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FIT FOR PURPOSE?

*An Examination of the Jurisdiction of the Health and Disability Commissioner
in New Zealand*

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This paper examines the role of the Health and Disability Commissioner. It does so by first describing the Commissioner's origins and place in the overall regulatory landscape for doctors in New Zealand. Different frameworks are then described within which the Commissioner's purpose, practice and outcomes can be assessed. Applying these frameworks, an assessment is made of the Commissioner's jurisdiction. Finally, informed by the foregoing assessment, this paper examines the regulatory landscape from a broader perspective, making tentative proposals for reforms.

I Summary

Of the wide range of health care providers¹ in New Zealand, this paper focusses on medical practitioners registered by the Medical Council of New Zealand (MCNZ) (doctors). The term 'doctors' is readily understood and, as a group, they play a central role in the provision of health care.

This paper examines the role of the Health and Disability Commissioner (Commissioner), who is appointed pursuant to the Health and Disability Commissioner Act 1994 (HDC Act). It identifies that the Commissioner's origins and place in the overall regulatory landscape for doctors in New Zealand have a strong patient rights focus. Therapeutic jurisprudence, patient safety/error prevention, patient rights and professionalism are then described as analytical frameworks or paradigms against which the outcomes of the Commissioner's jurisdiction can be assessed. The Commissioner's jurisdiction is also looked at from the different perspectives of patients, doctors and systems/organisations.

With this background, a study of the 20 most recent opinions published by the Commissioner which involve a doctor is described. Each opinion was analysed against seven different factors. The results of this study enables conclusions to be drawn about how the Commissioner uses expert evidence, makes factual findings, and reaches findings about whether or not a doctor has breached a right under the Code of Health and Disability Services Consumers' Rights (Code).²

Taking into account the results of this study and the identified analytical frameworks, a range of legal criticisms of the Commissioner's jurisdiction is then explored and tested. By applying the identified frameworks, the paper concludes that the Commissioner's jurisdiction is currently sub-optimal. A range of existing proposals for change are then canvassed, before the paper describes and puts forward its own suggestions. It is proposed that the Commissioner's jurisdiction should assume a more therapeutic focus, with serious conduct taken out of the jurisdiction to be dealt with by the MCNZ.

It is noted that some of the ideas in this paper raise questions which cannot be answered definitively without empirical research. In medicine, and medical law, the stakes are often high. Where possible, policy should not be implemented without evidence that it will work, and be an improvement of the status quo. Nor however should existing policy remain sacrosanct and unchallenged. While in some areas of public policy there is an unfortunate tradition of the law responding to political imperatives without careful analysis and balancing of the affected interests (for example criminal sentencing), a better approach is to test policy assumptions with data. Because the ideas in this paper are untested by empirical research, the proposals for reform discussed in part V are necessarily tentative.

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¹ The term "health care provider" is defined in the Health and Disability Commissioner Act 1994 [HDC Act], s 3.

² Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

II Background

A Overview of the Regulatory Framework for Doctors

While the health care sector is subject to a wide array of different laws, this paper focusses on the professional regulation, and structures for the accountability, of doctors. The starting point is the Health Practitioners Competence Assurance Act 2003 (HPCA Act). This provides that a medical practitioner is a person registered with the MCNZ. As the responsible authority for doctors under the Act,³ the MCNZ is the foremost regulatory institution. It is a statutory body currently comprised of 12 members: four doctors elected by the profession; four doctors appointed by the Minister of Health; and four laypeople.⁴ The MCNZ is responsible for prescribing required experience, qualifications and scopes of practice.⁵ In part, this is done by reference to professional bodies for vocational registration such as the Royal New Zealand College of General Practitioners. The MCNZ also assesses fitness to practise and applications for registration, together with issuing annual practising certificates.⁶ The HPCA Act includes powers and processes for reviewing the competence and health of doctors, which allow the MCNZ to impose conditions on scope of practice as well as requirements such as retraining. In certain circumstances, the MCNZ may also order the interim suspension of a doctor.⁷

The HPCA Act also establishes the Health Practitioners Disciplinary Tribunal (HPDT),⁸ which hears charges brought by either a professional conduct committee of the MCNZ or the Director of Proceedings appointed by the Commissioner. The grounds on which a doctor may be disciplined by the HPDT include:⁹

- (a) being found guilty of professional misconduct because of any act or omission that, in the judgment of the HPDT, amounts to malpractice or negligence in relation to the scope of practice in respect of which the doctor was registered; and
- (b) being found guilty of professional misconduct because of any act or omission that, in the judgment of the HPDT, has brought or was likely to bring discredit to the medical profession.

Where there is a finding against a doctor under one or more of the grounds in s 100 of the HPCA Act, the penalties which may be imposed include ordering that the doctor's registration be cancelled.¹⁰ The HPDT functions much like a criminal court, albeit applying the civil standard of proof.¹¹

Another role of the MCNZ is to set standards and guidelines,¹² which it does so through publications such as *Cole's Medical Practice in New Zealand*¹³ and *Good Medical Practice*.¹⁴

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³ Health Practitioners Competence Assurance Act 2003 [HPCA Act], s 5.

⁴ Refer to HPCA Act, s120 and Medical Council of New Zealand "Our Council and senior managers" <www.mcnz.org.nz>.

⁵ HPCA Act, ss 11–14.

⁶ HPCA Act, ss 13–33.

⁷ HPCA Act, ss 34–51.

⁸ HPCA Act, ss 84–90.

⁹ HPCA Act, s 100.

¹⁰ HPCA Act, s 101.

¹¹ Refer to *Z v Complaints Assessment Committee* [2008] NZSC 55, [2009] 1 NZLR 1.

¹² HPCA Act, s118.

¹³ Ian St George (ed) *Cole's Medical practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013).

Other structures which doctors may need to interact with following an adverse medical event include:

- (a) an employer such as a District Health Board (including through the conduct of an investigation, or undertaking a protected "quality assurance activity" under the HPCA Act¹⁵ such as a mortality review committee);
- (b) the Accident Compensation Corporation, which may refer treatment injury claims to other authorities where it believes there is a risk of harm to the public;¹⁶
- (c) the Ministry of Health;
- (d) the regulator under the Health and Safety in Employment Act 1992;
- (e) the Health Quality and Safety Commission;¹⁷ and
- (f) the Commissioner.

In broad terms, every complaint about a doctor must be referred first to the Commissioner. While a complaint is being dealt with by the Commissioner, the MCNZ may in certain circumstances take interim steps against a doctor to protect the public, but nothing else. Where the Commissioner is not, or is no longer, involved, the MCNZ may refer the matter to a professional conduct committee which itself may, amongst other things, bring a charge against the doctor before the HPDT. How the Commissioner deals with complaints is addressed below, however following an investigation which concludes that a doctor has breached the Code, a charge may be laid either (a) by the complainant before the Human Rights Review Tribunal (HRRT); or (b) by the Director of Proceedings before the HRRT (alleging a breach of the Code) or HPDT (alleging a breach of the HPCA Act).

The Commissioner's jurisdiction is therefore central. It can resolve a complaint; initiate a disciplinary process following investigation; or provide a link through to the jurisdiction of the MCNZ. The Commissioner can also prevent or delay the MCNZ from taking disciplinary proceedings of its own.

B Origins of the Health and Disability Commissioner Act 1994

As part of the 1988 report of the Committee of Inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital (Cartwright Inquiry), Silvia Cartwright¹⁸ recommended that:¹⁹

The Human Rights Commission Act 1977 should be amended to provide for a statement of patients' rights and to provide for the appointment of a Health Commissioner. The Commissioner's role would include:

- (a) negotiation and mediation of complaints and grievances by patients;
- (b) heightening the professionals' understanding of patients' rights;
- (c) the entitlement to seek a ruling or sanctions from the Equal Opportunities Tribunal on behalf of a patient or class of patients.

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¹⁴ *Good Medical Practice* (Medical Council of New Zealand, April 2013).

¹⁵ HPCA Act, ss 52–63.

¹⁶ Accident Compensation Act 2001, s 284.

¹⁷ Established under the New Zealand Public Health and Disability Amendment Act 2010.

¹⁸ At the time a District Court Judge, now Hon Dame Silvia Cartwright.

¹⁹ Silvia Cartwright *Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (Government Printing Office, Wellington, 1988) at 214.

... The Commissioner should have access to the disciplinary procedures pursuant to the Medical Practitioners Act 1968. ...

The HDC Act was a direct response. It has been described as one of the Cartwright Inquiry's "most important recommendations".²⁰

At the centre of the Cartwright Inquiry was Dr Herbert Green, who was an Associate Professor of Obstetrics and Gynaecology at the National Women's Hospital in Auckland. Green believed that cervical carcinoma in situ (CIS) (a precursor or incipient form of cancer) might be benign. At the relevant time the orthodox treatment of CIS was to remove it. Green endeavoured to test his hypothesis by observing CIS in some women over time, rather than treating the condition. He did this without the consent of his subjects. Retrospective analysis has shown that the women who were observed but not conventionally treated were more likely to develop invasive cancer. While some debate over the statistics persists,²¹ the conventional or non-revisionist view is that "Those left with CIS were almost 25 times more likely to progress to invasive cancer than those without it."²²

The Cartwright Inquiry's reference to the (now repealed) Human Rights Commission Act 1977 is evidence of the rights discourse which informed and shaped both the Inquiry and the law and policy which grew from its recommendations. That legislation was an "Act ... to promote the advancement of human rights in New Zealand"²³ and the Cartwright Inquiry report refers often to patient 'rights'; for example: "The focus [of informed consent] should be centred on the patient, and not on the doctor. It is a principle designed to protect and preserve the patient's rights, not to protect the doctor from liability."²⁴

In academic writing about the Cartwright Inquiry report, the former Commissioner Ron Paterson²⁵ has highlighted the final sentence of the chapter that deals with ethics and patient rights: "The focus of attention must shift from the doctor to the patient."²⁶ Phillida Bunkle has written of the "feminist voice and ... extent to which the Inquiry and subsequent reforms grew from the analysis developed by the Women's Health Movement which was focussed on systematically safeguarding physical safety premised upon respect for the ethical autonomy of patients."²⁷

This paper agrees that the Cartwright Inquiry can be viewed as a triumph of rights-based thinking. It is also accepts the importance of the Cartwright Inquiry as a "watershed in the history of medicine and health care in New Zealand",²⁸ as well as that "enduring changes"²⁹ have resulted from it.

Re-examining the enduring role of patient rights and how that framework might rub up against other ways of looking at the doctor-patient relationship is however worthwhile. It could be argued that what the Cartwright Inquiry wanted was to give patient rights appropriate (and significant) weight, rather than

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²⁰ Anne Else "The 'unfortunate experiment' and the Cartwright Inquiry, twenty years on: why getting it right matters" (2010) 24 WSJ 2.

²¹ For example, see Linda Bryder *A History of the "Unfortunate Experiment" at National Women's Hospital* (Auckland University Press, Auckland, 2009).

²² Else, above n 20, at 5.

²³ Human Rights Commission Act 1977, long title.

²⁴ Cartwright, above n 19, at 136.

²⁵ Now Professor of Law at the University of Auckland and Ombudsman.

²⁶ Cartwright, above n 19, at 176; and Ron Paterson "The Cartwright legacy: shifting the focus of attention from the doctor to the patient" (2010) 123 NZ Med J 6.

²⁷ Phillida Bunkle "Patient-centred ethics, the Cartwright Inquiry and feminism: Identifying the central fallacy in Linda Bryder, *A History of the 'Unfortunate Experiment' at National Women's Hospital*" (2010) 24 WSJ 8.

²⁸ David Skegg "Forward" in Joanna Manning (ed) *The Cartwright Papers, essays on the cervical cancer inquiry 1987-88* (Bridget Williams Books, Wellington, 2009) 7.

²⁹ Paterson, above n 26.

rights becoming the only lens through which medical law is seen. Indeed, the sentence picked out by Paterson was preceded by reference to the relationship *between* the patient and doctor:

In summary, I prefer to advocate a system which will encourage better communication between patient and doctor, allow for structured negotiation and mediation, and raise awareness of patients' medical, cultural and family needs. ...

Given this, it might have been better for the Cartwright Inquiry report to say that the focus of attention must shift from the doctor *towards* the patient.

Following the Cartwright Inquiry, the Bill which became the HDC Act was introduced to Parliament by the fourth Labour government in 1990. After a long and fraught gestation, the HDC Act was eventually passed in 1994 by the subsequent National led government. The first Commissioner, Robyn Stent, was appointed near the end of that year. The HDC Act required the Commissioner to prepare a draft Code of Health and Disability Services Consumers' Rights for the Minister of Health, which was then prescribed by regulations.³⁰

Since its enactment, the HDC Act has been amended twice - in 2003 and 2007.³¹ The 2007 changes were technical and minor. The earlier amendments followed the *Review of Processes Concerning Adverse Medical Events* conducted by Helen Cull QC (Cull Review). This was an inquiry aimed at informing draft legislation intended to improve the framework for regulating health professionals and processes for reporting and investigating adverse events.³²

The "principal problems" identified by the Cull Review were:³³

- (a) multiple complaint processes, with different agencies undertaking separate investigations into the same incident;
- (b) delays in undertaking investigations;
- (c) no disclosure of information between different agencies;
- (d) no centralised database to detect repeated poor practice;
- (e) no reporting by colleagues of practitioners below an acceptable standard;
- (f) no power to suspend practitioners during an investigation where the public may be at risk; and
- (g) insufficient, and delayed access to, compensation.

The consequential legislative changes which touched upon the jurisdiction of the Commissioner included routing all complaints about health practitioners through the Commissioner in the first instance;³⁴ allowing complaints to be triaged and dealt with at a lower level than full investigation; enabling the Commissioner to refer complaints to other agencies that may need to respond to them; and requiring the Commissioner to share certain information.

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³⁰ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

³¹ The Health and Disability Commissioner Amendment Act 2003 and Health and Disability Commissioner Amendment Act 2007.

³² Helen Cull *Review of Processes Concerning Adverse Medical Events* (Ministry of Health, Wellington, 2001) at 5. Following the Cull Review, the HPCA Act was enacted together with the Health and Disability Commissioner Amendment Act 2003.

³³ Cull, above n 32, at 15–16.

³⁴ HPCA Act, s 64.

One of the Cull Review's recommendations not taken up was for a "one-stop shop" approach to complaints to be developed and considered as a "long-term solution".³⁵ This recommendation was based on a conclusion that:³⁶

There is a need for one investigation process, which can investigate breaches of the Code, cross-check ACC entitlements for patients and recommend action where appropriate ... all relevant complaints/claims on health professionals could be recorded on a centralised database ... it would minimise the number of investigations and hearings by incorporating one investigation with one disciplinary tribunal ...

A lengthy critique of the Cull Review by Jonathan Scragg³⁷ rejected this "one-stop shop" proposal on the basis that "complaint investigation, discipline, compensation and error prevention" "simply cannot operate effectively" when combined as proposed.³⁸ Scragg applied a patient safety/error prevention framework based on the work of James Reason in the field of human error, commenting that, as a result of the Cull Review's "almost exclusive focus on the interests of patients, [it] does not consider adequately two other key issues - the role registered medical practitioners (doctors) and systems play in adverse medical events."³⁹ While to say that the Cull Review did not adequately deal with the role doctors play is perhaps unfair, a point well made by the critique is that being disciplined by the Commissioner or MCNZ does not necessarily make doctors better at their jobs.

C The Commissioner's Role and Functions in Greater Detail

I General

The statutory purpose of the HDC Act is "to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights".⁴⁰ Attaining this purpose is pursued in four main ways: the appointment of the Commissioner; the promulgation of a Code; the designation of a Director of Proceedings; and the establishment of a health and disability services consumer advocacy service.

The Commissioner's statutory functions include those set out below,⁴¹ which have been categorised here according to judgements made by this paper about the core purpose of each:

Function	Purpose
To promote respect for and observance of the rights of consumers, including awareness of such rights and the means by which they may be enforced.	Rights advocacy.
To act as the initial recipient of complaints about providers, and to ensure that each complaint is appropriately dealt with.	First-stop shop for complaints.
To investigate, on complaint or on the Commissioner's own initiative, any action that is or appears to be in breach of the Code.	Rights enforcement/investigation/discipline.

³⁵ Cull, above n 32, at 28–29.

³⁶ Cull, above n 32, at 89–90.

³⁷ Jonathan Scragg "A critique of 'The Review of Processes Concerning Adverse Medical Events'" (2003) 9 *Canta LR* 37.

³⁸ Scragg, above n 37, at 76.

³⁹ Scragg, above n 37, at 39.

⁴⁰ HDC Act, s 6.

⁴¹ HDC Act, s 14.

To refer complaints, or investigations on the Commissioner's own initiative, to the Director of Proceedings for the purpose of deciding whether or not any further action should be taken (such as proceedings before the HRRT).	Rights enforcement/discipline.
To make recommendations to any appropriate person or authority in relation to the means by which complaints involving alleged breaches might be resolved and further breaches avoided.	Rights advocacy/patient safety.
To make suggestions to any person in relation to any matter that concerns the need for, or the desirability of, action by that person in the interests of the rights of consumers.	Rights advocacy/patient safety.
To report to the Minister from time to time on the need for, or desirability of, legislative, administrative, or other action to give protection or better protection to the rights of consumers.	Rights advocacy.

It can be seen from this that the Commissioner's array of functions devolves into several different purposes which may, in some cases, pull in different directions. These can be put in context by looking at the Commissioner's own views about the role's purpose:⁴²

Our vision is to have "Consumers at the centre of services", reflecting the aim of the Health and Disability Commissioner legislation "to promote and protect the rights of consumers".

Accordingly, HDC champions consumer-centred health and disability services for New Zealand so that all services are delivered with care, competence, and compassion. We believe that this country should lead the world in promoting and protecting health and disability services consumers' rights.

This suggests that, in the Commissioner's view, patient rights may come before other objectives such as, for example, patient safety or facilitating a safety culture.

Turning to the complaints themselves, it is likely that many issues between consumers and doctors are resolved directly without input from any third party. Many complaints are also resolved with the assistance of the consumer advocacy service that is required and mandated by the HDC Act.⁴³ For those complaints which reach the Commissioner, the resolution pathway commences with a preliminary assessment. The Commissioner may then take one or more of the following courses of action:⁴⁴

- (a) to refer the complaint to another agency or person (for example to the MCNZ for interim action if a doctor's competence, fitness to practise or appropriateness of conduct is in doubt);
- (b) to refer the complaint to an advocate for resolution;
- (c) to call a mediation conference;
- (d) to investigate the complaint; and/or
- (e) to take no further action on the complaint.

Where an investigation is commenced, the responsible authority (being the MCNZ for doctors) may not take any action under Part 4 of the HPCA Act until that process comes to an end. As noted above, this has a delaying effect in cases where a complaint has been made. Only once any formal investigation by

⁴² Anthony Hill *Statement of Intent 2013/2016* (Office of the Health and Disability Commissioner, June 2013) at 8.

⁴³ For example, see Anthony Hill *Annual Report for the year ended 30 June 2012* (Office of the Health and Disability Commissioner, October 2012).

⁴⁴ HDC Act, s 33.

the Commissioner is complete can a charge be laid by a professional conduct committee before the HPDT, or by the Director of Proceedings before the HPDT or HRRT.

An overview of the Commissioner's functions can also be gained from the annual reports required by the Crown Entities Act 2004. The Commissioner's most recent annual report covers the 2011/12 year, during which 1,564 complaints were received, of which approximately 600 were about individual doctors.⁴⁵ The publicly available data does not include how many of those complaints resulted in investigations, but during the 2011/12 year, of the 1,380 complaints "closed" by the Commissioner, 44 were by investigation (as opposed to, for example, being closed by a decision under s 38(1) of the HDC Act to take no action).⁴⁶

In general terms, the trend over time has been of increasing numbers of complaints, but decreasing investigations and low numbers of referrals to the Director of Proceedings. This is shown in the following tables, assembled for the purposes of this paper from data in the Commissioner's annual reports.⁴⁷

	2007/08	2008/09	2009/10	2010/11	2011/12
Complaints received	1292	1360	1573	1405	1564
Investigations completed	100	112	51	27	44
Referrals to the Director of Proceedings	22	22	5	4	8

Limited referral to the Director of Proceedings is coupled with few charges against doctors being prosecuted by professional conduct committees before the HPDT. Over the 2008-12 calendar years, the HPDT has reported the following numbers of decisions involving medical practitioners.⁴⁸

	2008	2009	2010	2011	2012
Charges laid by professional conduct committee	6	4	10	6	3
Charges laid by Director of Proceedings	1	1	1	-	2
Unresolved	-	-	1	-	1

There has been some criticism of the picture this paints of complainants' access to justice in the sense of accountability/sanction and restoration.⁴⁹ While all complaints are routed through the Commissioner,

⁴⁵ As opposed to other types of "health care providers" that fall within the Commissioner's jurisdiction. Refer to the HDC Act, s 3.

⁴⁶ Hill, above n 43.

⁴⁷ Hill, above n 43; Anthony Hill *Annual Report for the year ended 30 June 2011* (Office of the Health and Disability Commissioner, October 2011); Anthony Hill *Annual Report for the year ended 30 June 2010* (Office of the Health and Disability Commissioner, November 2010); Ron Paterson *Annual Report for the year ended 30 June 2009* (Office of the Health and Disability Commissioner, September 2009); and Ron Paterson *Annual Report for the year ended 30 June 2008* (Office of the Health and Disability Commissioner, September 2008).

⁴⁸ Health Practitioners Disciplinary Tribunal "Tribunal's Decisions - Medical Practitioners" <www.hpdt.org.nz>. Note that the year indicates when the proceeding was commenced. Data about who laid the charge is not available until the proceeding is concluded.

⁴⁹ For example, see Joanna Manning "Access to justice for New Zealand health consumers" (paper presented to the Health and Disability Commissioner Medico-Legal Conference: A Decade of Change, Wellington, March 2010); and Wendy Brandon "Complaints against medical practitioners" [2001] NZLJ 249.

only a small number result in formal investigation and, short of judicial review, a complainant has no remedy against a decision not to investigate. Only complaints that are investigated and result in an opinion finding a breach of the Code can move on to the HRRT. While the subject matter of a complaint can be taken up by the MCNZ after it has been moved through the Commissioner's jurisdiction (irrespective of the outcome), consumers have no direct access to professional conduct committees or the HPDT.

In a relatively recent conference paper, Joanna Manning argued that the Commissioner should adopt a clear policy on when formal investigations will be commenced;⁵⁰ and that consumer access to the HRRT should be liberalised by amending the HDC Act.⁵¹ Wendy Brandon has also highlighted that "the number of charges heard by the Tribunal is a fraction of the number of complaints and charges previously dealt with by the Medical Council".⁵² In the same article she questioned whether low level resolution of complaints is appropriate given the power imbalance usually present in doctor-patient relationships;⁵³ and asked, with reference to "therapeutic jurisprudence",⁵⁴ whether formal hearings and sanction have a role to play in healing aggrieved consumers.⁵⁵ This paper will ask some of the same questions.

2 *Process of investigation by the Commissioner*

Once a decision to investigate has been made, the Commissioner must inform any doctor to whom it relates of the details of the complaint and the doctor's right to submit a written response.⁵⁶ As soon as reasonably practicable after completing an investigation, the Commissioner must advise the doctor of the results of the investigation, as well as any further action the Commissioner proposes to take.⁵⁷

If, following an investigation, the Commissioner is of the opinion that any action was in breach of the Code, the available responses include referring the doctor to the Director of Proceedings; making recommendations to the doctor; and reporting the Commissioner's opinion, with reasons, to any person considered appropriate.⁵⁸

In general terms investigations can be conducted as the Commissioner sees fit, subject to some limited procedural safeguards. All a doctor can insist on under the HDC Act is to be told the details of a complaint; submit a written response; and make a written statement in answer to any proposed adverse comment.⁵⁹

In 2000 the Commissioner wrote an article describing the process of being "under investigation". This included:⁶⁰

In practice, doctors are almost invariably sent a copy of any written complaint ... However, requiring the level of factual and legal specificity expected in disciplinary or criminal

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⁵⁰ Manning, above n 49, at 13.

⁵¹ Manning, above n 49, at 20–21.

⁵² Brandon, above n 49. The "Tribunal" Brandon refers to is the then Medical Practitioners Disciplinary Tribunal, which replaced the Medical Practitioners Disciplinary Committee in 1995.

⁵³ Brandon, above n 49, at 249–250.

⁵⁴ Therapeutic jurisprudence is discussed below in part III of this paper.

⁵⁵ Brandon, above n 49, at 249–252.

⁵⁶ HDC Act, s 41.

⁵⁷ HDC Act, s 43.

⁵⁸ HDC Act, s 45.

⁵⁹ Refer to the HDC Act, ss 59 and 67.

⁶⁰ Ron Paterson "Under investigation by the Commissioner" (31 May 2000) Health and Disability Commissioner <www.hdc.org.nz>.

charges would not be appropriate for investigations of possible breaches of the Code. Parliament clearly intended a simpler process.

The HDC investigation notification letter will invite you to make a written response within 21 days. ... a legalistic response is unnecessary and may be unhelpful. ... You should also forward copies of all relevant documentation, including clinical records for that patient, and respond promptly to HDC requests for such information.

... The HDC is not a court of law, and evidence is rarely heard on oath and is not subject to cross-examination ...

It is likely that the HDC investigator assigned to your case will telephone you to clarify any points that remain in issue. ... After the initial fact gathering stage, the HDC's usual next step is to request independent advice from a peer. ...

Ultimately, it is for the Commissioner to form an opinion, on the basis of expert advice where necessary (and it will almost invariably be needed in cases involving standards), whether a patient's rights have been breached. All relevant parts of the expert advice will be included in the HDC opinion. ... Current practice is to send a covering letter with the provisional breach opinion inviting comment on the findings and recommendations, usually within 10 working days of receipt.

Combined with a review of the Commissioner's published opinions, this confirms that the investigative process is largely written. While some parties may be interviewed (particularly the complainant), recordings or transcripts will not necessarily be made available. This is in stark contrast to the HPDT, which requires prior evidence exchange and witnesses to appear in person.

III Framework for Analysis

From the foregoing, it can be concluded that the Commissioner's jurisdiction was established with patient rights in mind, and this remains at the centre of the Commissioner's work. It can also be seen that differing perspectives on how to evaluate the Commissioner's jurisdiction, its purpose and value exist. The most prominent of these perspectives are therapeutic jurisprudence, patient safety/error prevention, patient rights and professionalism. These are not ethical or moral frameworks, but operate at a higher level as paradigms against which to measure the outcomes of different laws and policies. As world views, these approaches inevitably inform the way those who ascribe to them experience and value different parts of the regulatory framework for doctors.

The fact that medical law is subject to competing paradigms has been written about by Mark Hall. In one of several articles discussing the potential for unifying principles, Hall argues that medical law "has in recent years entertained two competing paradigms - the patients' rights approach and the law and economics approach."⁶¹ While this paper will examine the former, it does not address the latter. The level of state involvement and the way in which medical care is funded in New Zealand makes it inherently unlikely that the field can be regulated in the market by consumers making purchasing decisions. Indeed, Hall rejects the unifying potential of both of these paradigms on the basis that "they imagine a patient who does not exist".⁶² He argues that medical encounters are not transactional, but part of an on-going web of relationships.⁶³

A relational web perspective ... views medical encounters more holistically, as part of a larger context formed by the parties' interactions with each other and their relationships with other individuals and institutions.

Further ways of analysing medical law (if not paradigms in the same sense as the four frameworks discussed below) include techniques such as comparative institutional analysis, "which contends that the

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⁶¹ Mark Hall and Carl Schneider "Where is the 'there' in health law? Can it become a coherent field?" (2004) 14 Health Matrix 101 at 102.

⁶² Hall and Schneider, above n 61, at 102.

⁶³ Hall and Schneider, above n 61, at 103.

pursuit of any substantive goal is necessarily mediated through different institutional processes that will affect outcomes, so that institutional analysis is required and such analysis must be comparative."⁶⁴ Yet another approach is suggested by Wendy Mariner as a conceptual framework for describing medical law: "It is not a theory, nor a set of normative standards, but a description - an architecture, if you will." Mariner's architecture endeavours to "offer a blueprint for identifying the principles worthy of consideration in identifying and analysing legal issues affecting health".⁶⁵

Hall has proposed what he calls an "essentialist" approach to medical law, which starts by identifying the essential features of medicine that distinguish its legal issues from other fields.⁶⁶ The essential features proffered by Mark Hall are:⁶⁷

- the experience of being a *patient* - illness, vulnerability, suffering, and in need of care;
- the *professionalism* of health care providers - professing a higher ethic, submitting to a social compact, and engaging in a learned practice;
- the *treatment relationship* between patients and providers, consisting of very large measures of trust, dependency, authority, and caring;
- the existential *stakes* of medical care - death, disability, and the essence of being human;
- the nature of *medical practice*, especially its uncertainty, complexity, and technology;
- the *high cost* of care and *wide variability* of need, which necessitate public or private insurance that fundamentally alters medical economics.

It is noteworthy that the first five of these features (combining the fourth and fifth) line up with the four paradigms this paper will limit itself to.

A *Therapeutic Jurisprudence*

Therapeutic jurisprudence was first developed in the field of mental health law. David Wexler has said it is:⁶⁸

... the "study of the role of the law as a therapeutic agent". It focusses on the law's impact on emotional life and psychological well-being. ... therapeutic jurisprudence is a perspective that regards the law as a social force that produces behaviours and consequences. ... [It] wants us to be aware of this and wants us to see whether the law can be made or applied in a more therapeutic way so long as other values, such as justice and due process, can be fully respected.

Specific to medical law, Hall has developed ideas from therapeutic jurisprudence in his search for a unifying theme.⁶⁹ He has observed that therapeutic jurisprudence "invites us to think instrumentally and empirically about the law, rather than in terms of intrinsic rights or a priori principles";⁷⁰ and "therapeutic

⁶⁴ Gregory Shaffer "Comparative Institutional Analysis and a New Legal Realism" (2013) Wis L Rev 607 (forthcoming).

⁶⁵ Wendy Mariner "Toward an architecture of health law" (2009) 35 AJLM 67.

⁶⁶ Mark Hall "The history and future of health care law: an essentialist view" (2006) 41 Wake Forest L Rev 347.

⁶⁷ Hall, above n 66, at 358.

⁶⁸ David Wexler "Therapeutic Jurisprudence: An Overview" (2000) 17 Cooley L Rev 125. In this passage Wexler is quoting from David Wexler and Bruce Winick *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Carolina Academic Press, 1996). Wexler and Winick are regarded as founders of the therapeutic jurisprudence concept.

⁶⁹ Mark Hall "Law, Medicine and Trust" (2002) 55 Stan L Rev 463.

⁷⁰ Hall, above n 69, at 467.

goals should be primary considerations in a body of law that arises from and governs a common enterprise whose central objective is individual health and well-being."⁷¹

Hall has developed this further to argue persuasively for trust as his unifying agent. He describes a deeply personal type of trust as the core, defining characteristic of the doctor-patient relationship.⁷² This paper accepts that the therapeutic benefits of trust can be intuitively recognised at a human level without reference to empirical data. In other words "It is uncontroversial that trust in a caring relationship facilitates healing".⁷³

While Hall does not propose trust as a trump suit, he does conclude that its pervasive and fundamental importance to medicine makes it a unifying concept that ought always to be taken into account; particularly when medical law "can (and does) enforce trust-related expectations, punish violations of trust, facilitate the psychology of trust, *and undermine trust*."⁷⁴

B Patient Safety/Error Prevention

This could be described as the practical paradigm. Its focus is the reduction of acts and omissions which cause harm. This framework has grown from recognising that patients can be and are harmed by doctors; the influential work of Reason;⁷⁵ and the application of Reason's human factors/safety systems approach to medical care.⁷⁶

In relation to medicine, Reason has said "it is important to recognise that health care possesses a number of characteristics that set it apart from other hazardous domains. These include the diversity of activity and equipment, a high degree of uncertainty, the vulnerability of patients, and a one to one or few to one mode of delivery."⁷⁷ This can be contrasted with, for example, a nuclear power station where the mode of delivery generally involves many trained individuals focussed on one well-planned process with multiple designed safeguards.

Reason proposed a model of 'organisational accidents' that distinguishes between 'active failures' and 'latent conditions'.⁷⁸ Latent conditions are the defensive gaps in systems that allow a hazard to present itself to a human. Active failures are the unsafe acts of that human (whether they be simple errors or rule violations) which allow the hazard to then cause an adverse event. For example, a hazard is administering the wrong gas to an anaesthetised patient. A latent condition might be having the right and wrong gas present in the operating theatre and equipment that allows both to be connected to the patient's breathing apparatus. An active failure is the anaesthetist not checking carefully and connecting the wrong gas. The adverse event is the consequential harm to the patient.

The patient safety/error prevention paradigm is not focussed on the rights of the harmed patient or the moral culpability of the anaesthetist, but rather on what can be done to reduce the likelihood of a similar event occurring again. The paradigm seeks the development of a 'safety culture' where an absence of

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⁷¹ Hall, above n 69, at 468.

⁷² Hall, above n 69, at 470–71.

⁷³ Hall, above n 69, at 480.

⁷⁴ Hall, above n 69, at 525 (emphasis added).

⁷⁵ James Reason *Human Error* (Cambridge University Press, Cambridge, 1990).

⁷⁶ LT Kohn, JM Corrigan and MS Donaldson *To Err is Human: Building a Safer Healthcare System* (National Academy Press, Washington DC, 2000).

⁷⁷ James Reason "Beyond the organisational accident: the need for 'error wisdom' on the frontline" (2004) 2 *Qual Saf Health Care* 28.

⁷⁸ For example, see Reason, above n 77.

blame encourages all adverse events and near misses to be socialised and become opportunities for improving systems.

The safety culture model is universal in the aviation industry, and looked to as an example for medicine.⁷⁹ In this context it has been suggested that that:⁸⁰

... the sole objective of the investigation of an accident or incident shall be the prevention of accidents and incidents. It is not the purpose of this activity to apportion blame or liability.

The need for patient safety/error prevention thinking in New Zealand is underscored by research which estimated 12.9% of studied New Zealand hospital admissions were associated with an adverse event (a rate that compared to 16.6% in Australia and 10.8% in the UK).⁸¹

C Patient Rights

The evolution of patient rights in New Zealand has already been discussed in relation to the origin of the Commissioner and the Code.

In contrast with therapeutic jurisprudence, it could be said that rules like the Code are more concerned with trustworthiness (adherence to standards) than with maintaining trust itself. This point has been made by Hall, who has also observed that publicity around suboptimal behaviour by doctors may not restore trust: "More plausibly, however, such publicity has just the opposite effect, since highlighting the very worst in the profession casts seeds of doubt about all physicians. The law is not concerned with these consequences because its only intent here is to hold physicians to a level of performance that it considers trustworthy."⁸²

Nevertheless, rights are an important lens through which individuals see the world and their place in it. It is also possible that rights-based thinking lies behind at least some of the motivations patients experience in response to adverse events.⁸³

D Professionalism

Medical professionalism has a long lineage - from the Hippocratic Oath to the Declaration of Geneva,⁸⁴ which includes the promise to "practise my profession with conscience and dignity" and that "My colleagues will be by sisters and brothers". Along with other professions, such as law, medicine has traditionally been regarded as having a social function that separates it from ordinary occupations and trades. Until relatively recently, this 'separateness' went hand-in hand with professional self-regulation.

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⁷⁹ Kathleen Callaghan and Graham Hunt "Making 'safety' the focus of investigations into adverse events in health care" (2010) 123 NZ Med J 99.

⁸⁰ Callaghan and Hunt, above n 79. The quoted text is from the Convention on International Civil Aviation, 15 UNTS 295 (opened for signature 7 December 1944, entered into force 4 April 1947), Annex 13.

⁸¹ Peter Davis and others "Adverse events in New Zealand public hospitals I: occurrence and impact" (2002) 115 NZ Med J 271. A detailed discussion of the quality of medical care and rate of preventable adverse events in New Zealand is also included as part of Jonathan Coates "Improving the quality of health services: Is the regulatory framework up to the task?" (PhD Thesis, Victoria University of Wellington, 2005).

⁸² Hall, above n 69, at 492.

⁸³ For example, see Charles Vincent, Magi Young and Angela Phillips "Why do people sue doctors? A study of patients and relatives taking legal action" (1994) 343 Lancet 1609; Marie Bismark and Edward Dauer "Motivations for medico-legal action, Lessons from New Zealand" (2006) 27 Journal of Legal Medicine 55; and Marie Bismark and others "Accountability sought by patients following adverse events from medical care: the New Zealand experience" (2006) 175 Can Med Assoc J 889.

⁸⁴ "WMA Declaration of Geneva" World Medical Association <www.wma.net>.

The authors of one defence of medical professionalism argue that it is a "structurally stabilising, morally protective force in society."⁸⁵ For example, "professional groups, through the establishment of standards, education, and peer review, can go a long way toward supplying quality assurance."⁸⁶ Their model of professionalism is that it requires a moral commitment to the ethic of medical service/a devotion to medical service and its values; the normative act of a public profession of this ethic; and engagement in a political process of negotiation, in which professionals advocate for health care values.⁸⁷

This paper suggests that one of the reasons professionalism remains important is that it is likely to be how many doctors see their world. If professionalism does motivate doctors, then laws which undermine it may adversely affect the quality of the medical workforce over time.

E A Balanced Approach?

While each of these frameworks can be applied in isolation, none excludes any application of the others. No single law can simultaneously respond to and secure the benefits of all the values presented by these different frameworks. They can each be used as analytical tools to test the efficacy of our existing laws and, if necessary or desirable, craft new ones.

The potential advantages of synthesis have been written about - for example finding a "third way" that taps both professionalism and developments in patient safety.⁸⁸ Others have written about the need to balance 'no blame' with accountability, developing a 'just culture' which differentiates between blameworthy and blameless acts.⁸⁹

Charlotte Paul has warned against external morality (regulation) usurping internal morality, which she describes as "those values, norms, and rules that are intrinsic to the practice of medicine."⁹⁰ Paul concludes that "There needs to be a place for both external and internal morality and an effort to understand their connection. In New Zealand we face the danger of reducing one set of norms and values to another, so that there is only external morality. We are finding that external controls are blunt instruments in particular cases and require a functioning internal morality to interpret them."⁹¹

This paper endeavours to take a balanced approach by using all four of the frameworks outlined above to shed light on the Commissioner's jurisdiction.

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⁸⁵ Stephen Latham and others "Medical Professionalism in Society" (1999) 341 N Engl J Med 1612.

⁸⁶ Latham and others, above n 85, at 1613.

⁸⁷ Latham and others, above n 85, at 1613.

⁸⁸ Randall Bovbjerg, Robert Miller and David Shapiro "Paths to Reducing Medical Injury: Professional Liability and Discipline versus Patient Safety - and the Need for a Third Way" (2001) 29 J Law Med Ethics 369.

⁸⁹ Robert Wachter and Peter Pronovost "Balancing 'no blame' with accountability in patient safety" (2009) 361 N Engl J Med 1401.

⁹⁰ Charlotte Paul "Internal and external morality of medicine: lessons from New Zealand" (2000) 320 BMJ 499.

⁹¹ Paul, above n 90, at 502.

IV Analysis of the Commissioner's Jurisdiction

A Perspective of Patients

The work of Marie Bismark and others has examined what patients seek from the complaints process. Bismark and Edward Dauer have argued that the motivations behind deciding to take legal action following a medical injury, while all representing a demand for some form of accountability, generally fit into four themes. These are:⁹²

- (a) restoration, including financial compensation or some other intervention to 'make the patient whole again';
- (b) correction, such as a system change or competence review to protect future patients;
- (c) communication, which may include an explanation, expression of responsibility or apology; and
- (d) sanction, including professional discipline or some other form of punitive action.

In New Zealand the first of these themes is muted somewhat by the availability of compensation under the Accident Compensation Act 2001. While civil proceedings before the HRRT for breach of the Code allow damages to be sought,⁹³ where the relevant person has cover under the Accident Compensation Act 2001, only punitive damages will be claimable.⁹⁴

Bismark and Dauer's analysis is validated to some extent by a study of 154 injured patients whose complaints were sufficiently detailed to allow them to be coded. The following results were obtained:⁹⁵

Form of accountability sought by the complainant	% of complainants
Communication	39.6
<i>Explanation</i>	33.8
<i>Apology, expression of responsibility</i>	9.7
Correction	50.0
<i>Lessons learned, system change</i>	45.4
<i>Review of provider's competence</i>	6.5
Restoration	22.1
<i>Compensation for economic losses</i>	18.2
<i>Intervention with care or waiting lists</i>	3.9
Sanction	12.3

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⁹² Bismark and Dauer, above n 83.

⁹³ HDC Act, ss 52(1), 54 and 57.

⁹⁴ HDC Act, s 52(2).

⁹⁵ Bismark and others, above n 83, at 891.

<i>Professional discipline</i>	8.4
<i>Other punitive measure</i>	5.2

(Percentages do not add up to 100 because complainants could seek more than one outcome.)

Less well studied is the degree to which the Commissioner's jurisdiction satisfies these motivations. As part of its 2011 annual report, the Commissioner surveyed a random sample of consumers and providers who had participated in the complaint process. The results were that 81% agreed their complaints were taken seriously, and 73% were satisfied that the Commissioner had managed the complaint well.⁹⁶ This paper suggests that more empirical research on the experiences (as opposed to the motivations) of complainants is warranted. For example, a comparison of those patients whose complaints were resolved through advocacy or mediation, as opposed to formal investigation and opinion.

B Perspective of Doctors

Doctors take the Commissioner's investigations seriously. One study has reported the profound effect a patient complaint has on a doctor's personal and professional self-worth, concluding:⁹⁷

Some effect on practice is expected following a complaint. The profession's regulatory processes are intended to ensure that doctors do change their practices. However, the change is expected to be positive, to remedy dangerous or disrespectful care, and to ensure that future patients benefit from the process. This study suggests there is doubt as to whether these assumed benefits necessarily accrue.

The Medical Protection Society (a stakeholder in the regulatory framework for doctors), has written that "Findings made by the HDC can have a devastating impact on a doctor's professional and personal life".⁹⁸ This is consistent with research which has found that receiving a complaint has a significant negative impact on a doctor, with no evidence that the receipt of a complaint improves the delivery of patient care.⁹⁹ There has also been academic consideration of whether the jurisdiction is a negative influence on developing safety culture, with a focus on disclosure and learning from mistakes.¹⁰⁰ That research concluded "The overall impression of the complaint experience ... is generally negative ... Only a small minority of respondents felt that they or the patient had gained anything from the complaint."¹⁰¹

The court has held in *Stubbs v Health and Disability Commissioner (Stubbs)*¹⁰² that the Commissioner "has no authority to take any action affecting ... providers' rights or liabilities". In other words, if the Commissioner's opinions mean little, why should doctors worry about process? This paper does not accept that assessment. While the Commissioner's powers are limited, they include the ability to name doctors and, through a finding of breach, expose them to the jurisdiction of the HRRT. Furthermore, as noted above, the human impact of the Commissioner's opinions can be very real and significant. This is

⁹⁶ Hill *Annual Report for the year ended 30 June 2011*, above n 47, at 7.

⁹⁷ Wayne Cunningham and Susan Dovey "The effect on medical practice of disciplinary complaints: potentially negative for patient care" (2000) 113 NZ Med J 464. See also Wayne Cunningham and Susan Dovey "Defensive changes in medical practice and the complaints process: a qualitative study of New Zealand doctors" (2006) 119 NZ Med J 2283.

⁹⁸ Denys Court "Response to former HDC's editorial 'Lessons from complaints'" (2010) 123 NZ Med J 128.

⁹⁹ Wayne Cunningham "The immediate and long-term impact on New Zealand doctors who receive patient complaints" (2004) 117 NZ Med J 972.

¹⁰⁰ Refer for example to Richard Tapper, Laurence Malcolm and Frank Frizelle "Surgeons' experiences of complaints to the Health and Disability Commissioner" (2004) 117 NZ Med J 975.

¹⁰¹ Refer for example to Tapper, Malcolm and Frizelle, above n 100.

¹⁰² *Stubbs v Health and Disability Commissioner* HC Wellington CIV-2009-485-2146, 8 February 2010 at [33] per Ronald Young J.

likely amplified by the publicity usually associated with the publication of opinions. Peter Skegg has observed that "Media, providers and the wider public appear unaware of the very limited legal consequences that flow from a Commissioner opinion, or that they are reached by a process that would not be thought acceptable with the most minor criminal charge."¹⁰³

More practically, a finding that the Code has been breached will almost invariably result in the doctor having a 'record' with the MCNZ. Skegg has written of other potential consequences as well. He suggests that sometimes peers will learn of an investigation and the Commissioner's opinion, or aggrieved patients will provide a doctor's name to the media. "Furthermore, many people working in the health and disability sector place high importance on doing their best for those in their care, so an independent assessment that they have failed their patient can be devastating, even if it does not become widely known."¹⁰⁴

All of that said, research has also shown that "doctors strongly support society's right to complain, having lay input into the process, [and] achieving a sense of completion for both parties".¹⁰⁵ In a similar vein, John Jarvis and Frank Frizelle have written:¹⁰⁶

The complaints system has a purpose, and that is to maintain trust between society and the medical profession, act as a voice for patients, provide the opportunity for reconciliation and closure between doctor and the complainant, and to maintain standards of patient care.

C Perspective of Systems

The change that the Commissioner aims to contribute to New Zealand includes safe and high quality health services.¹⁰⁷ This paper suggests that the principal modes by which this might be achieved are:

- (a) complaints changing the behaviour of specific doctors;
- (b) the Commissioner's opinions and other educational activities changing the behaviour of doctors generally, and/or the health care systems within which doctors work;
- (c) the specific recommendations made as part of the Commissioner's opinions; or
- (d) the existence of a complaints jurisdiction of itself motivating doctors to provide safer, higher quality services.

While these means have a 'common sense' quality to them, there is little or no research showing that the Commissioner's jurisdiction does result in the desired outcomes or change systems and the organisations within which doctors work. Skegg has written that "There are grounds for scepticism about the extent to which the data available in Commissioner opinions can assist with the improvement of practice generally".¹⁰⁸ Other authors have similarly concluded "The implication is that health care overall is made

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¹⁰³ Peter Skegg "A fortunate experiment? New Zealand's experience with a legislated code of patients' rights" (2011) 19 Med L Rev 235 at 258.

¹⁰⁴ Skegg, above n 103, at 260.

¹⁰⁵ Wayne Cunningham "New Zealand doctors' attitudes towards the complaints and disciplinary process" (2004) 117 NZ Med J 973.

¹⁰⁶ John Jarvis and Frank Frizelle "Patients' complaints about doctors in surgical training" (2006) 119 NZ Med J 2026. Here Jarvis and Frizelle are referencing Cunningham and Dovey "The effect on medical practice of disciplinary complaints: potentially negative for patient care", above n 97.

¹⁰⁷ For example, see Hill, above n 43, at 9.

¹⁰⁸ Skegg, above n 103. See also Sara Temelkovski and Kathleen Callaghan "Opportunities to learn from medical incidents: a review of published reports from the Health and Disability Commissioner" (2010) 123 NZ Med J 18.

better through the process of receiving reports of care that are perceived to be inadequate. We could find no evidence that this assumption has been tested."¹⁰⁹

While it is true that any recommendations made as part of the Commissioner's opinions are almost always implemented by the relevant provider (resulting in system improvements),¹¹⁰ error by error, case by case changes in response to specific complaints is a slow and inefficient way to improve overall safety performance.

D Review of Commissioner's Opinions

One of two published studies of the content of the Commissioner's opinions is by Sara Temelkovski and Kathleen Callaghan.¹¹¹ As well as collecting some basic data about timing and the parties to the investigation, the Commissioner's findings were analysed against the 'domains of competence' set out in *Good Medical Practice*.¹¹²

1 Method

A study with some similarities to the work by Temelkovski and Callaghan has been undertaken for this paper. The 20 most recent opinions published on the Commissioner's website were selected for analysis, commencing with the most recent as at 1 September 2013, and moving consecutively back in time until 20 opinions were found. Opinions that did not involve a doctor were excluded.

The following aspects of the opinions selected for study were analysed:

- (a) if an expert had been engaged to provide advice about whether a doctor had breached right 4(1) of the Code ("Every consumer has the right to have services provided with reasonable care and skill");
- (b) whether the Commissioner's opinion was consistent with any advice received from an expert engaged by him;
- (c) whether the doctor submitted any independent expert evidence;
- (d) what, if any, comment was made about onus/the burden of proof;
- (e) whether the Commissioner made a material factual finding that was in dispute between the complainant and doctor;
- (f) what follow-up actions were taken; and
- (g) whether a doctor was found to have breached right 4(1) of the Code and, if so, how.

2 Results

The study's results are fully presented in an appendix to this paper. In summary:

- (a) The Commissioner engaged one or more experts in 19 of the 20 opinions (95%). The only exception was a complaint concerning a breach of sexual boundaries which, if true, was

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¹⁰⁹ Cunningham and Dovey "The effect on medical practice of disciplinary complaints: potentially negative for patient care", above n 97.

¹¹⁰ Hill, above n 43, at 36.

¹¹¹ Temelkovski and Callaghan, above n 108. The only other published study being Skegg, above n 103.

¹¹² *Good Medical Practice*, above n 14.

clearly a breach of rights under the Code. Of the 19 opinions for which an expert was used, six (32%) involved the use of the Commissioner's 'in-house' clinical advisor (an employee), rather than an independent person.

- (b) In every case where an expert was engaged, the Commissioner's opinion was consistent with the advice received.
- (c) Three of the opinions (15%) indicated that expert evidence had been submitted by a doctor. In one of those cases the expert was a professional colleague at the same hospital, rather than being completely independent.
- (d) None of the opinions discussed evidential onus or the burden of proof. Eight of the opinions (40%) did however refer to the standard of proof. All eight adopted the civil standard by referring to the "balance of probabilities" (1); "more likely than not" (5); or both (2).
- (e) The Commissioner made one or more material factual findings which required a person's evidence to be rejected in seven opinions (35%). The relevant doctor's evidence was preferred in only one of those seven instances.
- (f) Every opinion was sent to the MCNZ together with the name of any doctor involved, regardless of whether or not the Commissioner had concluded that the Code had been breached. It was also common for a doctor's name to be disclosed to the relevant District Health Board and professional body for vocational registration. In nine cases (52% of the 17 opinions which concluded that the Code had been breached by a doctor) the Commissioner also "recommended" or "requested" that the MCNZ undertake a performance assessment. Four of the opinions referred a doctor to the Director of Proceedings. Each of these related to a breach of sexual boundaries and involved disputed material factual findings.
- (g) Across all 20 opinions, a total of 48 separate breaches by a doctor of a right under the Code were found. Nineteen of these (40%) were a breach of right 4(1).

3 *Discussion*

Assuming the 20 opinions analysed are a representative sample (no testing was done to determine statistical significance),¹¹³ it is relatively common for the Commissioner to choose between conflicting evidence about material issues of fact. This is surprising given that the Commissioner's process does not necessarily allow for the subject of the investigation to hear all of the evidence. Nor is the cross-examination of witnesses provided for. Each of the opinions concerning alleged breaches of sexual boundaries required the Commissioner to make a contested factual finding. The potential unfairness of this is significant given the gravity of the allegations and the Commissioner's practice of always disclosing the name of any doctor to the MCNZ. The utility of conducting an investigation is also doubtful when subsequent prosecution by either the Director of Proceedings or a professional conduct committee seems inevitable. While one potential benefit might be to encourage an early guilty plea (thereby sparing the complainant from having to give evidence in person), the price of blackening a doctor through a potentially unfair process is a high one. If subsequent charges are defended, then the Commissioner's process may have an anti-therapeutic effect by adding to the complainant's stress and delaying resolution of the factual contest.

In relation to how doctors engage with the investigative process, it is possible that the inevitability of being reported to the MCNZ may encourage defensive behaviours. Along similar lines, the relatively

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¹¹³ The study in this paper represents a sample of 20 opinions from a total of 509 which involve one or more doctors that are published on the Commissioner's website.

common use of an in-house clinical advisor to determine whether right 4(1) of the Code has been breached may give doctors the impression that they are not being judged by their peers in the true sense.

Another interesting aspect of the study was the grounds on which it was concluded that right 4(1) of the Code had been breached. It appears that the standard of "reasonable care and skill" is a high one in the Commissioner's jurisdiction, and arguably a counsel of perfection. What degree of skill and care the common law requires of doctors has been well litigated in the civil courts of analogous jurisdictions such as England. In England, a doctor is required to meet the standard of the ordinary skilled practitioner exercising and professing to have the special skill in question. An error of judgment will not amount to negligence unless it is one that would not have been made by a reasonably competent practitioner with the standard and type of skill of the defendant, acting with ordinary care. Where there are differing and well established professional schools of thought on an issue, a doctor will not be regarded as negligent in following one rather than another, even if the outcome suggests that the wrong choice was made. However, in certain circumstances, treatment will be held to be negligent if it cannot be demonstrated to the satisfaction of the court that the body of opinion relied on is reasonable or responsible. Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis it must be shown (a) that there is a usual and normal practice; (b) that the defendant has not adopted it; and (c) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care.¹¹⁴

This can be compared to the following examples identified by the study.

In *Report on Dr B, General Surgeon; Dr C, General Surgeon; and a District Health Board*,¹¹⁵ a patient presented during the evening to the emergency department of a hospital with acute abdominal pain. He was seen by a general surgeon (Dr B), who correctly diagnosed an irreducible hernia. At issue was whether or not the hernia was also undergoing strangulation. Dr B concluded there was no sign of strangulation. That, combined with reasons why undertaking surgery at night in the circumstances would be risky, prompted Dr B to decide that the patient's surgery could wait until the following day. In fact the patient's hernia was strangulated and, with hindsight, surgery should have been undertaken urgently despite the other risks.

This case involved difficult clinical judgements. The Commissioner's expert pointed to no protocol or other documentary evidence of normal practice that Dr B's decision had breached. Nor did the expert explicitly consider whether Dr B's decision was consistent with a well-established professional school of thought. While it is impossible in this paper to second-guess whether Dr B provided services to the patient with reasonable care and skill, his actions can be regarded as constituting an "error", rather than a "violation" as those terms are used by Alan Merry and Alexander McCall Smith.¹¹⁶

A further example is *Report on Southern District Health Board and Dr B, Surgical Registrar*.¹¹⁷ This opinion concerned a Surgical Registrar (Dr B) who charted an incorrect dosage of methadone (recording the dose in millilitres instead of milligrams). Dr B took appropriate steps to check whether the dose, which was based on information given to her by a patient, was correct, but should not have charted the methadone until those actions had been completed. While the chain of events began with an error, it

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¹¹⁴ *Halsbury's Laws of England* (5th ed, 2001) vol 74 Medical Professions at [24]. See in particular *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB) [*Bolam*] at 586 per McNair J. The *Bolam* test was approved in *Whitehouse v Jordan* [1981] 1 WLR 246 (HL). See also *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL).

¹¹⁵ *Report on Dr B, General Surgeon; Dr C, General Surgeon; and a District Health Board* (Health and Disability Commissioner, Case 10HDC00950, 12 June 2013).

¹¹⁶ Alan Merry and Alexander McCall Smith *Errors, Medicine and the Law* (Cambridge University Press, Cambridge, 2001).

¹¹⁷ *Report on Southern District Health Board and Dr B, Surgical Registrar* (Health and Disability Commissioner, Case 11HDC00710, 28 June 2013).

arguably resulted in a violation when Dr B charted the medicine knowing it might be incorrect (albeit that she gave instructions for the dose to be checked). This type of violation should probably be regarded a routine rather than exceptional,¹¹⁸ and therefore, to borrow the former Commissioner Paterson's words, an opportunity for learning rather than lynching.¹¹⁹

A final example is *Report on Dr B, Dermatologist and a Skin Cancer Detection Company*.¹²⁰ At the heart of this opinion is a dermatologist (Dr B) who reported a false negative or, in other words, failed to diagnose a mole or lesion he had examined as a melanoma. The Commissioner concluded that Dr B had breached right 4(1) of the Code despite a review of Dr B's false negative rate showing that his work fell well within acceptable tolerances. The nature of screening tests is that many samples are examined with the prospect of detecting most, but not all, positive instances. An example of this is the *Report of the Ministerial Inquiry into the Under-reporting of Cervical Smear Abnormalities in the Gisborne Region*.¹²¹ If it is accepted that a Commissioner's opinion finding breach amounts to punishment in some form, this paper suggests that *Report on Dr B, Dermatologist and a Skin Cancer Detection Company* is the epitome of error being punished.

E Legal Criticisms of the Commissioner's Jurisdiction

Skegg has commented that:¹²²

There is a (usually unacknowledged) tension between the [HDC] Act's objective of fairness in a complaints resolution and its related objectives of simplicity, speed, and efficiency. ... In some respects, Commissioner investigations are less fair than judicial proceedings. ... It would be very surprising indeed if a Commissioner's opinion would always have been the same, if complainants and providers had had the opportunity to present their case in the way that it commonplace before the courts and tribunals.

In some respects such criticisms are also rights issues, being about the right to fairness and justice as opposed to patient rights. This paper suggests that the legal criticisms able to be levelled against the Commissioner's jurisdiction are relevant to an analysis that applies patient rights, therapeutic jurisprudence, professionalism and patient safety/error prevention. For example, opposing rights need to be described before they can be compared, and the way doctors experience the Commissioner's jurisdiction may impact upon their professionalism and patient relationships.

I Reasonable care and skill, and the burden of proof

It has been said that "Right 4(1) [of the Code] encapsulates the common law standard of care in negligence. In determining whether there has been a breach of right 4(1), the [Commissioner] will apply relevant principles of common law negligence."¹²³ The relevant English law has been summarised above. In New Zealand, these principles have been most clearly summarised in recent times by the court

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¹¹⁸ Merry and Smith, above n 116, at 106–111.

¹¹⁹ Ron Paterson "Inquiries into health care: learning or lynching?" (Nordmeyer Lecture presented at Wellington School of Medicine, September 2008).

¹²⁰ *Report on Dr B, Dermatologist and a Skin Cancer Detection Company* (Health and Disability Commissioner, Case 11HDC00700, 28 June 2013).

¹²¹ AP Duffy, DK Barrett and MA Duggan *Report of the Ministerial Inquiry into the Under-reporting of Cervical Smear Abnormalities in the Gisborne Region* (Ministry of Health, April 2001).

¹²² Skegg, above n 103, at 247.

¹²³ PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (1st ed, Brookers Ltd, Wellington, 2006) at 64.

in *Ambros v Accident Compensation Corporation* (in the context of medical error under the then Accident Insurance Act 1998):¹²⁴

[30] Judges have a positive duty to analyse all evidence (whether factual or expert opinion) to ensure it is reliable. That is the approach adopted in all areas involving allegations of negligence against professionals. There is no reason why that approach should not be adopted when medical error is alleged against registered health practitioners for the purpose of the accident compensation legislation.

[31] In *Sulco Ltd v E S Redit & Co Ltd* [1959] NZLR 45 (CA) at 88, Henry J put the point as follows:

Since the Court must ultimately itself determine the question of negligence as a fact in all the circumstances of the case, I do not rest my finding on evidence as to the general practice of the profession alone. The Court may come to the conclusion that the standards deposed to by the witness do not reach the standard required by law - namely, a reasonable and prudent architect engaged on work such as this.

That approach has been adopted consistently in cases of professional negligence in New Zealand ...

...

[34] Some suggestion can be found in earlier authorities that the standard of care in medical cases was generally a matter for medical judgment. But a close reading of the authorities reveals that general proposition to be unsupportable. In *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587, it was stated that the standard of care was to be determined by reference to the "responsible", "reasonable" and "respectable" body of professional opinion. In *Bolitho* the House of Lords revised the *Bolam* test by interpreting the terms "responsible", "reasonable" and "respectable" to mean that such opinion must have a logical basis which can be analysed by the Court: *Bolitho* at 778 per Lord Browne-Wilkinson.

In addition, the burden of proof rests on the plaintiff/prosecution, and the appropriate standard of proof is the civil standard; that is proof to the satisfaction of the decision-maker on the balance of probabilities.¹²⁵

Evidence of how the Commissioner has approached the issue of reasonable care and skill can be found in one of the articles published by Paterson:¹²⁶

The Code of Consumers' Rights - in particular the statement in Right 4(1) that "every consumer has the right to have services provided with reasonable care and skill" - does not require the Commissioner to be bound by the *Bolam* principle. Rather, HDC is expected to form an independent opinion on the reasonableness of the care provided. ...

In practice, HDC is very cognisant of the reasons that underpin the *Bolam* principle, and accepts that there can often be a legitimate range of responsible opinion and practice. We closely scrutinise any conflicting opinions ... We are well aware of the unfairness of finding a doctor 'in breach' for following a practice recognised as acceptable within the profession. But we are also conscious of HDC's responsibility, as an independent guardian of patients' rights, to distinguish between mediocre and good practice. On rare occasions, even a commonly accepted practice may, when viewed objectively, fall short of a patient's entitlement to "reasonable care and skill". In the areas of assessment, diagnosis and treatment, we will naturally tend to defer to expert clinical opinion. But in areas such as communication, referral, and follow-up, we are prepared to question accepted practice, to see if it reflects custom rather than care.

Given this, one outcome of the Commissioner's jurisdiction and the Code is that, arguably, doctors in New Zealand are held to a higher standard than in those countries where the main remedy available to

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¹²⁴ *Ambros v Accident Compensation Corporation* HC Auckland CIV-2004-404-3261, 21 March 2005 at [45]. Although this judgment was subsequently overturned, this part of the decision was not appealed. Refer to *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

¹²⁵ Refer to *Z v Complaints Assessment Committee*, above n 11.

¹²⁶ D Wong and R Paterson "Commissioner's Comment: Ovarian Cancer and Expert Advice" (2005) 32 NZ Family Physician 50 at 52.

patients is tort law; in which the required standard of care is framed around the *Bolam* test and its subsequent development by the House of Lords in *Bolitho* and other cases.¹²⁷

In relation to onus, the court in *Stubbs*¹²⁸ seems to accept that the Commissioner starts from a neutral position, with no party bearing any onus. Following an inquisitorial process the Commissioner will reach a preliminary view, after which a burden will shift to the party attempting to challenge that view. Assuming this is an accurate description of the Commissioner's method, it is at odds with the familiar position in New Zealand. The general rule in civil cases is that the plaintiff must prove all the elements of liability that together constitute the cause of action. The only burden which can shift from one party to another is what is sometimes called the 'tactical burden'. The tactical burden simply means that a party stands to lose on an issue unless it produces some more evidence.¹²⁹ That a preliminary decision can cause a doctor to assume the burden of proving no rights under the Code were breached seems particularly harsh given that the doctor may not be provided with access to all of the information available to the Commissioner until after a preliminary decision has been made.

Also noteworthy is analysis undertaken by Skegg which showed that the Commissioner's opinions hold little (if any) weight in the HPDT.¹³⁰ The preceding Medical Practitioners Disciplinary Tribunal held that the question of whether particular conduct was in breach of the Code was separate from the question whether that conduct amounted to a disciplinary offence,¹³¹ and "a breach of the Code does not necessarily constitute a professional disciplinary offence".¹³² Skegg's 2011 research also found that, of the 18 proceedings brought by the Director of Proceedings against medical practitioners before the HPDT, in only three did the HPDT's decision refer to the Code. None referred to the Commissioner's opinion.

In another recent case the HPDT was careful to note that only the evidence heard by it would be taken into account, and not the earlier opinion of the Commissioner.¹³³ Nevertheless, the Commissioner's investigation (in particular part of the doctor's written response to the complaint) was relied upon in the High Court to support the Tribunal's decision.¹³⁴

The view can be taken (and no doubt is by some doctors) that the Commissioner applies a 'gold standard', as opposed to what is expected by the common law or the MCNZ. While it is hard to argue against the Commissioner encouraging best practice and medical practitioners 'lifting their sights', whether admonishing less than best practice will result in safety/quality improvements, happier complainants and improved doctor-patient relationship can be questioned.

2 *Approach to factual evidence*

*Report on Dr C, General Practitioner and an After Hours Clinic*¹³⁵ is an example where the Commissioner was required to choose between starkly conflicting accounts of a general practitioner's consultation with a patient. The opinion accepted the patient's account and doubted the doctor's

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¹²⁷ *Bolam*, above n 114, and *Bolitho v City and Hackney Health Authority*, above n 114.

¹²⁸ *Stubbs v Health and Disability Commissioner*, above n 102.

¹²⁹ Don Mathieson (ed) *Cross on Evidence* (9th ed, LexisNexis, Wellington, 2013) at [2.3.2] and [2.5].

¹³⁰ Skegg, above n 103, at 254-255.

¹³¹ *Dr Nealie* Medical Practitioners Disciplinary Tribunal 28/97/16D, as cited in Skegg, above n 103, at 254, n 126.

¹³² *Dr O* Medical Practitioners Disciplinary Tribunal 153/00/66D, as cited in Skegg, above n 103, at 255, n 127.

¹³³ *Re Vatsyayann* Health Practitioners Disciplinary Tribunal 428/Med10/170D, 21 December 2011 at [201].

¹³⁴ *Director of Proceedings v Vatsyayann* [2012] NZHC 2588.

¹³⁵ *Report on Dr C, General Practitioner and an After Hours Clinic* (Health and Disability Commissioner, Case 11HDC00871, 11 December 2012).

credibility. While the patient and doctor were separately interviewed by the Commissioner, it is not clear whether a transcript of the patient's interview was shown to the doctor (or vice versa). Transcripts were however provided to the in-house clinical advisor engaged by the Commissioner. It can also be inferred that the Commissioner's reliance on this expert reached beyond being a provider of opinion evidence in the true sense, to an assistant fact-finder. For example, in his opinion the Commissioner "notes" the expert's comment that "The only explanation I [the expert] can see for this sequence of events is that Dr C has deliberately and retrospectively falsified the medical history to support his stated version of events".¹³⁶

A further example of this is *Report on Dr B, Plastic Surgeon*,¹³⁷ in which the advice from the expert engaged by the Commissioner includes "On the balance of probabilities ... I expect that there was discussion of the possible complications, and it is unlikely that assurances of low risk were given as 'no risk'."

One criticism that can be made of the investigative process adopted by the Commissioner is the absence of an oral hearing and the doctor potentially not having access to all of the evidence available to the decision-maker.

In relation to oral hearings, the New Zealand position is that "There is no general right to an oral hearing even where the decision may be significantly prejudicial".¹³⁸ Further, the rule of natural justice applicable to the Commissioner's opinions demands no more than that each finding must be based upon some material that tends logically to show the existence of the facts consistent with the finding, and that any reasoning supportive of the finding is not logically self-contradictory.¹³⁹ That said, the question remains whether the Commissioner's practice of determining factual contests from written submissions and (sometimes) separate interviews is substantively fair. How this question is answered is likely to depend on how the rights at stake in the Commissioner's investigations are valued. In relation to the need for such an assessment the House of Lords¹⁴⁰ has affirmed the following passage from the High Court of Australia's decision in *Kioa v Minister for Immigration and Ethnic Affairs*:¹⁴¹

In this respect the expression 'procedural fairness' more aptly conveys the notion of a flexible obligation to adopt fair procedures which are appropriate and adapted to the circumstances of the particular case. The statutory power must be exercised fairly, that is, in accordance with procedures that are fair to the individual considered in the light of the statutory requirements, the interests of the individual and the interests and purposes, whether public or private, which the statute seeks to advance or protect or permits to be taken into account as legitimate considerations ...

The House of Lords went on to say that "an oral hearing is most obviously necessary to achieve a just decision in a case where facts are at issue".¹⁴² Consistent with this is *Rose v Humbles*,¹⁴³ where a hearing that turned on the credibility of the subject person's evidence was held to have been unfair because it was conducted without oral evidence.

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¹³⁶ *Report on Dr C, General Practitioner and an After Hours Clinic*, above n 135, at [136].

¹³⁷ *Report on Dr B, Plastic Surgeon* (Health and Disability Commissioner, Case 11HDC01438, 21 June 2013) at 24.

¹³⁸ Philip A Joseph *Constitutional and Administrative Law in New Zealand* (3rd ed, Brookers Ltd, Wellington, 2007) at 976.

¹³⁹ *Re Erebus Royal Commission* [1983] NZLR 662 (PC) at 671.

¹⁴⁰ *R (West) v Parole Board* [2005] UKHL 1, [2005] 1 WLR 350 at [28].

¹⁴¹ *Kioa v Minister for Immigration and Ethnic Affairs* [1985] HCA 81, (1985) 159 CLR 550. See also *Ali v Deportation Review Tribunal* [1997] NZAR 208 (HC).

¹⁴² *R (West) v Parole Board*, above n 140, at [31].

¹⁴³ *Rose v Humbles* [1972] 1 WLR 33 (CA).

The courts in New Zealand have also recognised that, in some circumstances, it will be desirable to allow oral evidence in judicial review proceedings (by way of cross-examination). In *Stratford Racing Club Inc v Adlam*¹⁴⁴ the Court of Appeal said that cross-examination will "Always be permitted where it is necessary to enable the application for review to be decided properly and fairly" and that "Cross-examination is particularly useful in cases where ... the credibility of a deponent is in issue".¹⁴⁵

The desirability of testing evidence also has a relationship with the standard of proof that doctors would be subject to by the HPDT. There the degree of satisfaction called for will vary according to the gravity of the allegations. In *Z v Complaints Assessment Committee*,¹⁴⁶ a majority of the Supreme Court held that the civil standard is to be applied flexibly, because it must accommodate serious allegations through the natural tendency to require stronger evidence before being satisfied to the balance of probability standard.

In relation to the manner in which the Commissioner gathers evidence and only makes a distillation available by way of a provisional opinion, the court has previously criticised a Coroner for breaching natural justice by speaking privately with two witnesses during an inquest.¹⁴⁷

The decision in *Re Erebus Royal Commission*¹⁴⁸ made the point (which applies equally to the Commissioner's opinions) that "whatever is written about someone to his discredit ... is the subject of absolute privilege under the law of defamation, devoid though the allegation may be of any factual foundation ... So he who has been traduced is deprived of any remedy".

Thus doctors face an investigation process that is largely written, but where the Commissioner may nevertheless reject their evidence as incredible. While this could have real consequences for a doctor's reputation, there is no right of appeal and, based on current precedent, limited prospect of judicial review.

This can be compared with the next level in the disciplinary process for breached of the Code - the HRRT - which approaches fact-finding and credibility in the familiar adversarial way, for example:¹⁴⁹

[32] The primary issue before the Tribunal is a stark one. ... If events did not unfold as alleged by the aggrieved person, the Director's case fails in its entirety. ... In this sense the credibility determination is the key to the outcome of this case.

[33] Two primary challenges to the credibility of the aggrieved person were made by Mr Emms either in his evidence or in cross-examination.

It can be concluded that the Commissioner's approach to factual evidence is different from New Zealand's courts and tribunals, and in particular the HPDT. This has some obvious advantages. The Commissioner's process is less expensive; less dependent on lawyers; less onerous for complainants; and (potentially) faster. The corollary is that it may be less satisfactory for those who are subject to adverse opinions. It is suggested that this tension calls for a careful assessment of the role played by and value of Commissioner's opinions. If their value to the regulatory framework for doctors is low, should that part of the framework be changed?

3 *Approach to expert evidence*

In his chapter 22 of *Medical Law in New Zealand*, the former Commissioner Paterson comments:¹⁵⁰

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¹⁴⁴ *Stratford Racing Club Inc v Adlam* [2008] NZCA 92, [2008] NZAR 329 at [63]. See also *Geary v Psychologists Board* [2009] NZCA 134, [2009] NZAR 338.

¹⁴⁵ Here the Court of Appeal was quoting Joseph, above n 138, at 883.

¹⁴⁶ Refer to *Z v Complaints Assessment Committee*, above n 11.

¹⁴⁷ *Matthews v Hunter* [1993] 2 NZLR 683 (HC).

¹⁴⁸ *Re Erebus Royal Commission*, above n 139, at 667.

¹⁴⁹ *Director of Proceedings v Emms* [2013] NZHRRT 5 at [32].

Clinical advice is particularly valuable in relation to investigation of alleged breaches of rights 4(1) (what is "reasonable care and skill" in such circumstances?) and 4(2) (what are the applicable "professional standards"?) of the Code. Typically, during an investigation, the Commissioner gathers the available evidence (from clinical records and statements from parties and witnesses) and forwards it to a suitably qualified expert, with a request for advice on specific questions relating to the standard of care expected from a practitioner in such circumstances.

The way in which the Commissioner engages experts consists of a document titled *Guidelines for Independent Advisors*,¹⁵¹ together with instructions and questions specific to the case. The *Guidelines for Independent Advisors* are vague about what lies at the heart of the expert's role and do not articulate the contemporary (or any) incarnation of the *Bolam* test. It appears most likely that the Commissioner will ask either direct questions seeking an opinion (such as "Should the caesarean section have been done at 40 weeks/2 days given the history and the reduced foetal movements?"¹⁵²), or simply whether, in the expert advisor's opinion, the actions in question were reasonable in the circumstances.¹⁵³ Expert advisors are not asked whether another reasonable body of medical opinion exists that might give a different answer.

It is suggested by this paper that there is force to criticisms about the Commissioner's use of experts given that their advice is invariably followed.¹⁵⁴ The usual rule in an adversarial setting is that experts are not fact finders, and an expert opinion about a set of facts may be relied upon only if those facts are proved.¹⁵⁵ The Law Commission has also considered the issue of court-appointed experts in the past and was mindful of "judicial 'descent into the arena'".¹⁵⁶

The reliance placed on expert evidence in prosecutions of health professionals has been studied by Oliver Quick.¹⁵⁷ Based on interviews with medical experts for gross negligence manslaughter charges, Quick discusses how they can develop their own working rules of interpretation and analysis. He also observed that experts can enjoy adopting a hybrid medic-lawyer role. This suggests that, to ensure a fair process, experts should be used and managed with caution.

4 *No appeal/limited judicial review*

The Commissioner's opinions cannot be appealed under the HDC Act, leaving judicial review as the only available remedy. Only two such challenges have been made: *Culverden Group Ltd v Health and Disability Commissioner*¹⁵⁸ and *Stubbs*.¹⁵⁹

In the first of these cases the Commissioner's opinion was essentially upheld, although the court made some recommendations about how the process could be improved. In reaching its decision the court commented that s 27(1) of the New Zealand Bill of Rights Act 1990 is applicable,¹⁶⁰ and.¹⁶¹

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¹⁵⁰ Skegg and Paterson, above n 123, at 605.

¹⁵¹ *Guidelines for Independent Advisors* (Office of the Health and Disability Commissioner, 5 March 2007) (Obtained under Official Information Act 1982 request to the Commissioner).

¹⁵² *Report on Dr D, Obstetrician and a District Health Board* (Health and Disability Commissioner, Case 11HDC00515, 11 July 2013) at 22.

¹⁵³ *Guidelines for Independent Advisors*, above n 151, at 7.

¹⁵⁴ This was the case in all 19 of the opinions included in the study undertaken for this paper where expert advice was obtained.

¹⁵⁵ Evidence Act 2006, s 25(3).

¹⁵⁶ Law Commission *Evidence: Reform of the Law* (NZLC R55 - Volume 1, 1999) at 26.

¹⁵⁷ Oliver Quick "Expert Evidence and Medical Manslaughter: Vagueness in Action" (2011) 38 J Law & Soc 496.

¹⁵⁸ *Culverden Group Ltd v Health and Disability Commissioner* HC Auckland M1143-SD00, 25 June 2001.

¹⁵⁹ *Stubbs v Health and Disability Commissioner*, above n 102.

[105] ... as a general rule the process the Commissioner follows as explained in his affidavit would satisfy the rules of natural justice and the provisions of the statute (taking account of the fact that the process is an investigative as against adversarial one). A court would not generally interfere with any fair procedure followed by the Commissioner, given the rights of the Commissioner to regulate procedure ...

The application for review of the Commissioner's opinion in *Stubbs* was also unsuccessful, with the court observing.¹⁶²

[33] ... The Commissioner therefore has no authority to take any action affecting health care providers' rights or liabilities. The Commissioner's function is to express an opinion about the health care provider's conduct and if appropriate refer the matter to other authorities to consider prosecution or other form of disciplinary process.

[34] Having said that I accept that the health care providers, however, do treat any negative opinion by the Commissioner as significant. This is understandable given the high standing of the Commissioner and the understandable desire of the health care providers to guard their reputations closely.

[35] The tenor of the legislation suggests that this situation is not one where 'hard' look judicial review is appropriate. The Commissioner's opinion is just that, an opinion not directly affecting the legal rights or liabilities of the health care provider; the prescribed process has a high level of 'fairness' attached with its insistence on referral of any proposed negative comment by the Commissioner to the health care provider before the final report is prepared; the Commissioner has a high level of expertise in the field; the report of the Commissioner is an opinion albeit well informed but where there may be genuine scope for disagreement.

Thus the court to date has taken a deferential approach to the Commissioner's opinions and seems reluctant to demand too much of an inquisitorial/investigative process intended to be "simple, speedy, and efficient".¹⁶³ By way of contrast, this differs from Dobson J's discussion of the relative intensity of review that would be brought to bear on a decision made by the MCNZ to require a doctor to undergo counselling.¹⁶⁴

A further decision worth noting is *R v Kong*,¹⁶⁵ which related to a charge under s 177(e) of the Crimes Act 1961 that Dr Kong had attempted to pervert the course of justice by altering clinical records provided to the Commissioner as part of an investigation. The court determined that inquiries undertaken by the Commissioner in relation to a complaint were within the scope of the 'course of justice', and thus the charge could be heard. In reaching this decision the court commented that:¹⁶⁶

[44] ... the Commissioner's role at the preliminary assessment stage is not adjudicative and that, even at the investigative stage, it does not incorporate all of the trappings of a quasi-judicial body.

That the Commissioner's investigations do not include everything that would be expected from a quasi-judicial body is agreed. Whether the Commissioner's limited powers under s 45 of the HDC Act are sufficient to disqualify it from being quasi-judicial in substance (in other words whether to agree with the court that the Commissioner's opinions do not affect doctors' rights) is worthy of further consideration. In *Royal Australasian College of Surgeons v Phipps* the Court of Appeal noted that an independent examination of the conduct of a medical practitioner is "exactly the type of situation in which high

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¹⁶⁰ *Culverden Group Ltd v Health and Disability Commissioner*, above n 158, at [39]. Section 27(1) provides: "Every person has the right to the observance of the principles of natural justice by any tribunal or other public authority which has the power to make a determination in respect of that person's rights, obligations, or interests protected or recognised by law."

¹⁶¹ *Culverden Group Ltd v Health and Disability Commissioner*, above n 158, at [105].

¹⁶² *Stubbs v Health and Disability Commissioner*, above n 102, at [33] (references to authorities omitted).

¹⁶³ HDC Act, s 6.

¹⁶⁴ *C v Medical Council of New Zealand* [2013] NZHC 825, [2013] NZAR 712 at [41].

¹⁶⁵ *R v Kong* [2011] NZCA 537.

¹⁶⁶ *R v Kong*, above n 165, at [44].

standards of procedural fairness are expected, to support the process of making the careful professional judgements that are called for".¹⁶⁷

F Applying the Analytical Framework

A patient rights perspective on the Commissioner's jurisdiction is generally positive. The Code is consumer-centred and the Commissioner's processes are designed with consumers in mind. The overwhelming majority of complaints that reach the Commissioner are resolved without formal investigation. That said, investigation by the Commissioner can delay more formal discipline before the HPDT or HRRT, as well as putting patients through a duplicate process which arguably adds little when charges are to be brought. The Commissioner's jurisdiction can also function to block patients' access to more punitive sanctions which, in some cases, may be required to heal a particular person's experience of the doctor-patient relationship.

This paper considers that the Commissioner's jurisdiction is generally damaging to the ethic of professionalism. While it is true that the Commissioner's opinions provide opportunities for learning and professional self-improvement, anecdotally this is not how they are perceived. Particularly damaging may be individual doctors' experiences of the investigative process, the standards applied by the Commissioner, and the way in which opinions are publicised.

There is also no evidence that the Commissioner has a widely felt positive impact on patient safety/error prevention. While the subjects of an investigation are likely to be affected, it is possible the same outcomes could be achieved through, for example, internal investigation by a DHB. This paper suggests that the impact of the Commissioner's opinions and other educational activities (whether they change the behaviour of doctors generally, and/or the health care systems within which doctors work) ought to be subject to further research.¹⁶⁸

The Commissioner's impact on therapeutic relationships also warrants further investigation. This paper suggests that, provided (a) avenues exist for vindicating patient rights where resolution of a complaint cannot be achieved; (b) clear boundaries exist beyond which the imperatives of harm prevention and professional discipline take over; and (c) complaints remain an opportunity for future error prevention, the primary focus should be on restoring the therapeutic relationship.

V A Broader Perspective

A Existing Proposals

Various suggestions for reforming the existing regulatory framework are made from time to time. The Cull Review proposed combining several functions into one institution that would receive complaints, ensure compensation, investigate and discipline. Wayne Cunningham carried out a cross-sectional survey of randomly selected doctors to develop a proposal for change. He concluded that there was support for a 'complaints tribunal' providing "a single point of entry for all complaints, and which uses a

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¹⁶⁷ *Royal Australasian College of Surgeons v Phipps* [1999] 3 NZLR 1 (CA) at 12.

¹⁶⁸ Refer to Deanne Wong "The Health and Disability Commissioner and the development of the complaints resolution process" (Master of Public Policy Research Essay, Victoria University of Wellington, 2007) at 74–77.

process that is transparently appropriate for both doctors and complainants."¹⁶⁹ Cunningham's survey identified the desirable characteristics of the proposed complaints tribunal as being:

- Be the point of entry for *all* complainants
- *Be capable of rapid response to a complaint*
- Provide a safe environment for dialogue and mediation between complainants (and their advocates) and doctors (and their advocates)
- Be based on rights and responsibilities of *both* parties
- Be capable of rapidly resolving complaints lacking in substance, or malicious or vexatious complaints
- Seek to improve the delivery of healthcare, being able to discriminate between failings attributable to medical (healthcare) systems, error in the practice of medicine, or of wrong-doing
- Be aware of the limitations of medicine
- Consist of members or appointees who are properly trained and funded, appropriately experienced, and whose judgments are seen as being fair and appropriate
- Not composed ad hoc
- Be grounded and competent in the field in question
- Be capable of seeking improved outcome for the patient
- Be independent of the influence of the media

As noted above, Manning has suggested liberalising access to the HRRT.¹⁷⁰

Jonathan Coates has proposed creating a "genuinely non-punitive environment" by legislating a new and higher statutory threshold before there can be a punitive response to deviations from acceptable standards of care.¹⁷¹ The HDC Act would also be amended to apply this new standard to the Commissioner, in conjunction with other changes designed to make the Commissioner focus more on error prevention.

B Tentative Suggestions

This paper also makes tentative proposals for reform which take into account the analytical framework applied to the Commissioner's jurisdiction, and the need to strike a balance between the potentially different world-views of different stakeholders. Were these reforms to be implemented, some amendment would also be required to the HDC Act so that the Commissioner's functions and purpose remained aligned with its modified role in the regulatory framework.

The suggestions are:

- (a) A transparent and clear test for determining what type of conduct justifies referral to the MCNZ for reasons of safety or professional discipline is articulated (in legislation if necessary). This is similar to one of Coates' proposals.
- (b) The Commissioner remains responsible for receiving and triaging all complaints. Following preliminary investigation and triage, all complaints about conduct above the new threshold are referred to the MCNZ. All other complaints are subject to a process of resolution/conciliation

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¹⁶⁹ Wayne Cunningham "The medical complaints and disciplinary process in New Zealand: doctors' suggestions for change" (2004) 117 NZ Med J 974.

¹⁷⁰ Manning, above n 49.

¹⁷¹ Coates, above n 81, at 384.

facilitated by the Commissioner and designed to heal the doctor-patient relationship. (Patients who have experienced conduct which justifies sanction are more likely to be seeking a punitive outcome and less receptive to resolution/conciliation. It is also appropriate that serious conduct is investigated and prosecuted in a forum which has appropriate procedural safeguards.)

- (c) Only if resolution/conciliation has been attempted and failed will the complainant have the option of requesting an investigation (funded by the Commissioner). Provided the same conduct has not been referred to the MCNZ, at any stage following failed resolution/conciliation a complainant will be able to take a claim in the HRRT.
- (d) The Commissioner's powers to name parties would be abolished. The resolution/conciliation process would also be without prejudice and communications within it protected.
- (e) The Commissioner would work together, and share data, with the Health Quality and Safety Commission in relation to every complaint.
- (f) The Health Quality and Safety Commission would take on an additional function, similar to the regulator under the Health and Safety in Employment Act 1992. It would police the systems within which doctors work (potentially with powers to prosecute organisations). This would create an enforceable expectation at the employer level of safety culture and open disclosure.

In other words, the Commissioner's jurisdiction would assume a therapeutic focus. Serious conduct would be taken out of the jurisdiction to be dealt with by the MCNZ. Where resolution/conciliation failed, complainants would be able to access either an investigation by the Commissioner or the HRRT at their election. All complaints would feed into the Health Quality and Safety Commission, so providing opportunities for error prevention. A systems approach to patient safety would be promoted by expanding the Health Quality and Safety Commission's functions to include enforcement as well as promotion.

VI Conclusion

Medicine is an environment where some errors will always occur:¹⁷²

Health care is an unusually complex system. Some features that predispose to errors and aggravate their consequences coexist and interact to a degree that is seldom found in other human endeavours. ...

Errors are intrinsic to normal cognitive processes. Moreover, an error thought to be preventable in an individual case may, in fact, be statistically inevitable in the career of a physician. ...

It is also a profession that, understandably, is subject to significant regulation. It can be argued that the three main pillars of such regulation are patient rights, safety/quality and discipline. The Commissioner is the primary institution through which patient rights are affirmed and protected. The role played by the Commissioner also intersects with (or overlaps) other parts of the regulatory framework and other interests, such as the trust which underpins therapeutic relationships. William B Runciman and Alan F Merry have written that:¹⁷³

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¹⁷² William B Runciman and Alan F Merry "Error, Blame and the Law in Health Care - An Antipodean Perspective" (2003) 138 Ann Intern Med 974.

¹⁷³ Ron Paterson "Complaints and quality: handle with care" (2004) 117 NZ Med J 970.

Complaints offer a window of opportunity to improve health services. However, emerging evidence shows that complaints are not necessarily the treasure trove that quality improvement gurus would have us believe. Instead of providing reconciliation and closure, complaints can have toxic effects on patients and doctors.

This paper asked whether the Commissioner's jurisdiction was fit for purpose. In addressing this question, the importance of understanding the *purpose* and its relationship with the different interests and perspectives involved has emerged. This paper suggests that the purpose of the Commissioner's jurisdiction should be revisited, in conjunction with making some changes to how complaints about doctors are dealt with. It is suggested this may benefit doctors and patients, as well as the systems and workplaces which provide the context within which doctor-patient relationships take place.

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VIII Appendix

Opinion	A	B	C	D	E	F	G
<i>Report on Dr B, General Practitioner and a General Practice</i> (Health and Disability Commissioner, Case 12HDC01483, 12 July 2013)	✓ (in-house)	✓	X	X ("more likely than not" at [59])	X	Named to MCNZ and DHB	4(1) - Missed diagnosis of bowel cancer / failure to investigate differential diagnosis of bowel cancer.
<i>Report on Dr D, Obstetrician and a District Health Board</i> (Health and Disability Commissioner, Case 11HDC00515, 11 July 2013)	✓	✓	✓ (colleague)	X	X	Named to MCNZ and professional body	4(1) - Missed diagnosis of foetal growth restriction / decision not to monitor more closely or deliver earlier.
<i>Report on Dr A, Psychiatrist and Southern District Health Board</i> (Health and Disability Commissioner, Case 11HDC01072, 9 July 2013)	✓	✓	✓	X ("balance of probabilities" at [11])	X	Named to MCNZ	No breach
<i>Report on Dr C, General Surgeon and Capital and Coast District Health Board</i> (Health and Disability Commissioner, Case 09HDC01932, 28 June 2013)	✓	✓	X	X	X	Named to MCNZ and professional body	4(1) - Failure to adequately assess mental suitability for surgery / failure to consult psychiatrist.
<i>Report on Dr B, Dermatologist and a Skin Cancer Detection Company</i> (Health and Disability Commissioner, Case 11HDC00700, 28 June 2013)	✓	✓	X	X	X	Named to MCNZ, DHB and professional body	4(1) - Missed diagnosis of melanoma. 4(1) - Failure to recommend excision of lesions.
<i>Report on Southern District Health Board and Dr B, Surgical Registrar</i> (Health and Disability Commissioner, Case 11HDC00710, 28 June 2013)	✓	✓	X	X	X	Named to MCNZ	4(1) - Prescribing error / failure to check appropriate dosage of methadone. 4(5)
<i>Report on Dr B, Plastic Surgeon</i> (Health and Disability Commissioner, Case 11HDC01438, 21 June 2013)	✓	✓	X	X ("more likely than not" at [5] and [70])	✓ (in favour of doctor)	Named to MCNZ, DHB and professional body / Performance assessment	4(1) - Substandard treatment of post-operative infection. 6(1)(f) 4(5) 4(2)
<i>Report on Dr D, General Practitioner; Dr E, General Practitioner; and a Medical Centre</i> (Health and Disability Commissioner, Case 12HDC00203,	✓ (in-house)	✓	X	X	X	Named to MCNZ and DHB / Performance assessment	4(1) - Failure to take reasonable steps to follow up referral.

Opinion	A	B	C	D	E	F	G
21 June 2013)						Named to MCNZ and DHB	4(1) - Failure to take reasonable steps to follow up referral.
<i>Report on West Coast District Health Board and Dr B, Physician</i> (Health and Disability Commissioner, Case 10HDC01344, 20 June 2013)	✓	✓	X	X	X	Named to MCNZ	No breach
<i>Report on Dr B, General Practitioner</i> (Health and Disability Commissioner, Case 12HDC00518, 13 June 2013)	X	-	X	X	✓	Named to MCNZ, DHB and professional body / Director of Proceedings	4(2) 2
<i>Report on Dr B, General Surgeon; Dr C, General Surgeon; and a District Health Board</i> (Health and Disability Commissioner, Case 10HDC00950, 12 June 2013)	✓	✓	✓	X	X	Named to MCNZ and professional body / Performance assessment	4(1) - Decision that symptoms did not require immediate surgery.
						Named to MCNZ and professional body / Performance assessment	4(1) - Decision that symptoms did not require immediate surgery.
<i>Report on Bay of Plenty District Health Board; Dr C, Physician; and Dr D, Medical Registrar</i> (Health and Disability Commissioner, Case 10HDC00855, 30 April 2013)	✓	✓	X	X ("more likely than not" at [167])	X	Named to MCNZ and professional body	4(1) - Missed diagnosis of incarcerated femoral hernia.
						Named to MCNZ and professional body / Performance assessment	4(1) - Missed diagnosis of incarcerated femoral hernia (including substandard investigation and poor communication with responsible consultant). 4(2)
<i>Report on Dr B, General Practitioner</i> (Health and Disability Commissioner, Case 11HDC00237, 26 March 2013)	✓ (in-house)	✓	X	X ("balance of probabilities" at [102], [103], [109], [115] and [120]; "more likely than not" at [118])	✓	Named to MCNZ, DHB and professional body / Performance assessment / Director of Proceedings	4(1) - Failure to take reasonable care when prescribing codeine. 4(2) 4(2) 2

Opinion	A	B	C	D	E	F	G
<i>Report on Dr B, General Practitioner</i> (Health and Disability Commissioner, Case 11HDC00843, 19 March 2013)	✓ (in-house)	✓	X	X	X	Named to MCNZ, DHB and professional body / Performance assessment	4(1) - Missed diagnosis of bladder cancer / failure to investigate differential diagnosis of bladder cancer.
<i>Report on Dr A, Medical Practitioner and a Medical Centre</i> (Health and Disability Commissioner, Case 10HDC01250, 22 February 2013)	✓ (in-house)	✓	X	X ("more likely than not" at [105])	✓	Named to MCNZ and DHB / Performance assessment	4(1) - Missed diagnosis of prostate cancer / failure to take reasonable steps to follow up tests. 4(2) 4(5)
<i>Report on Dr C, General Practitioner and an After Hours Clinic</i> (Health and Disability Commissioner, Case 11HDC00871, 11 December 2012)	✓ (in-house)	✓	X	X	✓	Named to MCNZ, DHB and professional body / Performance assessment / Director of Proceedings	4(1) - Failure to examine vital signs / examination that was not clinically indicated (in breach of sexual boundaries). 6(1)(e) 7(1) 4(2) 6(1) 7(1) 1(1) 4(2) 4(4) 4(5)
<i>Report on Dr C, Psychiatrist</i> (Health and Disability Commissioner, Case 10HDC01018, 26 November 2012)	✓	✓	X	X ("balance of probabilities" at [160]; "more likely than not" at [169], [176] and [192])	✓	Named to MCNZ, DHB and professional body / Performance assessment / Director of Proceedings	4(1) - Failure to provide therapeutic relationship (in breach of sexual boundaries). 2 4(2) 4(2) 4(4)
<i>Report on Dr C, Orthopaedic Surgeon; Ms D, Registered Nurse; Ms E, Registered Nurse; and a Private Hospital</i> (Health and Disability Commissioner, Case 10HDC00158, 14 November 2012)	✓	✓	X	X ("more likely than not" at [235])	✓	Named to MCNZ and professional body	4(1) - Failure to conduct emergency surgery as soon as reasonably possible. 4(2) 4(5)

Opinion	A	B	C	D	E	F	G
<i>Report on Bay of Plenty District Health Board and Dr C, Psychiatrist</i> (Health and Disability Commissioner, Case 10HDC00805, 1 October 2012)	✓	✓	X	X	X	Named to MCNZ	4(2) 4(5)
<i>Report on Canterbury District Health Board; Dr E, Consultant Neurosurgeon; Dr F, Neurosurgical Trainee/Registrar; Ms I, Registered Nurse; Ms J, Registered Nurse; and Ms K, Registered Nurse</i> (Health and Disability Commissioner, Case 09HDC01565, 5 September 2012)	✓	✓	X	X	X	Named to MCNZ	No breach
						Named to MCNZ	No breach

- A If an expert had been engaged to provide advice about whether a doctor had breached right 4(1) of the Code ("Every consumer has the right to have services provided with reasonable care and skill")
- B Whether the Commissioner's opinion was consistent with any advice received from an expert engaged by him.
- C Whether the doctor submitted any independent expert evidence.
- D What, if any, comment was made about onus/the burden of proof.
- E Whether the Commissioner made a material factual finding that was in dispute between the complainant and doctor.
- F What follow-up actions were taken.
- G Whether a doctor was found to have breached right 4(1) of the Code and, if so, how.