THE MEDICAL TRIBUNAL
OF NEW SOUTH WALES
AT SYDNEY

Monday, 15 January 2007

No. 40014 of 2004

In Re: Dr Edmond KWAN and:

The Medical Practice Act 1992

DEPUTY CHAIR HER HONOUR JUDGE A AINSLIE-WALLACE

REASONS FOR DETERMINATION

on application for permanent stay

Background

The Health Care Complaints Commission (the "**HCCC**") by a document dated 23rd July 2004 complains that the applicant doctor has been guilty of unsatisfactory professional conduct and/or professional misconduct in relation to his prescription of drugs referred to in *Schedule 4D* of the *Poisons and Therapeutic Goods Act*. There are 6 particulars in the complaint [1].

1. *That between February 1997 and August 1999 the applicant prescribed benzodiazepines and/or codeine compounds to patients (referred to in a schedule);*

   a. *without exercising responsible medical judgement*

   b. *in circumstances when he knew or ought to have known that another medical practitioner was authorised under section 29 of the Poisons and Therapeutic Goods Act to prescribe drugs of addiction to the patients*

   c. *for purposes that did not accord with recognised therapeutic standards*

   d. *in circumstances where the practitioner knew or should have known the medications were likely to be abused.*

[1] The substance of the complaint is summarised here, the complete complaint and patient details is annexure A to these reasons.

2. *Between May 1996 and January 1998 the practitioner issued prescriptions for prescribed restricted substances, namely benzodiazepines and other compounds such as codeine compounds to the patients in excess of recognised therapeutic standards. (The dates and amounts are contained in a schedule to the complaint).*

3. *On 13th February 1998 the practitioner inappropriately prescribed a Schedule 8 narcotic to a patient where he knew the patient had a history of narcotic addiction and had recently been abusing alcohol.*

4. *Between September 1998 and August 1999 the practitioner prescribed to a patient (patient FF) a prescribed restricted substance in quantities in excess of recognised therapeutic standards.*

5. *Between September 1998 and August 1999 the practitioner prescribed for a patient (Patient GG) a prescribed restricted substance in quantities in excess of recognised therapeutic standards.*

6. *During the period 1997 to 1999 the practitioner inappropriately provided religious instruction and advice to patients during or in conjunction with professional consultations.*

1. By notice of motion dated 16th May 2005 the doctor (the "**applicant**") applied for a permanent stay of the complaint.

2. In order to give the application context, it is necessary to set out in some detail the history of this matter.

3. The applicant is a general practitioner.

4. On 19th June 1991 a representative of the Pharmaceutical Services Branch (the "**PSB**") visited the applicant in relation to his provision of drugs to drug addicted and drug seeking patients and discussed with him that he needed an authority to prescribe drugs of addiction to an addicted person or to prescribe them for more than 2 months to a person who is not addicted. After the visit, the PSB sent the applicant a letter which contained a summary of the matters discussed.

5. Between 1993 and 1994 the PSB received complaints about the prescribing habits of the applicant from pharmacists which resulted on 17th June 1994 in a visit to the applicant by a representative of the PSB and the applicant was again

spoken to in relation to his prescribing pattern and again, after the visit a letter was sent to the applicant summarising the matters discussed.

6. In September 1999 the PSB received further complaints concerning the applicant's prescription of benzodiazepines and similar substances.

7. On 14th October 1999 a representative of the PSB visited the applicant and a recorded interview was conducted [2]. During that interview the applicant discussed individual patients about whom complaints had been made. At the conclusion of that interview it was suggested to the applicant that he relinquish his right to prescribe these medications. On 20th October 1999 the PSB recommended that they be withdrawn, although, it seems from the material in the files that the applicant did not oppose that course.

8. It is undisputed that the applicant has not had that prescribing right restored.

9. On 24th November 1999, the PSB wrote to the HCCC (or NSW Health Department as it was then known) and recommended that, based on its investigations, a complaint be laid against the applicant of professional misconduct.

10. On 7th December 1999 the HCCC wrote to the applicant notifying him of the complaint and enclosed the investigation report made by the PSB on which the complaint was based.

11. Thereafter there was a delay which the HCCC explained as an "*oversight*" in having the file allocated for "*follow up*". As a result the next letter from the HCCC to the applicant was on 20th March 2003. In that letter twenty-two patients were mentioned as being patients in relation to whom his treatment founded the complaint. The letter refers to the notification of the complaint sent to the applicant in December 1999.

12. In July 2003, the applicant responded to the complaint in detail and referred, both in general terms, to his prescribing protocols and to particular patients. In August

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[2] Exhibit A Volume 1, tab 8

2003 the HCCC requested Dr Linda Mann to undertake a peer review of the particular patients and the complaint. The files of the patients referred to in the letter of complaint dated 20th March 2003 were referred to Dr Mann who prepared a report dated 9th August 2003. In December 2003 she made an additional report after being sent further information about one of the patients named in the letter of complaint.

13. On 12th September 2003, the applicant was notified that the investigation process was complete.

The complaint

14. The essence of the first five matters in the complaint is that the applicant had patients who were drug addicts or who were drug dependent and who were receiving methadone from another doctor. The respondent alleges that the applicant knew or ought to have known that these patients were receiving methadone and that he did not contact the doctors who prescribed the methadone for his patients to inform them that he was prescribing Benzodiazepines for those patients.

15. The thrust of the complaint is two fold, that these patients are likely to be "*doctor shopping*", that is, looking for doctors who would supply them with Benzodiazepines which they could then sell on the street or use to supplement drugs obtained from other doctors and, secondly, that it is important for the methadone prescribing doctor to know what drugs the patient is receiving from another source.

16. The complaint is that any doctor from whom an addicted patient requests Benzodiazepines must be on notice of these concerns and act appropriately to ensure that they are not being misused or sold.

17. The applicant said that all patients to whom he prescribed Benzodiazepines were already receiving them when they first came to him for treatment.

The basis for the stay

18. The applicant swore two affidavits in support of the application in which he set out the bases for the stay.[3] He said that there are witnesses who he would have wished to call but who, because of the lapse of time, are no longer available. These witnesses would have been able to give evidence to the Tribunal about his prescribing practice as a whole and his practice generally which would have provided the Tribunal with a more balanced view of him as a general practitioner rather than the narrower view given by the patients referred to in the complaint.

19. He said that from 1989 (up until he surrendered his right to prescribe the nominated drugs) his therapeutic approach in relation to drug addicted patients was a slow reduction of Benzodiazepine levels until they reached therapeutic levels or a level at which the patient indicated to him that he or she no longer needed the prescription. He also used other treatment regimes which included counselling, meditation, physical exercises and sharing the "*Born Again Life*" in which he prayed with the patient and referring patients to particular chapters of the Bible in which he introduced them to "*Biblical Meditation*" through which the patients would be able to induce endogenous opiates in substitution for drug ingestion. He said that he made it clear to these patients that he would only prescribe the Benzodiazepines on the basis of an acceptance by the patient that he would place them on a safe slow reduction of the drugs and they must take up the other facets of his treatment regime.

20. The process included referring patients to particular Pastors of churches who would then introduce them to a better lifestyle and give them social supports. The applicant said that he received follow up reports from the various Pastors about the progress of the patients. Some of the patients he referred in this way made progress through the intervention of the church.

Pastors

21. During the periods covered in the complaint the applicant said that he had referred patients to four different Pastors.

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[3] 13th May 2005, 26th May 2005

22. The applicant said that he would have called the Pastors to give evidence about the progress of various patients but three of the four of them are dead. The fourth, the applicant says, has left the particular ministry and the applicant has not been able to find him. The evidence as to what the applicant had done to find this Pastor was scant.

23. The purpose of calling the Pastors is to show the Tribunal that he was engaging the Pastors and the patients in an ongoing therapy.

24. The respondent argued that there could be little if any relevance to evidence from the Pastors to whom the applicant referred patients. It was submitted that all the Pastor could say in evidence would go to the fact of the referral and that from time to time the applicant contacted the Pastor for a progress report about the patient. The Pastor could not say what levels of Benzodiazepines were given to the patient or whether or not the dose was reducing. That information was in the applicant's files. Further, it was argued that the applicant, if he thought that the fact of the referral to Pastors was relevant to the case, could give evidence about his usual practice.

25. This evidence seems to be of little relevance to the determination of the issues before the Tribunal.

Patients referred to in the complaint

26. The applicant said that of those patients whose treatment formed the basis of the complaint, he has lost contact with seven of them and he would have wished to call evidence from each of them about his general therapeutic approach.

27. It is not clear if it is the applicant's desire to call evidence from every patient whose treatment is referred to in the complaint. The respondent argued that most of these patients, given that they were drug addicted or drug dependent at the time, were receiving methadone and, in relation to some, they had been admitted to hospitals for treatment of overdoses would be unlikely to give the court a rational appraisal of the applicant's treatment regime, even if they could remember it.

28. Only seven of the thirty-three patients referred to in the complaint cannot be accounted for. It appears that some are still patients of the applicant[4] and the balance are available to be called by the applicant during the hearing if he so desires. That seven of the patients are not available does not, of itself, persuade me that any particular prejudice is caused to the applicant.

Patients not referred to in the complaint

29. The applicant also said that he would have called other patients who he had assisted in relation to their drug addiction. The applicant wanted to call these patients to give evidence of the depth of his commitment to their addiction by having consultations in which he would give them instructions on how to reduce their dependency and to build a relationship of trust between them and to show that his treatment involved more than the prescription of drugs.

30. Counsel for the applicant expanded on these matters in the course of oral argument. He said that the purpose of this evidence, should it have been available, would go to what the applicant did with the patients when he counselled them and it was expected that they would say that he focussed on a drug reduction programme. Further, it was argued that this evidence would show that the applicant stopped the patients going elsewhere to get the drugs and that he told them that he was checking on them through the records of the Health Insurance Commission. This evidence was important, in the submission of the applicant to show that the applicant's patients were not given scripts for Benzodiazepines *"on demand"*.

31. It was conceded in argument and an affidavit from the applicant's secretary confirms that no attempt was made to find any patient until late 2004 despite the applicant knowing in December 1999 that there was a complaint made against him concerning his prescribing of Benzodiazepines. Again, in 2003 when the applicant received the letter from the HCCC in which the particulars of the patients whose treatment formed the basis of the complaint were given, the applicant took no steps to find those patients.

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[4] Exhibit A

32. In relation to both categories of patients, the applicant says in his affidavit [5] that the purpose of calling them was to demonstrate his treatment methods but also to show the significant time he spent with the patients and:

> *"… many of these patients could have given evidence as to the extent to which their lives improved and their Benzodiazepine addiction improved as a result of their having been under my care. With the absence of these patients, I am unable to lead that type of support evidence to my case."*

33. In relation to both categories of patients, the applicant made this general comment. It is important to note that in relation to the patients referred to in the complaint, he has all of their records. This comment by the applicant is typical of the general way in which the asserted prejudice was raised. Nowhere in the affidavit, or indeed, in argument was each patient in the complaint considered and an indication of any particular difficulty with that patient noted. Similarly, in relation to patients who were not referred to in the complaint, there was no evidence at all that the applicant attempted to identify any patient who fell into that category and in relation to whom he would call to give evidence. The court is left to conclude that he made no such attempt. I am unable to find that some of the patients who fall into this category are not available to be called by the applicant.

Referral of patients to outside agencies

34. The applicant said that over time he had referred certain patients to doctors or institutions with the authority to prescribe methadone but he is unable, due to the passage of time, to recall the names of all of the patients he referred in this way, although, he has been able to identify some patients from his notes. Similarly, the applicant said that he had referred patients to the Salvation Army in Parramatta for assistance both in relation to drug addiction and for social matters but now he cannot recall the names of the Salvation Army members to whom he referred these patients.

35. The respondent conceded that the evidence of these referrals is of "*some*" relevance to the issues before the Tribunal but that there was no evidence which would persuade the Tribunal that the applicant had made proper attempts to find

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[5] Affidavit 13 May 2005 paragraph 24

the people to whom he referred patients. Further, it was argued that the applicant himself could give that evidence.

36. The attempts outlined in the affidavit to find the surnames of the Salvation Army officers to whom he made referrals are, in my view, superficial at best and I could not find that the witnesses were not available.

Contact with doctors prescribing Methadone

37. The complaint involves an allegation that the applicant, knew or ought to have known that his patients were receiving methadone from other doctors and he did not contact those doctors. The applicant said that:

> *"… there were some occasions when I checked. However I cannot now recall when I made either enquirie (sic) or to whom."* [6]

38. During the submissions it was argued that because of the lapse of time, the applicant could not remember who he had contacted or attempted to contact in order to convey that information. He said that he can remember some providers but only in relation to some of the patients mentioned in the complaint but not the majority.

39. During argument the question was raised with counsel for the applicant that if the referrals to Pastors and other support services formed part of the applicant's treatment regime, this would appear in the clinical notes for the patients. Similarly the contacts with the methadone-prescribing doctors would also be in the notes. Counsel for the applicant said that the notes did not always record those matters. In this respect it was argued that the applicant could not meet the claims made against him in the complaint that he had not made contact with the doctors prescribing the methadone.

40. In the interview between the applicant and the representative of the PSB in October 1999, the applicant was asked questions about a number of his patients whose treatment had aroused its interest. In relation to approximately seventeen of those patients, the applicant said that he either knew the patient was using methadone and did not contact the prescribing doctor, or that the patient had told

him that he or she had been using methadone in the past but he had not taken steps to enquire whether the patient was, in fact, receiving methodone or the patient had lied to him in the past about not receiving methadone and he did not attempt to verify the true position.

41. These answers were apparently based on the patient files or the applicant's memory. This is not to suggest that all of the patients to which his attention was then directed are included in the present complaint (although many of them are), but it is somewhat contrary to the broad assertion that the applicant cannot remember which patient he knew was on methadone and whether he took steps to contact the prescribing doctor.

42. In addresses, counsel for the applicant said that it is apparent that the applicant could remember then, in 1999, the detail about these patients but cannot now remember anything. The applicant must show prejudice such that an unfair trial will result. He has not done so. He had an obvious recollection in 1999. No attempt was made to deal with the other patients in the complaint individually to show that the notes did not assist his recollection.

Patients who the applicant refused to treat

43. Finally it was argued that there were patients who the applicant saw only once and who he determined were not genuinely interested in reducing their Benzodiazepine use but were merely looking for a compliant general practitioner to provide the drugs. These patients, the applicant said, he refused to treat. It was argued that he could not now find the cards of those patients to prove that he did not prescribe to all who presented to him.

44. According to the affidavit of the applicant's secretary [7], the process of file culling in the office was that if a patient had not seen the applicant for more than five years (this process apparently takes place every January) the card was placed in storage. In cases where there was nothing on the card written by the applicant, then that card was destroyed. It did not appear from her affidavit that cards on

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[7] Affidavit K Mourad 30th May 2005

which the applicant had written and which were in storage had been destroyed at some point. I accept that there may be many file cards held in storage.

45. The point of this argument was that the applicant could not produce the file cards to show that he refused to treat a particular patient because he could not remember who they were or when he refused to treat them. This argument depends on the applicant having a system where a card was prepared for every patient whether or not that patient was treated and that, where the applicant refused to treat the patient, he made a note of it on the card even if he sent the patient away. There was no evidence of the type of system adopted by the applicant.

46. In any event, it was conceded by counsel for the applicant that the applicant had not attempted to find any such card. The argument was that there may or may not be cards showing that the applicant declined to treat certain patients but that he had not looked for them. If there were cards available it was conceded in argument that they would contain little or no information. In that event, it is hard to see how this information could be of any relevance to the issues to be determined by the Tribunal.

The Argument

47. In this case, the applicant argues that witnesses who he would otherwise have called in defence or explanation of his conduct are not available. To this extent he says that he has suffered actual prejudice by reason of the delay in commencing this action. Further, in written submissions, it was submitted that it is fundamental to the applicant's case before the Tribunal that he be in a position to demonstrate that the patients, on whose treatment the complaint is based, are not representative of the applicant's practice generally, that is, there are patients who had successful reductions in their use of Benzodiazpines as a result of his treatment, patients who he saw only once and refused to treat because he formed the view that they were seeking inappropriate treatment, that he referred patients to other treatment facilities and has, in the past, contacted the methadone prescriber for various patients. The applicant could not put this complete evidence before the court because of the reasons already discussed.

48. As to the steps taken to find these witnesses, the court was informed from the bar table that the applicant had in fact been advised in 1999 to attempt to contact these patients and other relevant people. Clearly that advice was not heeded until at least October 2004. Counsel for the applicant submitted that if the attempts had been unsuccessful in 2004 and 2005, they would have been equally unsuccessful in 1999 and afterwards. There is no basis for making this assertion, and, so far as the Pastors were concerned, their deaths were said to have occurred between 2000 and 2003. Although it was submitted that no-one would know that the Pastors were going to die, one imagines that it would not have been difficult to have statements taken from them in 1999.

49. The applicant has been on notice of this complaint since December 1999. The applicant's secretary swore an affidavit [8] of attempts to contact various patients that she was instructed to attempt to find in October 2004. One cannot know whether earlier attempts would have had more success.

50. It has to be remembered that the patients whose treatment comprise the complaint were all patients of the applicant and in respect of each he has kept records. There is no suggestion that any records have been lost or destroyed. This is not a case where the applicant is left to rely only on his memory.

51. In the recorded interview conducted in October 1999 with a member of the PSB and in his response to the HCCC in relation to the complaint in July 2003, the applicant was able to give details about the patients referred to in the complaint. I accept the submission of counsel for the respondent that in neither instance did he complain of not being able to respond properly because his notes or memory were not adequate.

52. In relation to all of the applicant's evidence on the stay it was submitted by the respondent that it consisted only of general claims of needing a class of witnesses or not having a recollection without any recourse to particularities. There is force in this argument, for example, the claim as to failure of recollection about contact with Methadone prescribing doctors made in general terms in the affidavit, cannot

[8] Affidavit K Mourad, 26th May 2005

stand when considered in relation to patients in the record of interview where the applicant clearly had a recollection of much detail. In the general statement of his inability to recall, the applicant does not distinguish between the patients but simply makes the type of wide statement referred to.

53. Counsel for the respondent argued that evidence of all of these matters referred to by the applicant could be given by him and that there was no need to call patients or other witnesses.

54. It was submitted for the applicant that witnesses such as the Pastors, Salvation Army officers and patients are corroborative of the applicant's evidence. His credit would be adversely affected if he was not able to call witnesses to support his account of his usual practice. There is some force in this argument assuming the applicant's credit is challenged. However, it is always open to a Tribunal to take into account that time has caused recollection to fade or witnesses to become unavailable when making an assessment of reliability. In such a case as this the Tribunal would take these matters into account in determining reliability of the applicant. I do not accept the applicant's argument that a Tribunal comprising three non-judicial members would not properly take those matters into account.

Law

55. There is no doubt that the court has power to order a stay of proceedings such as these. It is useful to commence with *Jago v District Court of New South Wales* [1989] 168 CLR 23 and, in particular, the judgment of Mason CJ at pages 33-34 where, after discussing the court's power to prevent its processes being used in a way which gives rise to unfairness, his Honour said:

> *"… the touchstone in every case is fairness….The test of fairness which must be applied involves a balancing process, for the interests of the accused cannot be considered in isolation without regard to the community's right to expert that persons charged with criminal offences are brought to trial.*

56. After considering the factors which should be taken into account in deciding whether or not to order a stay his Honour said:

> *"In any event, a permanent stay should be ordered only in an extreme case and the making of such an order on the basis of delay alone will accordingly be very rare."*

57. In Jago at page 34, the court referred to the unfairness as being a: *"defect which goes to the root of the trial"* and said further that there is nothing which the trial judge can do to alleviate the unfairness.

58. Hodgson JA in *R v Littler* (2001) A Crim R 12 referred to a permanent stay as a: *"remedy of last resort"*.

59. In *Walton v Gardiner* (1992-1993) 177 CLR 378, in the joint judgment of Mason, CJ, Deane and Dawson JJ their Honours found an analogy between criminal proceedings such as those in *Jago* (supra) and proceedings in the Tribunal, noting that the jurisdiction of the Tribunal is a protective one. At page 395-6, their Honours said;

> *"…the question whether criminal proceedings should be permanently stayed on abuse of process grounds fall to be determined by a weighing process involving a subjective balancing of a variety of factors and considerations. Among those factors and considerations are the requirements of fairness to the accused, the legitimate public interest in the disposition of charges of serious offences and in the convictions of those guilty of crime and the need to maintain public confidence the administration of justice…*
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> *In particular in deciding whether a permanent stay of disciplinary proceedings in the Tribunal should be ordered, consideration will necessarily be given to the protective character of such proceedings and to the importance of protecting the public from the incompetence and professional misconduct on the part of medical practitioners."*

60. Counsel for the applicant argued that not only is the court bound to consider actual prejudice arising from any delay but also presumed prejudice occasioned by the effluxion of time. This concept is well understood in the context of cases such as *Brisbane South Regional Health Authority v Taylor* (1996) 186 CLR 541. It was argued that the Court of Appeal in *Carson v Legal Service Commissioner and Anor* [2000] NSWCA 308 introduced this concept into disciplinary proceedings. At paragraph 263, Sheller J considered the issue of the respondent bringing a complaint against the appellant very late after the conduct complained of and he referred to the quality of justice deteriorating with delay. His Honour referred to McHugh J's judgment in *Brisbane South* (supra) at page 551 and noted

that the relevant legislation required expeditious handling of complaints. His Honour then said at paragraph 265;

> *The delay between 30 March 1995 and 17 December 1996 leads, in my mind, to the inevitable inference that the investigation was not conducted expeditiously and that the delay over this period was unacceptable. To this must be added the lack of any communication with the appellant and the other persons referred to in the affidavit of Ms Chang of 28 February 1997. Those persons were likely to be able to throw light on the validity of some of the complaints. During this period none of them was ever contacted by anyone from the Legal Services Commission about the complaints. To this may be added the circumstances in which the Information was filed hours before an arranged appointment with the appellant's legal advisers and the failure of the Commissioner to comply with the statutory requirements to give reasons. Against this background and in the context of the statutory requirements there is, on the ground of this delay alone, a powerful case to say that the conduct of the Commissioner was oppressive and an abuse of process.*

61. It is from this paragraph in the context of his Honour's mention of *Brisbane South* (supra) that counsel for the applicant submitted that the Tribunal must consider presumptive prejudice. In my view that passage which Sheller JA quoted from *Brisbane South* does not necessarily lead to the conclusion that in every case where there is a delay between the events and the trial of them that there is prejudice. In the passage at page 551, the court was considering the deterioration of evidence and memory over time. There was no argument in this case, nor could there reasonably be, that time between events and trial will always have an impact on recollection and memory. Whether that deterioration of recollection amounts to a presumed prejudice is not in my mind clear from Sheller JA's judgment. In the event perhaps in this case it is a distinction without a difference.

62. Counsel for the applicant argued that the *Medical Practice Act* mandates that complaints be dealt with expeditiously and that, there having been a delay of some years, this Tribunal should not be seen to be winking at conspicuous unexplained delay to the detriment of the applicant. The delay is unfortunate, and has resulted in the applicant not being able to produce all of the witnesses he would like. It was argued that one of the legitimate approaches in a case such as this is to denounce the unexplained delay by granting a stay. I do not accept that argument. The delay and its affect is one of the many matters which the law requires the court to consider in determining whether to make a stay but would rarely of itself by the sole basis. In any event, this is not such a case.

63. In the course of submissions, it was put that the applicant was prepared to undertake to the court to continue to practise with the present prescribing restriction on his registration and that he would not apply for that restriction to be lifted. In this way, it was said, the court would grant the stay comfortable that public safety will be assured. The protective jurisdiction of the Tribunal is wider than that. The Tribunal must take into account public confidence in the medical profession and protect the public as well as the standing of compliant doctors within the community. It was implied in the respondent's submissions on this point that this may well be a case which, if it proceeded, be one in which the respondent sought orders for deregistration. Even if it were a legitimate matter for the court to have regard to in determining whether to make a stay (and I am not persuaded that it is), it may not be a complete answer to the need for protective orders in the exercise of the Tribunal's functions. There is also the wider community interest in having complaints fully heard and determined.

64. For the applicant it was argued that his inability to recall matters relevant to the complaint, the unavailability of witnesses and the other factors to which I have referred in these reasons have worked a prejudice. It is important to bear in mind that it is not simply the fact of prejudice or delay or even a combination of those factors which determine a stay. The court must find that those factors are such that the applicant could not have a fair trial.

65. Even though individual matters may not of themselves amount to significant or any prejudice to the applicant, it is important to consider all of those claimed prejudices together to see whether they either of themselves or together with the other factors which the court must take into account amount to a prejudice which would result in the applicant not having a fair trial.

66. The applicant has records in relation to all patients in the complaint and, no doubt records of other patients should he wish to call them. I accept that the passage of time has had an effect on the way in which the applicant would have wished to put his case to the Tribunal and I find that there is some prejudice to the applicant in not having available all of the witnesses whom he would have wanted to call. In making this finding it should be noted that some of this could have been avoided

had the applicant taken some reasonable steps in December 1999 to speak to the witnesses or marshal the files and facts.

67. The delay is unexplained other than for the assertion that there was an *"oversight"* in having the file *"allocated"*. To the extent that these words constitute an explanation, it is a paltry one indeed. Even though the applicant was on notice about this complaint in December 1999, for the HCCC to do nothing about it until October 2003 is extremely unfortunate.

68. In this case, one must balance the needs of the community to have complaints of this type heard and determined alongside the interests of the applicant to have a speedy disposition of the complaint, and the prejudice which is occasioned by a delay in bringing a disciplinary action. Even having found that the applicant is prejudiced in the presentation of his case, I am not persuaded that this prejudice is such as to deprive him of a fair trial and looking at the whole of the case, this is not one of the rare or exceptional circumstances in which a permanent stay should be granted.

Orders

1 Application dismissed.

2 Applicant to pay the Respondent's costs of the motion.

3 Confirm the hearing dates allocated to this matter commencing 11 August 2005.

I certify that these 68 paragraphs are a copy of her Honour's judgment.

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Associate to Her Honour Judge Ainslie-Wallace

3 June 2005