether the respondent was found wanting in his treatment of Mrs A, as charged, or as it transpired, of conduct unbecoming, the fact remains that his conduct was found by the Tribunal to reflect adversely on his fitness to practise medicine. In these circumstances the Tribunal is bound to conclude that no adjustment of costs in a downwards direction is justified, by way of departure from the rule of thumb of "50% of total reasonable costs".

7.5.6 **MR** McClelland has informed the Tribunal that the costs incurred by the CAC in respect of the investigation and prosecution of the charge are as follows:

(1) CAC's interim costs of investigation - section 110(1)(f)(ii):	
Fee	$ 1,728.69
GST	$ 216.09
TOTAL	**$1,944.78**

(2) CAC Costs of prosecution (29 September to 1 December 1997) - section 110(1)(f)(iii):	
Fee	$ 9,200.00
GST	$ 1,150.00
Disbursements (GST incl.)	$ 479.11
TOTAL	**$10,829.11**

The above costs do not include Mr Smart's fee nor disbursements such as hotel and airfares.

7.5.7 **MR** Hodson's final submission is recorded, that as a rule of practice the Tribunal should not allow costs of investigation. He explained:

"There are many objections to such a course. For example, a prospect of recovering costs of the investigation could be a factor, unjustifiable on the merits, in deciding whether or not to lay charges. Investigations may include many aspects unrelated to the ultimate charge. There may be aspects of counselling for the complainant or unsuccessful attempts at conciliation. Nor is it the practice in the Courts for preliminary work to be included in costs orders, unless the Court can be persuaded to exercise its discretion otherwise. It is submitted that where a costs order is sought to include costs of investigation the Tribunal should require to be persuaded that this is appropriate in whatever particular circumstances may apply."

7.5.8 **THE** first point to be made in response to this submission is that the Tribunal is not prepared, as a rule of practice, to disallow costs of investigation. To do so would clearly be outside the spirit of Section 110 of the Act.

7.5.9 **SECONDLY**, Mr Hodson can be assured that the Tribunal will always use its best endeavours to ensure where a costs order is sought to include costs of investigation, that such costs are appropriate in the given circumstances of the particular case.

7.5.10 **IN** this case the Tribunal is satisfied it is appropriate that the respondent be required to pay the sum of $13,732.60 as representing 50% of the costs of and incidental to the inquiry and hearing. An order is made accordingly.

DATED at Auckland this 22nd day of January 1998

.....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal