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OUR HANDS ARE TIED: THE COMPLAINTS PROCESS FOR PSYCHOLOGISTS UNDER THE HEALTH PRACTITIONERS COMPETENCE ASSURANCE ACT (HPCAA)

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Abstract

This research endeavours to understand and describe the dissatisfaction of psychologists with the complaints process administered by the Psychologists Board under the Health Practitioners Competence Assurance Act 2003 (HPCAA). This issue was raised in previous research[1] that sought opinions of psychologists within the Family Court regarding changes to the Care of Children legislation. The issue was of sufficient import to be self-reported by psychologists even when it was not part of the original interview questions. The purpose of this research is therefore to develop on discussions and consultations that followed that research, to consult those working with the psychologists' complaints system and other bodies operating within the HPCAA. The research focuses particularly on whether the issues raised relate to the process or to the legislation. Consideration is given to whether the introduction of an early resolution process into the Act is feasible and preferred. The research also asks whether there are other amendments that the various bodies would like incorporated should the Act be amended in the future. In order to determine this, it is necessary to firstly understand how the HPCAA was developed and how it appears in the regulatory environment. Secondly, it is necessary to consider the legislative environment to determine whether the legislation needs improvement. This is done by contrasting the legislation with that of another professional body, in this case the Law Society, in terms of the Lawyers and Conveyancers Act 2006. Health complaints can also be lodged with the Health and Disability Commissioner, so that process and legislation[2] are considered as well.

[1] Debra Ridgway "Principles and Practice of Psychological Reporting in the Family Court" (LAWS389 Research Essay, Victoria University of Wellington, 2013).

[2] Health and Disability Commissioner Act 1994.

Thirdly, how the HPCAA is administered with regards to the complaints process by the Psychologists Board is considered, along with two other Boards operating under the same Act for comparative purposes. Within the research the bicultural considerations of the process are also considered, with particular focus on the restorative process. Finally, where possible the research considers other dispute resolution methods(ADR). This ADR may require specific amendments to the HPCAA.

Word length

The text of this paper (including abstract, table of contents, footnotes and bibliography) comprises 49,903 words.

Subjects and Topics

e.g. Health sector legislation, or

Complaints process for psychologists or

Health Practitioners Competence Assurance Act 2003 or

Complaints process for lawyers or

Lawyers and Conveyancers Act 2006.

Chapter 1 Identifying the Problems: Complaints about the Complaints Process Reported by Psychologists

I *Background*

This research follows an earlier paper which involved interviewing psychologists working within the Family Court. During the interview process it became clear that the majority of psychologists spoken to were dissatisfied with the complaints process, as the issue was raised by interviewees even when initially the research interview questions did not relate to that issue. This developed into a discussion at the New Zealand Psychological Society conference followed by consultations between the New Zealand Psychologists Board (NZPB) and psychologists working in various parts of the country within the Family Court system. The report that resulted from those consultations[3] indicated, with regard to a number of issues raised by psychologists, NZPB felt constrained by the terms of the Act as to what it could legally do to address those issues. This research aims to go a step further and see if the constraint arises out of the complaints process or the legislation.

I worked for the New Zealand Psychological Society for six years and during my time there I developed an interest in the work done by psychologists. The anecdotal stories I heard from psychologists have stirred my interest in this area of law as it is relatively under-researched.

This research uses interviews to provide information that guides the theory whether it is the legislation or its interpretation that needs amendment, with potential legislative changes that may be identified as desirable by those who operate under the HPCAA.

[3] Steve Osborne Consultation Document - "Concerns raised in regard to the Board's management of complaints" (6 October 2013).

II *Introduction*

This thesis is therefore about the complaints process for psychologists in New Zealand. The purpose of this investigation is to determine if improvements can be made to the process or accommodated in the legislation so as to improve outcomes not only for psychologists and others operating under the Health Practitioners Competence Assurance Act 2003 (HPCAA) but also for those who are making the complaints (complainants).

A Hypotheses

The focus of this thesis therefore is to consider three hypotheses and to determine if there is any improvement to be made in the legislation underlying the complaints process in the HPCAA.

Hypothesis 1 - Non-legislative changes that could be made to alleviate difficulties in the complaints process for psychologists. (Process)

Hypothesis 2 - Legislative changes that could alleviate difficulties in the complaints process for psychologists. (Legislation)

Hypothesis 3 - A combination of the above hypotheses. In my opinion, it is likely that a number of issues raised could be managed either by legislative or non-legislative changes. To include this hypothesis at every stage leaves the issues too amorphous to be useful in the study and where the issue could be either, then the discussion is managed as a non-legislative change as that is the easiest remedy, except in some cases where the issue may need both remedies and therefore included in the discussion of both process and legislative changes. Hypothesis 3 by its virtue of inclusiveness lends itself more to a conclusion than a useful method of categorising issues.

The purpose of this thesis thus is to consider the complaints process and the legislation to see if it is possible to determine where issues arise and if any improvements can be made to either process or legislation.

B Roadmap

The thesis firstly identifies the issues with the complaint process that need consideration and determines whether the issue relates to the process being used or to the legislation. Once the issues are identified consideration is given to how the New Zealand legislation compares to similar international legislation and the contents of the New Zealand legislation. The thesis then reports on interviews with persons associated with governing bodies under the HPCAA, the Health and Disability Commissioner Act and the Lawyers

and Conveyancers Act. The interview questions endeavoured to give greater insight into the workings of the complaints process. The thesis concludes with a summary of the issues and suggests recommendations for their resolution where possible.

III *Research Methodology*

Research paradigms are described in the human and social sciences as a way to help understand the world. Creswell says "They advance assumptions about the social world, how science should be conducted, and what constitutes legitimate problems, solutions and criteria of proof".[4]

The study develops from the concerns identified taking a two-pronged approach. Firstly the study investigates the legislation under which the Boards operate, and comparative laws both internationally and in New Zealand. Secondly the study presents perspectives on the process, from the understanding of the law and expectations to improvements to the HPCAA and the current issues that have already been raised in previous reviews but not implemented.

Thus this research required the use of two methodologies as applied to the two disciplines of law and psychology respectively, with quantitative and qualitative methods being used for the legal aspects and qualitative methods for the interviewing of people. As literature points out there is much controversy over the purity of these methods[5] and there is some overlap in approach for both topics.

The qualitative approach used for the review follows some of the "quantitative assumptions" in terms of the reality being separate from the researcher and epistemologically the researcher being independent from the review, which should result in value-free and unbiased results. Some impurity arises in the methodological assumptions in so far as the deductive approach is being inverted to the inductive approach and the idea is not so much to identify cause and effect but rather to identify categories during the research process. However, the study does not depart far from

[4] John W Creswell *Research Design: Qualitative and Quantitative Approaches* (Sage, California, 1994) at 1.

[5] Ibid.

quantitative design in so far as it seeks to gather generalisations that can lead to predictions, explanations and understanding. It may, however, also suffer from quantitative failure in terms of accuracy and reliability as replicating the study and validity is difficult because of the researcher's interpretation that has to overlay the category assumptions made. The information was gathered by way of interviews with staff from the Psychologists Board, the Dental Council, the Medical Council and the Law Society as well as other contributors to the process. The interviews and main questions asked of the interviewees were approved by the University Human Ethics Committee[6]. The interviewees for the most part agreed to have the interviews taped and transcribed but requested that they only be recognised by organisation unless otherwise agreed.

Similarly the qualitative assumptions used in the interviews are impure. However, they contain more of the recognisable features of the "qualitative assumptions" where the reality described is subjective and epistemologically the researcher interacts with the research and some value-laden bias is expected. The methodological assumptions of inductive thinking will exist but the emerging design categories may be influenced by the results and categories derived in the reviews. The accuracy and reliability are able to be verified through the interview reports but are still subject to an inherent bias that is not compensated for in this study, but may be mitigated by using some Likert scale[7] questions within the interview to standardise at least some of the responses.

A limitation in determining causality in the conclusions is mitigated as far as possible by finding in the data, where possible, the links between cause and effect.

IV *Identification of issues to be addressed*

There is no definitive list that can be used for reference for the purposes of this study. The issues are therefore identified by interpretation of interview comments and previously existing discussion papers. As the issues are identified below there is a short-hand title attributed to the issue, as a handle for developing the list although some of the terms used are not explained until later after all the issues are canvassed.

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[6] Application number 0000021853

[7] S A McLeod "Likert Scale" (2008). Retrieved from http://www.simplypsychology.org/likert-scale.html

To facilitate further considerations when an issue is identified and given a short title the section for each source will conclude with a list of the identified issues in their considered hypothetical category i.e. process or legislation, while still acknowledging that the issue may truly belong to both categories.

V *Self-Reported Comments on the Complaints Process by Psychologists and Lawyers in Previous Research*

In previous research conducted in 2013, I interviewed 6 psychologists and 5 lawyers about changes in the Family Court legislation with particular reference to how the Family dispute resolution changes would affect psychological reporting in cases. While conducting these interviews the initial psychologist interviewees started reporting their dissatisfaction with their complaints process. I followed this up in the later interviews and while not everybody commented, there was sufficient information to support further research.

The comments about the complaints process were not canvassed in the previous research paper as it was not the focus of that project. However, it provided the genesis of this thesis and so I have taken as a starting point the comments received with the intention of considering each comment and then attempting to categorise the issue(s) raised in each comment, where comments were repeated by psychologists or lawyers then just the best representative comment is recorded. This provides a starting list for the issues identified to be addressed in the research.

In summary, the comments revealed that there were concerns that the complaints detracted from their work and were increasing in frequency. Psychologists reported that the process could take two or more years before resolution and they were subject to double jeopardy under both the Code of Ethics[8] with their Board[9] and the Code of Rights[10] with the Health and Disability Commissioner[11]. The court was sometimes helpful in responding that it found no grounds for complaint or even in pre-empting a

[8] The Psychologists Board, the New Zealand Psychological Society and the College of Clinical Psychologists *Code of Ethics: for Psychologists working in Aotearoa/New Zealand* (The New Zealand Psychological Society, Wellington, 2012) http://www.psychology.org.nz/Code_of_Ethics

[9] Ibid.

[10] The Code of Rights http://www.hdc.org.nz/the-act--code/the-code-of-rights

[11] Health and Disability Commissioner Act 1994

complaint, for example where Judge DA Burns said he did not accept the criticism being levelled at the psychologist (and every other professional involved): [12]

> "A full opportunity was given for him to obtain a critique, but having seen hundreds of psychologists' reports in my career as a specialist Family Court lawyer and as a Family Court Judge the methodology adopted by the psychologist was normal and routine. The criticism of time is either inaccurate or de minimis and I simply do not accept that she approached her task with any form of pre-determination or bias."

This type of response does not always occur however, and a gap is created leaving difficulties when the case has been heard but the complaint is not raised by a party with the Court until after the case is settled, requiring the complaint to then go through the Psychologists Board.

The lawyers generally reported satisfaction with their complaints process administered by the Law Society, finding it simple and reasonably quick with resolution reached in approximately four months.

Some comments made by the interviewees are very revealing at an anecdotal level and help to identify issues that may are considered further in this research:

Comments made by psychologists include:

A Psychologist 1

- *"There is always fear of complaint."*
  Comment: This raises the issue of how complaints are processed and are addressed as part of the concept of therapeutic jurisprudence.

B Psychologist 2

- "*If a party in the Family Court complains then it goes to the Court, who decides whether they will deal with the complaint. Sometimes the Judge deals with the complaint at the hearing by way of cross-examination. At other times an*

[12] *MJM v SM* FC FAM-2005-001937 12 March 2008 at 29 (xvi).

Administrator Judge hears the complaint and reads the report then decides whether there is a case to answer and if not then the complaint goes to the Psychologists Board… I am aware of one person in the process who had the Court saying there is no problem, the HDC (Health and Disability Commissioner) said there is no problem, but the Board is still holding on to it and the psychologist has been put through the wringer."

Comment: This comment indicates the psychologist's frustration with the multiple authorities hearing a complaint, a frequently perceived difficulty in a system that has many complaint directions. It has been described by some psychologists as a double-jeopardy because they are effectively tried multiple times for the same complaint.

- *"I understand that the Board is there to protect the public but I am wondering about the process as it is incredibly stressful, emotionally draining, takes time, funding, needs a lawyer, and time to go through paperwork and write responses."*
  Comment: This quote raises issues as to time and the therapeutic jurisprudence of the process.

- *"Please ask if it is possible if the professional bodies can liaise with the Board to see if the process could be more streamlined so it is not so stressful for the Psychologist. Because a lot of these complaints - they come from people with personality disorders, from left field and there are no boundaries on the complaint, it can be long after the fact, it can be about something the psychologist said at the hearing, they are open ended."*
  Comment: This quote identifies a number of issues like the amount of time taken, the type of complainant, the nature of the complaint and the unlimited time that a complaint can be brought in.

- *"There are more complaints now than there were. At the last Family Court Associates meeting the Administrative Judge, Judge Walsh said they are seeing an increasing wave of complaints against personnel in the courts, not just psychologists…The complaints are coming from worrying quarters and they are being taken seriously when they should not be but cause a hold up in Board process and in how they are dealt with."*

Comment: Again this quote raises the question of the type of complainant and whether there should be another way to deal with them, which is where the proposed ADR process may occur, as well as the time that it takes for a complaint to progress.

- *"People have to wait for 12 to 18 months to hear the outcome. And that is 12 to 18 months where the Court knows you have a complaint and they are going to be careful how much work they give you in that period"*
  Comment: This quote again speaks to how long the process takes and the impact it has on the practitioner. It raises therapeutic jurisprudence issues.

- *"At a meeting between the Board and Judge Boshier (former Principal Family Court Judge), I spoke as practitioner and raised the case where it was necessary to look at the status of a Court Report in a complaint, I wanted the report as part of the review but the report belongs to the Court, is confidential and the Court does not want to release the report because they then have to get permission of parties. At least it was decided that the report would have the same status as seeking supervision for the purposes of responding to a complaint. Now the psychologist can show their draft report, and go through parts in detail but still have the opportunity to use the report in that way."*
  Comment: This quote shows a process issue that has now been changed which reflects that changes to the process may be as helpful or more so than changes in the legislation. This simple process change may also be useful to other practitioners under the HPCAA in terms of reclassifying access to information.

- *"There has been lots of discussion on lots of issues and I don't know if the Board really knows what to do with all this stuff."*
  Comment: This quote speaks to the grounds for this thesis as in terms of what should happen to recommendations and a subsequent change to the process has already been implemented in the hope that feedback from participants after the complaints process is complete will help refine the process.

- *"One area that I am aware of as a sticky point from a colleague who has been through the protracted complaints process with Board, and in a later interview*

with complainant they said that they didn't want to damage the psychologist they just did not like the report but it took 12 months to get that far."
Comment: This quote refers to both the length of time that the process takes and therapeutic jurisprudence because an earlier intervention could have answered the complainant's issue of not liking the report with an explanation of the contents.

- *"Anybody who works in this domain is worried about a complaint and it impacts on how reports are written. Has a workforce effect as it has a notorious reputation..."*
Comment: This quote speaks to how the process affects the profession.

C Psychologist 3

- *"We have to respond to both of authorities, which takes time and effort."*
Comment: Again pointing to the difficulties with double jeopardy, an issue is also foreshadowed with the process as there are two different standards the psychologist is being held to and so the response generally has to be tailored to the authority. Nevertheless, advice was received from the Psychologists Board that they would receive the same information as was sent to the HDC. However, it may be a lack of awareness on the part of the psychologist that this is acceptable or alternatively as intimated during the interviews that the psychologist feels it necessary to respond in full even from the initial stage as they may not get an opportunity to do so later in the process.

- *"The complaint is sometimes not taken anywhere because of sheer frivolous and litigious nature of them. And if not careful in case work and did not document things properly you can be tripped up even if it is an innocent omission and the complaint has no merit you could still be censured, even if not part of the complaints process."*
Comment: This is a curious anomaly in the process in so far as the Psychologist Board's Professional Complaints Committee has the ability to consider grounds beyond the original complaint of their own accord. This approach raises questions as to the fairness of the process and the difficulty of dealing with unlimited complaints.

- *"The Board and HDC are very fair no two ways about it but it is a stressful process for most practitioners and it goes on for some time even when you are innocent."*

  Comment: This quote reflects that psychologist, in this case, did not feel as though they were unfairly discriminated against in the process but recognises the difficulty with stress in regards to therapeutic jurisprudence and with the length of time the process takes.

- *"If a psychologist is found wanting it doesn't automatically mean that you will get struck off, often it is just more training. Few cases with real outrageous behaviour. A technical issue arises if HDC finds guilt they would have to refer it back to the Board because they can't do any further training, deregistration etc."*

  Comment: This psychologist raises an interesting process issue of how the legislation is used to give access to other penalties where it is lacking in legislation.

D Psychologist 4

- *"I have been disappointed in Court responses to complaints, the Board passed the complaint to HDC and Court got a letter from HDC saying they won't deal with it because it is Family Court. Because the parties settled ... I have to respond but without any supporting report from the Family Court. I had always been led to believe that if the Family Court was able to say they asked for a report as a client and was helpful then those issues that had been identified in the complaint were identified and discussed at the Hearing then it has been dealt with and that would resolve the matter."*

  Comment: This psychologist identified another anomaly in the process where the process has not worked as normally expected. The psychologist has effectively asked for more flexibility in the process as to how information could be obtained and used. This is an item worth considering but it must be borne in mind that this type of anomaly is unlikely to occur frequently and therefore will not warrant legislative change and may not be addressed quickly in process changes. The author recognises that there are difficulties when making recommendations that affect multi-agencies and these types of issues may never

be resolved as it can be very hard to deliver coordinated services in a multi-agency environment.

The lawyers interviewed with regard to the same research also gave revealing comments that show some of the contrasts that are legislatively or procedurally different from those faced by the psychologists.

These comments were made by the lawyers:

E Lawyer 1

- *"Self-represented litigants are a nightmare. One of them did complain about me, the Law Society rang me up and said a madman has written in about you so go through motions but there doesn't look to be anything. Then they rang me back and said "No, they don't even want a comment" from me."*
  Comment: This quote reflects some discernment being applied to the complaint before the full complaints process is engaged. There is nothing similar for psychologists.

- *"Complaints are a risk that you run with a disgruntled person on the other side. If a self-represented litigant and writes a long complaint with capitals the Law Society will go 'oh yes warning bells'. Lawyers have a new statute, and whole new formalised complaints process, 0800 number, brochures about how to complain and on website as they want to be open about the process. So in my mind whenever I send a letter/ email out I go is it okay for a Judge to see this and, if I would not be embarrassed then I would send it out."*
  Comment: again the lawyer reflects both an early discernment of the complaint and also a sense of comfort in the process, knowing what is expected. Because the psychologists have a much more complex process with few limitations they do not display the same level of confidence in the process.

F Lawyer 2

- "*Had one case where there was a psychological report and the Mother said she had complained to the Board, and as result had special hearing had to be held which lasted over a day, needed Counsel to assist who cross-examined the psychologist on the complaints laid by the Mother, it was a horrible experience. After all the explanations the Mother said she accepted the report and would withdraw the complaint from the Board and the Court. But was a power play on the part of the Mother, and it was awful for the Judge, the psychologist and lawyer and the other party."*

  Comment: This reflects the difficulty with the type of complainant and the effect that it has on both the psychologist and the Court process.

- *"If it could be dealt with in another way I am not sure. I am aware of parties filing complaints after proceedings. I suspect there are many as it is also happening to Lawyer for Child"*

  Comment: This again speaks to the type of complainants being a particular group of difficult people who find the threat of complaint to be beneficial in addressing their power struggle. This group is increasing.

G Lawyer 3

- *"Only anecdotally I am aware there have been increasing numbers of litigants who have complained about Psychologists. The problem is that good Psychologists doing the reports are for completely understandable reasons saying that they don't want to do that work anymore. A number of them have been on knife edge saying if there is one more complaint etc then I am not going to do it anymore."*

  Comment: This shows that even some lawyers are aware of the detrimental effect the complaints process has on psychologists and shows the need for consideration of therapeutic jurisprudence.

- *"It is possible that complaints will increase with self-represented litigants and those who don't understand what is involved. I know for myself when I am acting for a party there is a lot of explaining to be done for your client - about the process of the report. … The explanation needs to include that the psychologist is*

not there to accuse and that they need to cooperate with the process and then they get upset when they can't take it (the psychological report) away as they think it is theirs and they should be able to have it and an explanation of the report. If you don't have the lawyers there preparing people for the process there are going to be greater problems for the psychologists and more room for complaint as people just don't understand."

Comment: This reflects the increase in complaints and the type of complainant; and also that many complaints would be avoided if the complainant had a greater understanding of what the psychologist was doing. I have also heard psychologists saying that they wished that they could explain the report or process to the complainants but that there is no room in the process for that to occur. This an alternative early intervention strategy for dealing with complaints.

H Lawyer 4

- *"The Law Society deals fairly promptly with nuisance complaints even if genuinely held views, which they have right to do. Usually responded and closed within a few months and determine the result to take no further action. If every complaint got a rigorous process then that would bog down the system."*

  Comment: This reflects both a more efficient process as it takes less time than that complained about by psychologists but also recognises that the early intervention process helps to facilitate the process and that there is some discernment exercised when considering complaints.

I Conclusion

The issues specifically identified or perceived in the comments appear remarkably consistent and I have listed them in summary by the hypothesis category previously formulated:

Hypothesis 1 - Process

- time taken
- type of complainant e.g. litigious, vexatious etc.
- therapeutic jurisprudence e.g. added workload, stressful process

- fear of complaint affecting work i.e. workforce issues
- early intervention - discernment and/or mediation
- increasing frequency of complaints
- double jeopardy
- fair process
- access to information and the place of feedback
- costs

Hypothesis 2 - Legislation

- double jeopardy
- multi-directional referral of complaints i.e. multi-agency
- no boundaries to complaint
- no limitation of the scope of complaint
- no limitation on the time of complaint being brought
- early intervention process

In listing the issues without a doubt the most referenced issues in the comments were: length of time the process took, the type of complainant, and the need for therapeutic jurisprudence. However, these issues are carried forward to see if they recur in the other forums considered. They at least give a beginning to the investigation of how the complaints process works and what improvements can be made.

VI *Complaints discussed at the NZ Psychological Society Conference 2013*

In the same year as my original research there was an organic increase in the discussions about the complaints process, no doubt as a result of the increasing level of complaints and already identified issues. I was privy to some of these discussions as a result of my presence at the New Zealand Psychological Society Conference where a session was dedicated to the complaints process and raised similar issues that I had identified already from the comments above and introduced new concepts for further consideration.

The New Zealand Psychological Society is a voluntary membership organisation for psychologists. The Psychological Society has no involvement in the complaints process beyond offering group access to an insurance scheme, which provides legal advice. The Society may also facilitate contact with other psychologists who have been through the complaints process and who may provide emotional support during the process. The Society holds an Annual Conference and in 2013 there was a session at the Conference called "Professional Complaints: Issues, Personal Impacts, and Legal Considerations" chaired by Assoc. Prof Dr Neville Blampied with three presenters followed by a panel discussion of complaints about psychologists. Psychologists and academics self-select topics to be presented at the conference, although it is then screened through an academic process for robustness of research and presentation value.

The following presentations were part of the session on professional complaints and were for psychologists and therefore are more from a psychological perspective rather than a strictly legal perspective. They nonetheless offer insight into the issues arising out of the complaints process.

A Presentation 1 - Dr Freda Walker (Psychologist)

The first presentation was given by Dr Walker in the address titled "*The 'C' Word: Issues arising from professional complaints*". This presentation looked at issues that arose from a sample of complaints noting that the issues raised have implications for practitioners in general as well as those subject to a complaint.

In her address Dr Walker identified a number of issues from her personal experience as a well-respected practitioner. After years of practice she had been subject to 5 complaints in the past 8 years, mostly as a result of her work with ACC. None of these complaints went to a Tribunal and all were dismissed. However, she noted that complaints are seen within the profession as "shameful for psychologists" and "a taboo matter" that is not talked about, which makes it difficult to raise issues about problems with the process.

I have taken some liberty when considering Dr Walker's address in listing the issues she raised by hypothesis and attaching some of the categories that I have already identified. It is not intended to reproduce Dr Walker's address within this section but there are some key issues that have previously been alluded to that bear reiteration for the purposes of this research as they help formulate a response to the Hypotheses as well as additional issues not previously identified.

Hypothesis 1 - Process Issues

Dr Walker talks of an occasion where "*I undertook a file review, at ACC's request,... recommended that ACC lodge a complaint with the Board...a big mistake... Because I had not declared myself as a co-complainant with ACC, I left myself at having a complaint laid against me, which is what happened.*" - this statement may be considered a process issue in two parts. Firstly the mistake that Dr Walker recognised in not including herself as a co-complainant which can be seen as a learning matter. But the second process issue is more concerning in so far as it seems prima facie an unfair process where cross-complaints can be laid but are not necessarily recognised as such. This alludes to the type of litigant and the type of complaint being issues.

Dr Walker also talked about her experience with the legal advice she initially received in part a presumption of guilt before any substantive information was provided. She then said, *"Indeed, I felt that the lawyer would prefer the complaint to go to a hearing."* Another issue was with the written submissions that were sent to a Complaints Assessment Committee by the lawyer which were his own and had not been checked by her and which were factually incorrect. This may be an isolated issue with one lawyer or it could point to the need for further training for lawyers who are involved in these regulatory processes that are quite different from ordinary litigation. These issues may be

summed up as legal process issues and should be further considered in terms of recommendations to the providers of legal advice.

Dr Walker raises the issue that "the lawyers simply accepted the PCC processes even when there were significant breaches of natural justice that should have been challenged along the way". Natural justice is an issue that requires consideration.

Dr Walker also refers to issues with the type of complainant. She says it is important to "*make sure you know about the complainant. I am well aware that complainants can have a 'political' agenda from my previous work on the Psychologists Board*". She refers to a client who's main complaint was about changes that ACC was making to its management of claims. She goes on to say "*We were targeted for complaint, at least in part, as the frontline face of clinical opinion for ACC.*" She offered as this issue as advice for psychologists because as she discovered "*When I Googled the client, I discovered this person held a position on the National Executive of one of the provider groups that was openly and vociferously opposed to the systems changes within ACC at the time.*" She says that the lesson she learned is to "*find out as much as you can about the complainant and what their range of motivations may be.*" This exemplifies one of the key issues with the type of complainant and the fact that there is no pre-screening of the complainant.

Dr Walker also refers to another complaint wherein she says of the complainant "*her complaint was emotionally driven, requested financial compensation in two forms, was factually inaccurate, had limited substance, and was pretty defamatory*" and notes that "*the client refused to provide my review or any other source documentation to the Board*". This again raises the issue of the type of complainant but also the nature of the complaint and a further issue as to education of the public as to what a complaint will achieve because there is no provision for any sort of compensation in the process, although the Psychologists Board's website does state that they are "*not able to arrange refunds or compensation*".

Dr Walker also considers workplace issues which might be considered as part of the process asking that workplaces consider the "*vulnerability of psychologists*" when there are changes that are "*unpopular with consumers and providers*". She says that "*practitioners need to be buffered from unnecessary and heightened risk in such*

circumstances". This workplace issue also points to the issue of the type of complaint, whether there should be scope to initially assess the environment from which a complaint arises and consider the type of complaint before it is progressed.

Dr Walker references a case where a complaint arose from legitimately accessed supervision, which is a continuing competence requirement imposed upon psychologists. In this instance, despite her having obtained a signed release as a broad waiver for consultation from the client a complaint was laid citing a breach of confidentiality. This complaint raised a few issues, firstly with the public as an educational item as they should be made aware that all psychologists are obliged to undergo supervision and that, while the discussion is confidential as is the name of the client, there will be some discussion of the case and actions taken. When this issue was raised with the Psychologists Board, it was acknowledged that these types of complaints should not occur and that they had taken steps to ensure that complaints of this type would not be considered in the future.

Dr Walker then explained her experiences with Professional Conduct Committees (PCC). She questions the process whereby a PCC can be established in the absence of a complainant who had withdrawn a complaint. Dr Walker asked the question "*If the complainant has withdrawn in this way, who then was the complainant? The Board? Did that mean sending the complaint to the PCC was actually a competence check? If so, why did the Board not take that route explicitly? Lastly, how can any complaint be defended in such circumstances?*" She talked about a series of procedural errors such as a major error in the summary of the complaint provided by the Board to the PCC which affected the process, the lack of access to information and information provided that was inaccurate without time in the process to correct these errors and the misapprehensions that it created in the process. These are process issues that should be considered by the Board.

Dr Walker said that "*My experience of the PCC process is that the focus of the original complaint gets completely lost*", she said that "*most of the questions from the PCC had nothing to do with what the complainant had raised*". This raises the question of whether there should be some limits on the investigation or as such the complaint because Dr Walker noted that to answer all the questions required "*40 pages of written submissions" and felt that allowing the complainant to comment on all the issues in those submissions*

"widens the complaint out quite inappropriately because it muddies what should be a clear boundary between complaint investigation and competency check".

She says "*The PCC process, for me, was quite unsafe*" which alludes to therapeutic jurisprudence. She identified the procedure "*where natural justice is at the forefront was often lacking*" because PCCs can work to their own processes and she notes "*it seemed that they were made up along the way*" resulting in what her lawyer commented as the PCCs approach as "*it was quite* 'dismissive' *in regard to natural justice*". Dr Walker recommends that these errors could easily be remedied had the PCC accessed advice from a legal advisor in the matter, as the write-up indicated that they had not done so in this matter. The writer notes that legal advice is available to the PCC and while consultation is not mandatory, this may be considered as a remedy to improve process issues. Dr Walker also asks "*What orientation, training and quality assurance checks do PCCs have? And what are they taught about natural justice principles and taking legal advice?*" These are very valid questions as the PCC is constituted in legislation independently of the Board and while the Board provides guidance for its operation, the Board does not have any control over the process and quality of the PCC beyond having selected suitable persons who may serve on the PCC.

Dr Walker also recognises a difficulty in the process as the psychologist is required to demonstrate innocence rather than any burden of proof being on the complainant. The outcomes of complaint investigations which she describes as "*disempowering at best, frightening at worst*" are on their face a question of therapeutic jurisprudence but the writer notes that there are also arguments in law about the placement of the burden of proof on the defendant in civil matters where they are more likely to have access to information and with the civil standard of proof of on the balance of probabilities. These arguments are not canvassed further in this thesis.

Hypothesis 2 - Legislation

Dr Walker also references the difficulties with multi-agency referrals and the problem with double jeopardy that can end up more like "*quadruple jeopardy*". She talks about a case where a complaint to do with supervision was sent to the Psychologists Board, who referred it to the HDC who ruled that it should be referred to the Privacy Commissioner.

She said that "*It seems ironic, given that the complaint was about privacy that now the client's business was open to the Family Court, HDC, the Board, and the Privacy Commissioner*". She added that although the complaint was dismissed by the Privacy Commissioner it was obliged to advise the complainants that "*they are entitled to have the matter reviewed by the Human Rights Review Committee if they so chose*". This comment also touches on therapeutic jurisprudence because there is some question as to whether the complainant would have been aware when they laid the complaint exactly how far it would travel and the amount of information that would be released.

Dr Walker raises, as an aside, an important issue with legislation (Privacy Act 1993) that allows the complaint to travel in a summarised form and the fact that she was not given a copy of either the complaint sent from the HDC nor was she provided with the submissions to and from the complainant that were given to the Privacy Commissioner. To her this was "*totally contra to the rules of natural justice*" and she had "*taken the matter up with the Ombudsman who has advised that I would have to challenge these processes in the courts.*" I include this issue here because although it is in reference to the Privacy Commissioner, which is beyond the scope of the research, there needs to be some consideration of whether this practice is perpetuated by HDC and HPCAA.

Dr Walker refers to the complaints process saying "*A lot of professional energy is wasted, income is lost, and practitioners must suffer stress and distress that comes with defending any complaint no matter what its merit or substance. While I am aware that the Board is constrained by legislation, even the Law Society has introduced early intervention, across parties, in advance of complaint investigation in some cases.*" This missing piece of legislation is sought by psychologists and alternative dispute resolution is discussed in this research.

B Presentation 2

The second session was presented by Dr JaneMary Castelfranc-Allen (Psychologist) - "When pointing the finger becomes pointing the bone" which considered the issues arising from a specific complaint and also looked at the effects it had on the practitioner under complaint, but this paper was not available and no further consideration was given.

C Presentation 3 - Dr Donald Poirier (LLD)

The third session presented by Dr Donald Poirier (LLD Canada)- "The nature of professional complaints against psychologists before the Board and the Professional Conduct Committee - inquisitorial or adversarial procedure?" specifically looks at the processes used by the Psychologists Board and PCCs. Dr Poirier notes that while a lot has been written about the Health Practitioners Disciplinary Tribunal there is relatively little available on the process before it arrives at that level. In his paper Dr Poirier frames four main legal issues in relation to the process: "*preliminary issues (such as limitation periods, withdrawal of a complaint, res judicata and abuse of process); principles of natural justice (including the right to know the nature of the procedure, the right to information, the right to make comments at all levels of procedure and the right to an impartial panel); Inquisitorial v adversary procedures (presumption of innocence, burden of proof in disciplinary cases, legal characterisation of the procedure before the Board and PCC); and remedies (or lack thereof) available to the psychologist when a professional complaint is dismissed.*"

1 Preliminary Issues

a) Time Limitations

Dr Poirier recognises that disciplinary procedures are excluded from general limitation periods[13] unless specifically included in the Act and that the HPCAA, s173, had referred to "information for an offence against the Act may be laid at any time within 3 years after the time when the matter of the information arose."

Dr Poirier notes that there is no "limitation period for the Board, a Professional Conduct Committee or the Health Practitioners Tribunal to investigate or proceed against a health professional. He suggests a limitation of 10 years would be suitable because the Act allows the destruction of a psychologist's notes after 10 years. Further he suggests that "*Parliament needs to clarify its intention concerning the limitation period in allowing the Board, the Health and Disability Commissioner and/or a Professional Conduct Committee to receive complaints against health professionals and that the Board should adopt guidelines concerning the limitation period and not leave it to be decided on a case by case basis.*"

[13] Limitation Act 2010.

The HPCAA, s173, was subsequently amended on 1 July 2013 shortly after this paper was produced to state:

> "Time for filing charging document - Despite anything to the contrary in section 25 of the Criminal Procedure Act 2011, the limitation period in respect of an offence against this Act ends on the date that is 3 years after the date on which the offence was committed.
> Section 173: replaced, on 1 July 2013, by section 413 of the Criminal Procedure Act 2011 (2011 No 81)."

This amendment serves to clarify the limitation but is a miscellaneous provision and may be interpreted to be offences against the Act rather than a limitation on complaints being brought. It would certainly clarify matters if a specific complaints limitation period was included in Part 4 of the HPCAA.

b) Withdrawal of complaint

Given the earlier example of a case proceeding after the complainant withdrew. Dr Poirier argues that this allows the PCC "*unlimited authority to go ahead even if technically there is no complaint in front of them*" and recommends that "*the Board should adopt guidelines concerning the withdrawal of complaints ... so that everybody knows what the rules are in this regard.*"

c) Res judicata

This is the rule of law that "covers situations where a matter has already been judged". The rule exists to "avoid discrediting the judicial system in case a different decision would be rendered in a second proceeding". Dr Poirier suggests that if one body has reached a decision then no further action should be taken by another body because "although the principle applies to civil matters decided by the courts, the same reasoning should apply to disciplinary matters."

d) Abuse of Process

Dr Poirier also invokes the principle of "autrefois acquit" which is more commonly referred to as "double-jeopardy". He references the Supreme Court case of *Z v Dental Complaints Assessment Committee* where the Court finds that the principle "*does not*

inhibit institution of proceedings before a disciplinary tribunal".[14] The Court recognised the public interest in the nature of the disciplinary tribunal and the nature of the process as being different from the criminal court and therefore proceedings of that nature would not be an abuse of process[15]. However, this does not clarify whether complaints proceedings in similar organisations with similar powers e.g. HDC, Board PCCs and Privacy Commissioner, would constitute an abuse of process. Dr Poirier suggests that the Board should adopt guidelines to protect health professionals who have been acquitted in one forum against the same proceedings in another forum.

2 Principles of Natural Justice

In this section, Dr Poirier argues that despite the PCC being authorised to operate as it thinks fit as long as it keeps the parties informed and abides by the rules of natural justice that the Psychologist Board has some procedures in place that defeat the right to natural justice.

a) Right to know the nature of the proceedings

Dr Poirier addressed the ambiguity between the two avenues taken by the PCC in regards to complaints or competency checks. He notes that one of the recommendations that can be given by a PCC is that a competency check is undertaken and argues that had the practitioner been aware that the PCC was also considering competency when addressing a complaint then they would have submitted information in regards to competence as well as addressing the complaint. He recommends that either the PCC should allow the practitioner to present information concerning a recommendation for a competency check or the practitioner should always submit on competency matters even when the nature of the proceedings is about a complaint. The second recommendation is onerous in the extreme and would greatly burden the system to have to consider both the complaint and competency at each PCC hearing. The writer concurs that a guideline that allows for the PCC to advise that they are considering a competency check recommendation and gives time for the practitioner to respond at that stage is a better option.

b) Right to Information

Dr Poirier refers to examples given by the previous psychologists of occasions where they were limited to a summary of the complaint and where the complainant was represented by an organisation so that they could not determine who the original complainant actually was. He argues that the information available should include the

[14] *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1, (NZSC) at [122].

[15] Above n 12 at [133].

original complaint in full so that the psychologist is not at risk of failing to respond to some part of the complaint that is not included in the summary but is then addressed at the hearing and that it is necessary for the psychologist to know who the original complainant was despite representation from an organisation because the principles of natural justice include the right to cross-examine witnesses.

c) Right to make comments at all levels of procedure

Dr Poirier refers to one of the procedures of the Board wherein a précis of the complaint and response by the psychologist is presented to the Board for their decision on whether to proceed the complaint to a PCC. He notes that the psychologist is not given an opportunity to comment on the précis before it is given to the Board and uses the example offered by Dr Walker of the difficulties of correcting errors in the précis after the PCC has been constituted, and in fact if the errors had been corrected before the matter went to the Board then the decision to refer to a PCC may not have occurred. He suggests that had the principle of natural justice been followed part or all of the proceedings may have been unnecessary.

d) Right to an impartial panel and procedure

Dr Poirier gives examples of occasions where the appearance of bias could appear in how the PCC addressed matters including conflict of interest on the part of panel members and an acceptance of another complainant due to an interview being conducted in a workplace rather than on neutral ground. He reminds the PCC that it is necessary not only to avoid actual bias but even the appearance of bias[16].

3 Inquisitorial v Adversarial Procedures

Dr Poirier considers the application of the presumption of innocence, the burden of proof, the onus of proof by the Board and PCC.

He notes that while the presumption of innocence is a fundamental principle of law in these proceedings the psychologist feels obliged to prove their innocence. He suggests that guidelines be adopted that recognise this principle and that health professionals are presumed innocent until the charges are proven. The writer is not sure that this is an issue as it may address the psychologist's feelings but it may not affect the process.

[16] Philip Joseph *Constitutional and Administrative Law in New Zealand* (2nd ed, Thomson Ltd, Wellington, 2001) at 882.

The burden of proof is recognised as a "flexibly applied civil standard of proof"[17] but Dr Poirier recommends that "*the Board should clarify who has the burden of proving elements of the complaint for the benefit of both the complainants and the health professionals*".

Dr Poirier also raises the issue of the legal characterisation of the Board and PCC in which he argues that the legislation is contrary to all legal requirements in both common law and civil law jurisdictions and against the rule of law in so far as the legislation allows for the PCC "to adopt its own procedures"[18] where in almost every other legal situation the procedure must be known in advance of the proceedings.

D Summary of Issues identified from the conference proceedings

The issues specifically identified or perceived in the comments are consistent with those previously identified with some additional issues for consideration. Below are listed the additions to the previous list:

Hypothesis 1 - Process

- nature or type of complaint
- legal process issues
- natural justice
- workplace issues
- procedural errors
- limits to the investigation or complaint
- unfair process
- burden of proof

[17] Above n 12, at [115].

[18] Health Practitioners Competence Assurance Act 2003, s72.

- res judicata
- abuse of process

Hypothesis 2 - Legislation

- natural justice
- withdrawal of complaints

VII *Consultation document produced by the New Zealand Psychologists Board - "Concerns raised in regard to the Board's management of complaints"*

In response to the issues raised at the Conference and discussed above the Psychologists Board ("the Board") consulted with psychologists' at meetings held in Auckland to gather more information about the opinions of psychologists in relation to the complaints process. The Board then produced a summary document of the discussions which will be considered below. This document summarised the key issues complained about and gave the Board's response.

The key issues in the document were grouped under the following headings:

a) Inappropriate complaints are accepted by the Board

b) the process places excessive demands on the organisations involved

c) the process places excessive and/or unreasonable demands on the psychologist

d) the process takes too long

e) the psychologist is exposed to a sort of "double jeopardy" when a complaint is considered by more than one authority

f) the process is otherwise unfair to the psychologist

g) suggestions made for improvement

Within these headings a number of issues were grouped and given a response from the Board. It is not intended to reproduce the document here but there are some key issues that have previously been alluded to that bear reiteration for the purposes of this research as they help formulate a response to the Hypotheses.

The following paragraphs list the issues and responses grouped by hypothesis.

Hypothesis 1 - process issues

1) Inappropriate complaints - all complaints are considered if any allegation of misconduct or incompetence is made unless the complaint is frivolous or vexatious (in the legal meaning of those terms - this is understood to be a high standard and hard to meet).

2) Unlimited complaints - the Board allows complainants to keep adding more allegations as the process unfolds. The Board has received legal advice that they cannot refuse to accept further submissions as it would leave the process open to judicial review.

3) Excessive/ unreasonable demands on psychologists - the process requires a lot of work and there is no compensation for psychologists when complaints are not upheld. The process has been improved by the Board accepting the same submissions that were given to the HDC. But in practice the psychologist generally responds to the complaints separately and in full even before the initial submissions are considered. This could be improved by some streamlining of the process but not everybody uses the complaints forms provided. Minimisation of time expended could be done with the assistance of an experienced advisor who could be provided by the professional bodies but that is not yet available.

The complaints are often unwieldy due to the nature of the complainant. Again this is addressed through the use of forms and the recommendation of the use of the HDC advocacy service but these are not always used. Other process issues that may arise in

this area are around communication, expectations and the understanding that the mandate for the Board is for the protection of the public not to support the parties through the complaints process.

4) The process takes too long - there is always room for improvement and efforts are made to see where the process can be expedited.

5) The Board should obtain feedback from the parties after the process - this is being implemented in the process.

Hypothesis 2 - legislative issues

1) Time frame - there is no constraint under the HPCAA as to when a complaint must be laid but the Board does consider in its deliberations when the complaint is delayed to a point where it might disadvantage the psychologist.

2) Unlimited complaints - similarly there is no limitation on the nature of the complaint or complainant. As above it is considered in the deliberations.

3) Excessive demands on organisations - it is a waste of resources to have different bodies considering the same complaint. These organisations are mandated to consider matters from their own perspective and standards. It would be better if once the appropriate organisation had received a complaint and made a decision that no further action would be required by any other organisation e.g. if the HDC makes a decision then the Psychologists Board is not required to take any further action unless it is specifically recommended in the decision.

4) The process takes too long - the use of alternative dispute resolution has been suggested as a way of expediting matters but there is no mandate in the legislation that specifically authorises the Board to be involved in this process.

5) Double Jeopardy - the complaint is considered by multiple authorities. This is a requirement of the legislation.

This brief summary of the consultation document points to a variety of issues that may need to be addressed.

VIII *Summary and Conclusions*

This chapter has identified a number of issues for consideration in this thesis. In aggregating the issues under the headings of Process and Legislation it becomes obvious that some of the process issues arise out of or are also legislative issues. Hypothesis 3 then comes into play in an understanding that it is hard to say that all the issues belong in one or other category as some of the process issues arise out of legislative issues and may be remedied by changes in legislation, others may require legislative change but could be managed by process guidelines in the interim.

In order to summarise the issues, it may be helpful to list the process issues as items that may be resolved by further efforts of the Board or the two professional bodies, the NZ Psychological Society and the College of Clinical Psychologists. These are, as discussed, items like support for the psychologist in the process to reduce the excessive demands and assist with the process; future legal advice on additional complaints, the understanding of definitions of frivolous and vexatious; and any improvements that can streamline the process like the use of forms and advocacy for complainants, reduce costs etc.

The legislative issues appear to be quite specific and may be achievable by changes in the legislation. For example, the time may be reduced by an alternative dispute option, the type or nature of complaint might be limited or consideration given to the complainant. There might also be some prioritising or acceptance of a decision by one regulatory authority as binding on another, i.e. a case dismissed by the HDC requires no further consideration by the Board or a case dismissed by the Privacy Commissioner needs no further consideration etc.

The following list is a combined list of all the issues determined during the canvas by hypothetical category. A number of issues were repeated from the various sources with quite a lot of consistency.

However in order to facilitate further investigation in this thesis the matters identified from all of the sources were condensed by grouping similar comments/items into one heading and leaving outlier items, i.e. those that only had one reference or those that had been addressed in the discussion out, which resulted in a manageable list of issues for consideration. The final list arrived at was:

Hypothesis 1 - Process

- time taken
- type of complainant e.g. vexatious etc.
- type or nature of the complaint - includes inappropriate/ unlimited complaints and withdrawals
- therapeutic jurisprudence
- fear of complaint affecting work i.e. workforce issues
- unfair process including procedural issues and legal process issues - natural justice
- limits to the investigation or complaint
- Excessive/ unreasonable demands on psychologists

Hypothesis 2 - Legislation

- Complainants
- Time frame for complaints - statute of limitations
- Grounds for complaints and limitations on the scope of complaint
- double jeopardy and multiple authorities for referral of complaints
- natural justice
- no boundaries to complaint e.g. unlimited complaints and withdrawal of complaints
- Process time limitations in the Act early intervention process or alternative dispute resolution
- Excessive demands on organisations

Chapter 2 Theories underpinning the Complaints Process

I *Introduction*

The purpose of this chapter is to firstly describe some of the theories that underpin the complaints process and secondly to describe the meaning of some of the terms used in this research. The first part of this chapter canvases some consumer law arguments that are useful in considering the benefits and appropriate levels of regulation used for practitioners under the HPCAA.

II *Consumer Law*

In theory the complaints process is analogous to consumer law in that the legislation has public protection as its purpose. This can be shown by way of how the legislation relates to consumer law. Once the analogy has been established it is then possible to use consumer protection theory to consider the levels of legislation.

The seminal case on consumer law was brought in Scotland, where Ms Donoghue found a snail in her bottle of ginger-beer, the case of *Donoghue v Stevenson*[19]. While this case discusses, for the most part, the tort of negligence, the relevance of the case was that it was the first time a consumer had brought a successful case against a manufacturer and the House of Lords recognised that the manufacturer owed the consumer a duty of care. This case, therefore, opened the field for development of law in this area.

The 'duty of care' is still widely debated and the points that are usually at issue and will be discussed in this context include:
a) who is the consumer;

b) the type of relationship between the consumer and the goods or services provider;
c) the meaning of duty of care and its relevance in this situation.

[19] *McAlister (or Donoghue) v Stevenson*, [1932] AC 562 (SC(HL)).

A The consumer and type of relationship

This thesis does not require further consideration of the meaning of consumer and the relationship that they are required to have with the service provider as the legislation provides the definitions. The consumer is defined in the HPCAA[20] by reference to the HDC Act[21] as "health consumer *includes any person on or in respect of whom any health care procedure is carried out*". This interpretation is given a broad meaning and covers almost all interactions with health practitioners The broad interpretation also rules out the need for any debate on the nature of the relationship as it is also described in the above section "*as any health care procedure*". The relationship merely requires that the person being complained about is a registered practitioner under the HPCAA.

B The duty of care

The 'duty of care' for health practitioners is easily found but not always easily understood. HPCAA prescribes the development of standards of practice for practitioners by the Regulatory Authorities (RAs)[22]. The standards or codes of conduct are usually accessible on the website of the RA. Some standards or codes are easier to interpret than others, for example to assist psychologists with their understanding of their Code of Ethics, there are best practice guidelines[23] and an entire book has been written[24].

Thus the tenets of consumer law are established in the HPCAA for the purposes of consumer protection.

III *Consumer protection*

The theories of consumer protection were developed around the concept that it was necessary to address an imbalance in power between the consumer and the provider but in doing so created a number of theoretical questions. Cranston's[25] raises these saying

[20] Health Practitioners Competence Assurance Act 2003.

[21] Health and Disability Commissioner Act 1994.

[22] Health Practitioners Competence Assurance Act 2003, s118(i).

[23] "NZPB Best Practice Documents and Guidelines" <http://www.psychologistsboard.org.nz/best-practice-documents-and-guidelines2>.

[24] Ian M Evans, Julia J Rucklidge and Michael O'Driscoll *Professional Practice of Psychology in Aotearoa New Zealand* (The New Zealand Psychological Society, Wellington, 2007).

[25] Colin Scott and Julia Black *Cranston's Consumers and the Law* (3rd ed, Butterworths, London, 2000).

"*Consumer law and consumer regulation are ostensibly aimed at providing consumers with protection from, and rights against, producers and suppers of goods and services. But how necessary are those measures? To what extent are consumers disadvantaged? And how should we see the consumer, and more fundamentally, consumption itself?*"

The answers to these questions are the basis for theses in their own right and so are not fully explored in this section. The main purpose is to consider whether the HPCAA sufficiently meets the needs of consumers in order to provide them with protection. Some key theoretical points of consumer law are addressed in relation to the HPCAA.

1 The consumer

The ideal consumer is understood to exercise "consumer sovereignty" in selecting a provider. This presumes the consumer has "*stable preferences that have been formulated rationally and autonomously, and who have the potential to exercise power in the economic system by their purchasing choices, so ensuring that producers and suppliers meet those preferences.*"[26]

Consumer sovereignty has been questioned because this idealised consumer generally does not exist in reality and particularly when considering consumers of health practitioner services this ideal is even less likely to be realised. People who are mentally or physically unwell are less likely to be rational or autonomous than even the average consumer. This indicates that there is a strong argument towards the need for higher levels of protection for health consumers.

In fact, health consumers are more likely to identify with the risk factors that have been developed in research relating to consumers. Research has defined seven categories of "vulnerable consumer: those on low income, the unemployed, those suffering long-term illness or disability, those with low levels of educational attainment, members of ethnic minorities, older people and the young."[27]

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[26] Scott and Black, above n 23.

[27] Above n23 at 4.

There is some argument that competition assists in protecting consumers[28]. In theory the "*more choice available to the consumer the better the service they will obtain as they will choose the best providers*"[29]. This argues against legislative control but most will agree that there needs to be a balance between competition, control and consumer protection, particularly in the case of vulnerable health consumers.

2 Rationales for consumer protection

There are a variety of rationales that support consumer protection beyond the status of the consumer. These include an imperfect market which arises from unequal costs in the marketplace, products/services vary, consumers do not have perfect information on which to make a choice and obtaining that information is difficult or costly[30]. The solution offered to these perceived market failures is regulation.

There can be either self-regulation and/or some form of state oversight by way of legislation or avenues such as Ombudsmen. Self-regulation occurs where individuals and organisations control their own conduct through the "*implicit or explicit development of norms, and mechanisms for monitoring adherence to them*"[31]. It is argued, however, that either of these forms of regulation can result in cartels or self-benefits which are effectively sanctioned by regulation[32] when included in legislation.

Ethical goals incorporated in legislation balance against these self-interests. These goals which are relevant to health care may include: [33]

- Distributive justice which attempts to assist equality by the distribution of resources equally e.g. equal access to services in health care and education, which is intended to assist vulnerable consumers who are unable to access good quality services or lack of knowledge.
- Offer consumer entitlements e.g. "right to be treated with dignity while not damaging self-respect"[34].

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[28] Scott and Black, above n 23 at 22.

[29] Above n 23 at 23.

[30] Above n 23 at 30.

[31] Above n 23 at 33.

[32] Above n 23 at 67.

[33] John Mickelburgh *Consumer Protection* (Professional Books, Abingdon, 1979) at 47.

- Support community values e.g. trust, honesty and fairness in dealing[35].
- Address issues of inequality of bargaining power[36]

Ideally the "*consumer regime will deliver 'social justice, economic and environmental progress' as well as being fair to business and consumers*",[37] thereby maximising the relationship between consumerism and citizenship. However, there are often difficulties in ensuring the legislation meets these lofty expectations, which may result in resistance by government to legislation of this type and the formation of opposition or lobby groups[38]. This is evidenced by the initial resistance to the HPCAA and subsequent lobby groups now wishing to introduce other health practitioner groups into the legislation e.g. acupuncture, natural health care, counselling etc, which is being resisted by Parliament.

Arguments against regulation include the diffusion of consumer interests, increasing costs of regulation and compliance with regulation, increasing fragmentation of consumers who do not have homogenous interests, and differing expectations as to cost and environmental factors[39].

The strongest argument is that government regulation results in competition among private, self-interested groups lobbying for legislation rather than a response to the public interest, effectively buying regulatory protection[40]. This argument is raised against the HPCAA which specifically protects titles in the legislation.[41] For example, only a person who is registered with a practising certificate can call themselves a psychologist. This excludes people, who for all intents and purposes, have exactly the same or greater levels of qualifications in psychology as a psychologist, especially academics who do not register and are therefore not allowed to call themselves psychologists: they are lecturers or professors of psychology but not a psychologist.

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[34] Mickelburgh, above n 31 at 52.

[35] Above n 31 at 53.

[36] Iain Ramsay *Consumer Protection: Text and Materials* (Weidenfeld and Nicolson, London, 1989) at 57.

[37] Iain Ramsay *Consumer Law and Policy: Text Materials on Regulating Consumer Markets* (2nd ed, Hart Publishing, Oregon, 2007) at 16.

[38] Above n 35 at 16 and 19.

[39] Above n 35 at 19 - 20.

[40] Above n 35 at 21.

[41] Health Practitioners Competence Assurance Act 2003, s7.

3 Techniques of consumer protection as relevant

There are also other techniques of market controls that can be used for consumer protection. These can include control of suppliers, form and content of transactions, e.g. standards, code of ethics, and the standard of goods or services via quality and restricting remedies.[42] In practice these techniques have even been included in much of New Zealand legislation[43], both by explicit reference to for example s3(1) HPCAA stating that the purpose of the Act is for the protection of the public and for example the use of standards and codes of ethics by health practitioners and the use of remedies such as the ombudsman-styled[44] Health and Disability Commissioner.

IV *Conclusion*

The HPCAA comfortably fits within the consumer law milieu with similarities in both theoretical and practical applications of consumer protection and the arguments that support the use of legislation for the protection of health consumers due to their specific vulnerabilities. This supports the efficacy and desirability of the HPCAA and therefore any changes made should consider the impact on consumer protection within the rationales for consumer protection.

[42] Mickelburgh, above n 31 at 5.

[43] For example: Fair Trading Act 1986 and Consumer Guarantees Act 1993.

[44] Geoffrey Woodroffe and Robert Lowe *Woodroffe and Lowe's Consumer Law and Practice* (7th ed, Sweet & Maxwell, London, 2007) at 10.56.

Chapter 3 Terms of Art

I *Introduction*

To facilitate understanding some of the discussions in this thesis, it is necessary to consider certain terms used that are based on underlying theories of law. These 'terms of art' carry a legal meaning encapsulating a number of underlying theories and meanings. The interpretation of the terms depend on the context, facts and use. This research does not canvas the full complexity of each term of art, only to the most basic theory and meaning that is the best interpretation for understanding the research. The terms selected and described, on account of their importance or frequent usage in the thesis, are: judicial review, natural justice, therapeutic jurisprudence and alternative dispute resolution.

II *Judicial Review or Appeal*

These terms are not frequently used but have been included because after the complaints process is complete, psychologists have a last form of appeal either through the HPCAA or judicial review. This was mentioned by psychologists as being prohibitively expensive and another difficult part of the process. For this reason appeals and judicial review are worth considering as they are part of the process but not explicitly referenced later in the complaints process.

Judicial review is defined briefly as law that "*refers to judicial control of public decision-making in accordance with the rules of administrative law*."[45] The relevance is that the HPCAA established the Regulatory Authorities (RAs) and the RAs act as a function of government for the protection of people thus placing their actions within the meaning of 'administrative law' and therefore why Part 5[46] appeals are similar to judicial review.

Judicial review as a theory attempts to describe the relationship of Parliament, the people and the Court. It raises debate around the issues of sovereignty, functions of government

[45] Peter Cane *Administrative Law* (4th ed, Oxford University Press, Oxford, 2004) at 2.4.

[46] Health Practitioners Competence Assurance Act 2003, Part 5.

and the role of the court in relation to administrative law[47]. The purpose of judicial review is to maintain checks and balances on legislation through the separation of powers between the judiciary and Parliament.[48] The HPCAA therefore, is not only administered by the RAs according to the Act, but can also be reviewed by a Court ensuring a judicial function and public accountability[49].

Appeals from the Health Practitioners Disciplinary Tribunal (HPDT) can be considered by the High Court under the HPCAA.[50] This appeal from the HPDT allows that the Court may make any decision that the Tribunal may make or it may refer the case back to the Tribunal with directions. However, the Court may also consider the use of judicial review to ensure that the HPDT acted within its remit according to the legislation if the appeal is brought on those grounds. The Court may look to the following grounds for review (which will not be described in detail but referenced for further information):

- Procedural impropriety relating to natural justice[51]
- Irrationality/ unreasonableness[52]
- Proportionality[53]
- Substantive legitimate expectation/ estoppel[54]
- Inconsistency/ even-handedness[55]
- Substantive fairness[56]
- Mistake of fact[57]

These grounds may be useful to health practitioners requesting an appeal or a review of their case outside the provisions of the HPCAA.

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[47] Cane, above n 42 at 2.4.

[48] Above n 42 at 19.1.4.

[49] Above n 42 at 19.1.3.

[50] Above n 43, s106.

[51] PP Craig *Administrative Law* (5th ed, Sweet & Maxwell, London, 2003) at 372.

[52] Dean R Knight "A Murky Methodology: Standards of Review in Administrative Law" in Claudia Geiringer and Dean R Knight (eds) *Seeing World Whole Essays Honour Sir Kenneth Keith* (Victoria University Press, Wellington, 2008) at 180.

[53] Mark Elliott Beatson *Matthews and Elliot's Administrative Law* (3rd ed, Oxford University Press, Oxford, 2005) at 288-291.

[54] Dean R Knight "Estoppel (principles?) in public law: the substantive protection of legitimate expectations" (LLM Thesis, University of British Columbia, 2004).

[55] *Pharmaceutical Management Agency Ltd v Roussel Uclaf Australia Pty Ltd* [1998] NZAR 58 (CA).

[56] *Thames Valley Electric Power Board & Ors v NZFP Pulp & Paper Ltd & Ors* [1994] 2 NZLR 641 (CA).

[57] *Daganayasi v Minister of Immigration* [1980] 2 NZLR 130 (CA).

HPDT lists all the cases that it has heard under the Act[58]. A review of these decisions found that of the cases considered (335 currently reported) only 36 were taken on appeal to the High Court. Of those 13 were dismissed, 5 were discontinued, 8 had HPDT Orders amended, 2 are currently in progress, 5 appeals were upheld and quashed with a further three being quashed in part. Statistically, therefore, only10.7% of cases are appealed or judicially reviewed and only 2.3% of cases determined by HPDT are successful on appeal. This indicates in part a successful system, in that the majority of appeals are not upheld so the determinations by the HPDT are mostly correct but, could also be indicative of the reluctance of health practitioners to appeal from the HPDT because of the cost.

It should be noted that it is possible for practitioners to appeal decisions by the PCC at District Court level[59] but there is no easily accessible information on how frequently this occurs.

III *Natural Justice*

Failure by any of the RAs or HPDT to observe natural justice gives ground for appeal or judicial review. Natural justice is a legal concept describing how decisions are more likely to be correct, received well and respected if they are the outcome of a fair process. The rules of natural justice are flexible and dependent on the situation. In order for there to be a fair process a number of factors need to be taken into account including the context, the status of the affected person and power imbalances. To achieve a fair process, a number of steps have to be observed to say that natural justice has been observed including:[60]

- A duty to exercise powers in a fair manner.
- Procedural propriety in terms of principles rather than fixed rules.
- Implied powers of proactive investigation and information gathering.
- Requirements to disclose information and documents, including prejudicial documents.
- The right to know the case the practitioner has to meet.

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[58] "HPDT > Tribunal's Decisions > All Professions" <http://www.hpdt.org.nz/Default.aspx?tabid=74>.

[59] Health Practitioners Competence Assurance Act 2003, s106(1).

[60] Matthew Smith *New Zealand Judicial Review Handbook* (Thomson Reuters, Wellington, 2011) at 787-822.

- Notification to parties of hearings.
- Appropriate explanations of the mechanics of hearings.
- Providing advance notice of important "live issues".
- Notification of potential outcomes.
- Identifying legal and factual "gaps" in a party's case.
- Giving a fair opportunity to be heard.
- Giving a right of reply.
- Allowing for legal representation.
- Advance notice of how evidence will be approached.
- Translations/ interpreters where necessary.
- Requirement to fairly communicate decisions made.

The above list illustrates many steps considered necessary to state that natural justice was observed. In the course of its consideration, RAs should bear in mind these natural justice principles as part of the process especially as it is directed in the HPCAA.[61]

IV *Therapeutic Jurisprudence*

Therapeutic Jurisprudence (TJ) is "*an interdisciplinary field of inquiry that focuses on the therapeutic and anti-therapeutic consequences of rules of law, legal procedures, and the roles and behaviors of actors*"[62]. The usual application of theories relating to TJ are commonly found in alternative Courts like the mental health, youth and drug and alcohol Courts[63].

The purpose of TJ is to reform law in an "*effort to improve the psychological and emotional well-being of those affected by the legal process*"[64]. This purpose is key to the definition of TJ that is understood in this thesis.

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[61] Health Practitioners Competence Assurance Act 2003, s72.

[62] David B Wexler "The Relevance of Therapeutic Jurisprudence and Its Literature" (2011) 23(4) Fed Sentencing Report 278.

[63] Priscilla Ferrazzi and Terry Krupa "Re: Mental health rehabilitation in therapeutic jurisprudence: Theoretical improvements" (2016) Int J Law Psychiatry (in press).

[64] Ibid.

Therapeutic jurisprudence focuses on the people involved in the process with the objective of making the process as therapeutic as possible by way of meeting people's needs. The use of creative solutions and structures are encouraged and reflect TJ's "conceptual breadth". However, TJ is ambiguous and there is no real definition of 'therapeutic'[65].

TJ is added to the process in ways "*to support more collaborative, less traumatic advocacy and conflict resolution and should be considered in policy-making decisions*"[66]. In considering the HPCAA, discussion focuses on whether the process is capable of being utilised in a therapeutic manner for the participants and how this is best achieved.

V *Alternative Dispute Resolution(ADR)*

Alternative Dispute Resolution (ADR) is one of the options promoted as a way of introducing Therapeutic Jurisprudence to the process as well as increasing efficiencies in processing of complaints, especially in the early stages of the complaint.

ADR in this thesis, is not so much an alternative to litigation but rather a step in the process, preferably before the more formal processes occur.

ADR can take many forms such as negotiation, mediation, arbitration - increasing in formality in order listed[67]. NZPB asked that if an ADR process was allowed, it not be defined but rather be available as an ADR option to allow for flexibility in how it is used.

ADR is fundamentally based on communication skills[68] which makes it especially useful to psychologists. Negotiation can occur between the parties, or with one or more

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[65] Erica Hei-Yuan Chan "Evaluating therapeutic jurisprudence" (2012) 37 Altern LJ 274.

[66] Amy T Campbell "Therapeutic jurisprudence: A framework for evidence-informed health care policymaking" (2010) 33 Int J Law Psychiatry 281.

[67] Peter Spiller *Dispute Resolution in New Zealand* (2nd ed, Oxford University Press, NSW Australia, 2007).

[68] Spiller, above n 64 at 4.

representatives[69]. The benefits of negotiation are low costs, the parties or representatives are intimately involved in the process, and the parties retain control over the process and outcomes of the resolution process[70]. This is the level used by the Law Society in its telephone complaints discussions.

Mediation is a more formal step with the use of an independent mediator who in a confidential consensual process assists the parties in defining their issues and reaching resolution[71]. The benefits of mediation are similar to negotiation, marginally more costly but still less than litigation but has an independent person who can assist the parties finding their way forward in the case of deadlocks[72].

Arbitration is more formal where the parties agree to be bound by the decision of a third party who is selected to judge a dispute[73]. While arbitration offers a number of benefits including finality to the decision it is not suitable for the complaints process as it reduces negotiation or mediation of the dispute and the parties lose control of the process[74].

The use of ADR processes in certain situations is regarded as problematic and these situations are actually quite common for psychologists. These situations include:[75]

- where mediation may cause risk for the parties in terms of personal safety (including psychological safety);
- where the participants' mental capacity is impaired by drugs, alcohol or mental health and cannot negotiate in their own best interests;
- where the power imbalance is such that it significantly and adversely affects the negotiating abilities of the party.

Despite these difficulties NZPB considers ADR as a suitable option for most cases, although there may be occasions where ADR would not be suitable.

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[69] Above n 66 at 19.

[70] Above n 66 at 24.

[71] Above n 64 at 70.

[72] Above n64 at 70-73.

[73] Above n 64 at 128.

[74] Above n 64 at 130.

[75] Tania Sourdin *Alternative Dispute Resolution* (2nd ed, Lawbook Co, NSW, Australia, 2005) at 126.

Government generally prefers mediation as the first choice and has incorporated it into a wide variety of legislative instruments[76]. Of relevance here is, lawyers being allowed to use negotiation, conciliation and mediation in resolving complaints made to the Standards Committees[77] and conciliation at PCC level for health practitioners[78].

[76] Spiller, above n 64.

[77] Lawyers and Conveyancers Act 2006, s143.

[78] Health Practitioners Competence Assurance Act 2003, ss180 & 182.

Chapter 4 The International Regulatory Frameworks

I *Introduction*

It is useful to compare New Zealand law with similar legislation globally, but for comparison purposes it is necessary to limit comparisons to those with similar jurisdictions using common law. Such a comparison could highlight issues that were approached differently in other jurisdictions or perhaps offer solutions in terms of changes to the legislation being sought.

For the purposes of this chapter four pieces of legislation are considered, the first of which is the New Zealand Health Practitioners Competence Assurance Act 2003[79] (HPCAA). The second is the Australian Health Practitioner Regulation National Law Act 2009[80] (Australian Act), the version used being from Queensland. The Act, however, is national and, while published differently in each state, forms the basis of all related state legislation. The third piece of legislation is the Health Professionals Act 2000[81] (Canadian Act) from the Canadian state of Alberta, recently set down due to the fact that each province has its own legislation. All three Acts originate in commonwealth Countries and therefore are loosely related to the English legal system which will also be considered in terms of the Health Professions Order 2001[82] (English Order), which, while not an Act, is the equivalent legislation for understanding complaints. These four pieces of legislation are collectively referred to as the Acts.

It is not the intention of this chapter to perform a clause by clause comparative analysis of the each piece of legislation, but rather to see how the Acts deal with the issues already identified in Chapter 1.

[79] Health Practitioners Competence Assurance Act 2003.

[80] Health Practitioner Regulation National Law Act 2009 (Qld).

[81] Health Professions Act RSA 2000 c H-7.

[82] Health Professions Order 2001 (Consolidated) 2009 (UK).

II *Issues*

A Complainants

In the HPCAA complaints can be made by any person but are referred to HDC provided that they meet the broad definition of health consumer and is voluntary for all types of behaviour. The only difference is that the direction the complaint takes depends on the type of complaint i.e. whether it is competence or conduct related.

Australia has mandatory reporting requirements for notifiable conduct[83] relating to serious harm, by health practitioners, employers and education providers and otherwise voluntary reporting for any other behaviour by any entity, which is defined to include a person[84].

Canada does not specify the nature of the complainant, only that complaints need to be made in writing[85]. The only mandatory reporting requirement is for practitioners and others to report anything that may constitute a threat to public health[86], which by definition[87] goes well beyond a conduct related complaint.

The English Order, similar to that of Canada, does not specify who may make a complaint[88] but does add a step which allows the Council to investigate of its own accord, should there be concern about fitness to practise even in the absence of any allegations, and have the concern be treated as an allegation[89].

Therefore New Zealand, like the other jurisdictions, has a broad scope to accept complaints from a variety of complainants but lacks the mandatory reporting requirements of other jurisdictions. In terms of the latter, this may be interpreted to mean that New Zealand has an easier legislative approach. However, in practice, the reporting

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[83] Health Practitioner Regulation National Law Act 2009 (Qld), s 140.

[84] Above n 79, s 5.

[85] Health Professions Act RSA 2000 c H-7.

[86] Ibid.

[87] Public Health Act RSA 2000 c P-37, s 1 (ee) and (hh1).

[88] Health Professions Order 2001 (Consolidated) 2009 (UK).

[89] Ibid.

is likely to be similar regardless of whether it is mandatory or not, although further research would be required to comment on this conclusively.

In conclusion, due to the public protection focus of the Acts, the unlimited nature of complainants appears necessary and so it would not be feasible to suggest that the legislation be amended in any way to prevent complainants of certain categories (e.g. frivolous and vexatious litigants). The public nature of the legislation requires that it be available to all to be most effective. It could be that New Zealand has more flexibility without any mandatory reporting which allows discretion in the routes that complaints take.

B Grounds for Discipline

The HPCAA lists the grounds for discipline, which are serious enough for referral to the Tribunal including professional misconduct, malpractice or negligence, misconduct that would bring discredit to the profession, conviction of certain offences, practising while not holding a current practising certificate or practising outside their field of expertise and practising in breach of any conditions imposed by the profession or orders of the Tribunal[90]. There is no limitation on the grounds for complaint in the first instance, although the complaints are expected to describe a breach of the Code of Ethics or practice standards for either competence or conduct matters.

In contrast, the Australian model defines two types of conduct for complaints. The first type is notifiable conduct, which includes practising while intoxicated by alcohol or drugs, sexual misconduct, public risk of substantial harm because of impairment or practising in such a way that is a significant departure from accepted professional standards[91]. The second type of defined conduct includes the practitioner's professional conduct, practice, knowledge, skills or judgment being below a standard that may reasonably be expected by their peers or the public, that the person is not a fit and proper person to be registered, that they have an impairment, have contravened this law or any conditions/undertakings given to the Board; or that the registration was improperly obtained[92]. The Australian law also differs in including conduct for complaints against

[90] Health Practitioners Competence Assurance Act 2003, s 100.

[91] Health Practitioner Regulation National Law Act 2009 (Qld).

[92] Above n 87, s 144.

students. Those grounds include a criminal conviction for an offence with 12 months imprisonment, suffering an impairment, or contravention of any registration conditions or undertakings. There is no law in New Zealand relating to complaints about students, as generally students are under supervised practice and their supervision is regarded as the forum for dealing with complaints as it is part of the learning process. This legislation regarding students might be recommended for inclusion in future legislation in New Zealand to cover more serious offences.

The Canadian Act defines "unprofessional conduct" as a ground for complaint. The definition is wide reaching, containing not only conduct, whether or not it is disgraceful or dishonourable, but also a lack of knowledge or skill or judgment in the provision of professional services, any contravention of the Act, a code of ethics or standards of practice, failure or refusal to do continuing competence training, or comply with practice visitors or inspectors or any orders given by the regulatory body. The final ground includes conduct that harms the integrity of the regulated profession[93]. There do not appear to be any other restrictions on the nature of the complaint being brought. This reaches further than New Zealand legislation where the grounds of complaint to the Tribunal are treated as exhaustive in contrast to the Canadian version.

The English Order allows allegations to be made if a registrant's fitness to practise is impaired by reason of misconduct, lack of competence, a conviction or caution in the United Kingdom, or equivalent elsewhere, for a criminal offence, or for physical or mental health, or fitness to practice, found lacking by a regulatory authority in the UK or abroad, or barred with working with vulnerable people[94]. This Article lists a number of situations in what it covers, and so appears to be quite exhaustive.

The Acts are similar both in the types of complaints that can be received as well as protection of the public.

C Time Frame - Statute of limitations for complaints

In the HPCAA there is no limitation on how long after an event a complaint may be lodged. There is an expectation amongst RAs that this time is limited in part by access to documentation and witnesses. Documentation is generally kept for a period of 10 years

[93] Health Professions Act RSA 2000 c H-7.

[94] Health Professions Order 2001 (Consolidated) 2009 (UK).

and so complaints predating a decade from the event would not be considered. However, access to witnesses and their memory fades faster than the retention of documents. Therefore, most of the RAs generally do not pursue complaints if there is no reasonable certainty that the matter is still investigable, or that the time would disadvantage either of the parties. The Act does not specify a timeframe for the action from start to completion of the process. Once the complaint is laid, the documents and other information are generally gathered at that point.

The Australian Act does not reference any time limitation for bringing a complaint.

The Canadian Act again does not include a limitation on how long it might be between the event and a complaint being lodged. The Act does contain some notification periods e.g. 30 days to notify the complainant of the actions that will be taken regarding the complaint.[95] The fact that complaints cannot be brought against former members if two years has elapsed since they became a former member[96] points to timeframes that may be considered reasonable despite there being no actual requirement.

The English Order does not speak to this issue.

D Double jeopardy and multiple authorities

Practitioners under the HPCAA complain that there is double jeopardy for complaints that are heard by both the HDC and the RA.

The Australian Act states that, if a complaint is received by a Board that does not have the person as registered with that Board but reasonably suspects the person may be registered with another Board, then it must pass the complaint on.[97] This would not constitute double jeopardy. However, s150 requires complaints that would also provide grounds for a "complaint to a health complaints entity under a law of a participating jurisdiction", the National Board must notify the health complaints entity and send the complaint and all associated information. This requirement is like the referral to the HDC from a New Zealand RA. The Australian Act has also been updated by way of

[95] Health Professions Act RSA 2000 c H-7, s55(1).

[96] Above n 91, s54(3).

[97] Health Practitioner Regulation National Law Act 2009 (Qld), s149(3).

review[98] to amend s147 to include the transfer of complaints to and from the Health Ombudsman which operates in a similar manner as the HDC transfer of complaints. **Comment:** This creates a situation of double jeopardy in Australia, which is a modern direction in legislation.

The Canadian Act and the English Order do not have any similarities to the HPCAA in this respect.

E Natural justice

The HPCAA includes provisions for natural justice[99] so the concerns raised in chapter 1 must relate to the practice rather than to the legislation.

A similar provision is contained in the Australian Act[100] but the words 'natural justice' are not specifically referenced in either the Canadian Act nor the English Order.

F No boundaries to complaint e.g. unlimited complaints and withdrawal of complaints

This is not referenced in any of the Acts or the Order.

Comment: It is unlikely that this issue has not occurred in other jurisdictions. The absence of any inclusion in any of the Acts indicates that this is properly a process issue rather than something that needs to be addressed in legislation. It could be argued that natural justice should compensate for any shortcomings in the lack of boundaries, in the Acts, with regards to the process.

G Process time limitations in the Act

The HPCAA has no limitations on the processing of a complaint in its entirety but it is consistent with the other Acts in having periods set for certain actions. For example,

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[98] Health Practitioner Regulation National Law Act 2009 reprint, s32.

[99] Health Practitioners Competence Assurance Act 2003, s72.

[100] Health Practitioner Regulation National Law Act 2009 (Qld), s185(2).

HPCAA requires that a practitioner is advised of a PCC hearing within 14 days of the decision been made to refer the matter to a PCC.

The Australian Act requires a preliminary assessment of a complaint within 60 days[101]. The Canadian Act requires that a response about a complaint is given to the complainant within 30 days of the complaint being laid[102] and that a hearing be scheduled within 90 days of a hearing being ordered[103]. The English Order has reference only to a 28-day appeal in various Articles[104].

Comment: None of the legislation, therefore, prescribes a set time frame in which a case must be addressed. The likely reason is because the time varies according to the complexity of the case but certainly it would be possible to include more time frames within the legislation.

H Early intervention process or alternative dispute resolution

HPCAA does not have an early intervention or alternative dispute resolution process provision in the legislation.

The Australia Act and English Order similarly do not have any such provisions.

However, the Canadian Act has such a provision and has been suggested at the HPCAA review as worth considering for adoption. The Canadian Act allows for dispute resolution as one of the first actions that the complaints director can take[105] at any stage of the proceedings before Tribunal level and is given a place in the process in s58(1) "*The complaints director may, with the agreement…refer the complainant and the investigated person to an alternative complaint resolution process provided for in the regulations at any time before the commencement of a hearing by the hearing tribunal*." Further

[101] Health Practitioner Regulation National Law Act 2009 (Qld), s150432(1).

[102] Health Professions Act RSA 2000 c H-7.

[103] Above n98, s69.

[104] Health Professions Order 2001 (Consolidated) 2009 (UK), Art 26(14), Art 29(10) etc,.

[105] Health Practitioner Regulation National Law Act 2009 (Qld), s55(2)(b).

sections describe the process in terms of an independent person conducting an alternative complaint resolution process etc.

Comment: It has been suggested that this clause be adopted in the HPCAA in order to allow for earlier alternative dispute resolution processes.

III *Conclusion*

The HPCAA is quite a progressive Act and compares well with peers in similar jurisdictions. There is room for amendments, one being the alternative complaints resolution from the Canadian Act. However, overall the HPCAA is no more onerous than any of the other legislative instruments.

Chapter 5 The Health Practitioners Competence Assurance Act 2003 (HPCAA)

I *Introduction*

To understand the Health Practitioners Competence Assurance Act 2003 (HPCAA or Act) it is necessary to consider the Act's origins, the meaning of the relevant sections and where any proposed changes have been suggested. This chapter will briefly consider the history and purpose of the Act, traverse relevant sections and the future via consideration of the proposals submitted to the Ministry of Health in the course of two reviews in 2008 and 2012.

II *History and Purpose of the Act*

The HPCAA is a relatively recent Act, being passed into law on 18 September 2004. However, this Act did not spring from a vacuum. The HPCAA repealed 11 existing Acts which regulated some of the existing health authorities. The Act created new "Responsible Authorities" (RAs), changing some existing authorities and creating recognition for other practitioner groups, all within the one Act. The rationale for the new Act, which covers health professionals in general, was that significant restrictions had been noted in some of the older Acts, the oldest of which was the Occupational Therapists Act, dating back to 1949. Even amongst the more recent Acts there were requests for modernisation.

The Ministry of Health (MoH) agreed that all the Acts needed modernisation, and so the question became was each Act updated or could they all be replaced by one modernised piece of legislation.

The process looked at moving away from a discipline-centric process for each authority to a more common disciplinary process. The Cartwright enquiry[106] and also the Cull report[107] suggested that there was greater need for interagency communication of issues and a discussion about consumer rights.

Government had already committed to changing how occupational therapists were regulated by way of a manifesto commitment. There was also a growing drive for greater attention to patient complaints with the Code and role of Health and Disability Commissioner (HDC), and a driver for better communication between agencies so that people were put on notice of risk to manage it. The case of Morgan Fahey in Christchurch, who was known to be acting inappropriately and breaching boundaries with patients, highlighted the need for change. While Fahey was under investigation by the Police[108], the Medical Council had no capacity to stop him from practising under the authority of the Act of the time.

Within this perfect storm for change, the decision was made that, rather than going through the tedious process of updating each piece of legislation, a broad sweeping Act would be introduced to replace and update them all. This update also gave greater interaction between HDC and RAs, greater authority for the RAs to describe the profession in the way that they wanted to describe it, to prescribe qualifications, have scopes of practice, to separate competence and disciplinary procedures, and put in place a common tribunal that could give greater consistency and elevated the status of the tribunal so that there was a permanent chair and deputy chair.

The new Act introduced the Health Practitioners Disciplinary Tribunal (HPDT) to deal with all cases across a variety of RAs. The Act also provided the opportunity to deal with cases such as that of Dr Fahey through the introduction of s69 of the Act, which allowed RAs to place conditions or suspension on practitioners while an investigation is being conducted. The new Act also re-arranged some of the professions, including: midwifery

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[106] S Cartwright *The Report of the Committee of Inquiry into allegations concerning the treatment of Cervical Cancer at National Women's Hospital and into other related matters 1988* (New Zealand Government Printing Office 1998).

[107] H Cull *Review of Processes Concerning Adverse Medical Events* (2001). < http://www.moh.govt.nz/notebook/nbbooks.nsf/0/773f196759b7ce0ecc256a220077235d/$FILE/Adverse%20Med%20Events%20Cull%202001.pdf>

[108] *R v Fahey [2000] BCL 1059*, (CA).

being separated from nursing, osteopaths getting their own authority and the Dental Council picking up dental hygiene and dental therapy in their authority. Psychotherapy was added as an authority and medical technicians were added to the medical science authority. By the time the Act was passed some 21 professions under 13 Acts came together under one Act.

Compromises were made in the formation of a common tribunal as the RA had to lay charges or findings under the Act which meant moving away from the way that some authorities had previously categorised misconduct. The Act adopted the approach that had been working well in the Act for the Nursing Council in that there would be two broad categories for professional misconduct. The Act also moved away from the 'fit and proper person' test which existed in some legislation. In terms of identifying fitness for registration in s16, the equivalent but detailed definition of what such a person might look like rather than the more subjective test used previously, in order get a consistent threshold for all the authorities[109].

That is not to say that the introduction of the Act was without controversy however, as evidenced in Hansard reports. At the second reading, after the Health Committee had received and considered 265 submissions on the Bill, there were still a number of issues in contention including that the Act was insufficiently similar to old Medical Practitioners Act 1995 upon which it was based and which had proven reasonably successful. Further issues were that the scope of the Act was trying to cover too much, that there had been insufficient public consultation, that the new Act excluded some health professions and that certain terms used within the Act were not sufficiently defined. The most concerning issue, however, was that the new Act was too focused on the professions and not enough on public protection[110].

Of particular interest to this research are the comments made in Parliament about the Part 4 complaints and disciplinary process. In the debate Dr Paul Hutchinson (NZ National—Port Waikato) recognised: [111]

[109] The information discussed in this history was provided by interview with David Dunbar, MCNZ Registrar, who was involved in the process at the time when the Act was considered and introduced.
[110] (31 July 2003) 610 NZPD 7536.
[111] (27 August 2003) 611 NZPD 8135.

> "The processes provided by the Bill are a very big jump from the way the old disciplinary and complaints procedures were held when there were huge complaints by patients and various health practitioners that there were long delays. The whole aim of this part is to try to speed up the processes so they are fair, efficient, and coherent, and in many respects this part, on the whole, has managed to achieve that. There are some worries that some of the smaller organisations will find the compliance costs associated with the requirements considerably difficult, but, overall, because the larger organisations such as the Nurses Organisation, the medical practitioners' organisations, and the dental groups have sufficient numbers, their organisations are sufficient to be able to cope with the costs implied in the Bill."

Comment: Both comments are borne out as the processes have improved overall in terms of efficiency. It is true that while the larger bodies are well able to bear the costs, smaller organisations struggle and have made accommodations, for example sharing offices and secretarial support, in order to make the process work. Despite these, most are happy with the process. It should be noted that the practitioners' annual practising certificate fee funds the RAs. No government funding is received which is why costs are higher for small RAs as they are spread over a smaller membership base.

Hon Annette King (Minister of Health at the time) commented on the purpose of the Act saying "*that professional self-regulation, with responsibility towards the public, is the Government's aim, and I think this part certainly encompasses that*".[112] The Minister was referring to the complaints section and pointed out that the purpose was to strike a balance between self-regulation and public protection.

Comments: Concerns regarding self-regulation being diminished under the MoH have not eventuated in practice and the RAs are all strongly focused on public protection.

In the same discussion, Judith Collins (NZ National—Clevedon) commented that

> "In relation to this particular complaints-processing part of the bill, the Health Committee, I felt, really tried hard to get a good, consensus view…We had some concerns,… noted…in the minority report"…"In particular, we were concerned that insufficient weight had been given by the balance of the committee to the submission from Wendy Brandon… that there should be two levels of charges before the

[112] Above n 107.

> disciplinary tribunal…that under this bill the severity of the offence makes no difference to the naming of the charge."

Comment: The concern of having two levels of charges was not amended in the Act. Obviously the most serious offences are charged at a criminal level and the Tribunal can choose a punishment appropriate to the level of offending. Thus, misconduct relating to a more minor error in treatment might be suspension rather than, for example, removal from the register for really serious offences.

In the end the RAs accepted the compromises, the Bill was passed into legislation with some changes and a reasonably good Act was the result. An interviewee commented that in the decade since the Act was passed, the Act has largely stood the test of time and that any proposed changes are more minor amendments rather than fundamental issues with the Act.

III *Understanding the Act with reference to the relevant sections*

The Act is designed to describe the full life experience of the practitioner with the RA from start to finish. The layout of the Act effectively starts with registration and requirements for registration, moves on to the annual issuing of a practising certificate issues and ultimately has provisions at the end for removing somebody from the registrar or having them removed. The Act also covers how to manage health issues, competence issues and conduct. For the purposes of this research Parts 3 and 4 are relevant

A Part 3

Part 3 of the Act covers competence, fitness to practise and quality assurance. Sections 34 - 44 specifically look at the issue of competence. The focus of this section is assessing competence, defining when the authority may consider competence, how the process to assess competence should operate and what orders may be made against those who do not have the required competence. There is also provision for interim suspension or conditions on practising until a competence review can be conducted.

The sections describe the use of competence and recertification programmes in order to restore practitioners to competence or to maintain competence, a completely

rehabilitative focus. Finally, the Act describes what can happen to practitioners who are not able to reach competence after further training. This first Part finishes with a section on confidentiality requiring the information gathered in competence reviews to remain confidential.

Sections 45 - 51 (Fitness to practise) deal with practitioners who are unable to undertake their usual work for reasons of health, either physical or mental health. There is a provision for obtaining medical advice or ordering a medical examination. Section 48 again allows for interim suspension or for conditions to be placed on the practice of the practitioner until they are recovered at which time the suspension or conditions may be revoked. For the purpose of this thesis, this area is not deeply canvassed as no problems were identified with this area noted in chapter 1.

B Part 4

Part 4 of the Act deals with conduct complaints. Conduct complaints may progress through the complaints process all the way to a Disciplinary Tribunal or beyond to the Courts. Part 4 lays out the path for complaints.

Sections 64 - 67 deal with the referral of complaints. These are the sections that identify the complainant and require the referral of complaints to the Health and Disability Commissioner (HDC), including communications with HDC. Under s70, the RAs are not to take action while the HDC investigates. The Act then addresses the requirement that the Courts notify the RAs about certain types of convictions.

Section 68 covers referral of complaints and notices of conviction to the professional conduct committee (PCC). Section 69 covers the interim suspension of practising certificates pending prosecution or investigation.

Sections 71 - 83 deal with the roles and operations of the professional conduct committees, including their powers, restrictions and decisions that they may reach, and the process thereafter.

Sections 84 - 105 deal with the creation and operation of the Health Practitioners Disciplinary Tribunal (HPDT), including the membership of the HPDT, the hearings, powers, restrictions, and determinations that it may make. The HPDT is also a transparent process enabling members of the public to attend unless there is an objection from one of the parties or the matter pertains to sexual misconduct, and there are some protections for certain witnesses. Under s100 the grounds on which a health practitioner may be disciplined are set out along with the penalties that may be incurred and under s101 and s103 the orders that can be given by the Tribunal.

IV *The legislation regarding the issues raised in chapter 1*

In the hypothesis regarding legislative changes discussed in Chapter 1, several issues were raised. Issues relating to the complaints in Parts 3 and 4 are canvassed here. It should be noted that this Act is framework legislation, in other words, only creating the skeleton on which the processes are hung in order to reach the objectives of the Act. In that regard, the Act is quite permissive and in the words of one interviewee "the current issues with the Act are not what is in the Act but rather in what is not." The issues arising from perceived omissions are considered here.

A Double jeopardy

Double jeopardy is enshrined in the Act at s64(1). Heather Roy (ACT)[113] commented that "*Complaints will now all go through the Office of the Health and Disability Commissioner, and it will be more like a one-stop shop than what we have had previously.*" The comment was made in response to consumer concerns that professional bodies were self-regulating and there was no assurance for consumers in that process. The HDC is independent from the professional bodies serving to assure consumers' protection. However, the HDC may refer the complaint back to the RA for investigation if it so determined, which balances the need for consumer assurance and professional self-regulation.

While legally the concept of double jeopardy is abhorrent in this context, it serves a worthwhile purpose in further consumer protection and the author is of the opinion that, despite the issues with legality, it should remain as it is in the legislation. I hold this view

[113] Above n 107.

bearing in mind that the RAs are aware of issues in this area and take as many steps as possible to mitigate the impact of double jeopardy.

B Natural justice

The legislation supports natural justice through being quite prescriptive about the constitution and operations of the PCC and HPDT. Specifically, s72(3) on the PCC operations and Schedule 1 clause 5 regarding the procedures of the HPDT state that the two processes are subject to the rules of natural justice. The legal advisor of the practitioner however, should assist in ensuring that natural justice is observed for their client.

C Multi-directional referral of complaints i.e. multi-agency

This issue was identified by psychologists as an issue relevant to them. The legislation does not have any specific direction to the RAs as to interaction with other legislation. For example the Privacy Act 1993 e.g. DCNZ consulted with the Privacy Commissioner and built it into their standards. This was noted by NZPB to be an uncommon occurrence and so this issue, while pertinent, should not be weighted too heavily. There is not enough evidence on the issue to warrant any change to the legislation but could be considered in a review of the process.

D No boundaries to complaint e.g. unlimited complaints and withdrawal of complaints

There is no direction on any of these issues in the legislation beyond the identification of complainants as health consumers under s64(1). This may warrant further development.

E Grounds for complaints and limitations on the scope of complaint

Again there is no direction on any of these issues in the legislation beyond the grounds for complaint that are identified at HPDT level in s100. This might be an area warranting further consideration.

F Time frame for complaints - Statute of Limitations

There is no limitation period in the legislation relating to when a complaint may be brought. This may warrant further discussion.

G Early intervention process or alternative dispute resolution

There is no early intervention process contained in the Act nor any early alternative dispute resolution process except as discussed above with reference to s82. This area definitely warrants further investigation.

H Excessive demands on organisations

The Act does not reference any demands on the RAs nor any other organisations involved in the process. This was discussed above when the Act was proposed with reference to self-funding difficulties for smaller organisations. The author is mindful that changes to the Act may result in further costs for the RAs, e.g. in an early intervention process.

V *Ministry of Health Submissions*

In 2012 the Ministry of Health issued a discussion paper[114] seeking submissions from interested parties on the HPCAA. The discussion paper focused on particular aspects of the Act that might require review and while the questions did not necessarily focus on the complaints process the responses from the three RAs support the feedback received in the interviews. This section focuses only on the comments made that specifically relate to complaint or changes in legislation suggested.

NZPB commented that "*the respective roles and responsibilities of the HDC and the RAs in addressing complaints need to be clarified*" and that the Act could be strengthened with regard to cultural matters[115]. There was also a note that the definitions of risk could be clarified and a threshold introduced for when a matter takes the more formal route[116].

In contrast, DCNZ commented that the legislation was flexible and did not need the definitions of risk but should be allowed to develop thresholds in order to meet the

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[114] *Ministry of Health 2012 Review of the Health Practitioners Competence Assurance Act 2003: A discussion document* (Ministry of Health, Wellington, 2012).

[115] *The New Zealand Psychologists Board Submission in Response to the Ministry of Health's 2012 Review of the the Health Practitioners Competence Assurance Act 2003: A Discussion Document at p196 < http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/C27798AE9A5B1007CC257C9E007C7A97?opendocument>*.

[116] Above n111 at 197 -199.

evolving profession[117] and nature of risk. DCNZ commented that costs could be made by streamlining the Act and giving RAs greater discretionary powers and cites s68(2) where a discretion for referral to a PCC would be preferable[118].

MCNZ commented with regard to the safety focus of HPCAA that "*The Act should be better aligned with other legislation, particularly those laws and regulations that deal with ACC and the supply, prescribing and administration of medicines and controlled drugs.*"[119] MCNZ also recommended changes to the following sections relating to complaints

> "Section 68(2) should be amended to provide RAs with less costly and time-consuming alternatives for action. This section currently requires a Professional Conduct Committee to be convened for relatively minor matters, such as a conviction for some alcohol related offences (e.g. drunk-driving), when a health review would be a more efficient and effective mechanism for protecting public health and safety.
>
> Section 69 should also be reviewed to allow for immediate suspension of a practising certificate due to concerns about conduct when there are concerns that the practitioner presents a risk of serious harm."[120]

Section 171 of the Act required the Director-General of Health to review the operation of the Act three years after it came into force. This consultation took place and a document[121] was released regarding the review in 2008. This document effectively summarised the feedback received from submissions and suggested some changes to the legislation. The changes with regard to the complaints process included:

- That sections 64 and 118 be amended to allow RAs to receive complaints about conduct where the complainant is not a health consumer as such, which would

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[117] *Dental Council submission in response to the Ministry of Health 2012 Review of the Health Practitioners Competence Assurance Act 2003: A discussion document at 53 <http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/C27798AE9A5B1007CC257C9E007C7A97?opendocument>*.

[118] Above n 113.

[119] *Medical Council of New Zealand HPCA Act Submissions at 6 <http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/C27798AE9A5B1007CC257C9E007C7A97?opendocument>*.

[120] Above n 115.

[121] *Review of the Health Practitioners Competence Assurance Act 2003 Report to the Minister of Health by the Director-General of Health*. <http://www.health.govt.nz/publication/2012-review-health-practitioners-competence-assurance-act-2003-discussion-document>

widen the type of complainant and also provide a protection for complainants who lay conduct complaints in good faith similarly to the other parts of the Act that allow this protection for competence and health complaints[122].

- That s68(2) be amended to allow the RAs discretion for minor offences to not be referred to a PCC[123].
- The report also recognised the issues of immediate interim suspension and the use of 'risk of serious harm' or 'serious risk of harm' be deferred as policy considerations until the 2012 review[124].
- The remaining recommendations relate mostly to funding of HPDT and issues that are not specifically relevant to the enquiries of this thesis.

Unfortunately all the reviews have to date not resulted in any amendments to the legislation, although another review is due in 2016 with proposed amendments being included in a Bill for Parliament.

VI *Conclusion*

A number of issues identified in relation to the legislation therefore can be progressed for further consideration after looking at the list. For the most part, the issues identified warrant further consideration, either through an amendment to the Act to accommodate the change or through additional processes as long as they fit within the legislative framework.

[122] Above n 117.

[123] Above n 117 at 31.

[124] Above n 117.

Chapter 6 The Administration of the HPCA Act by the Responsible Authorities

I *Introduction*

This section contains the results of interviews with three responsible authorities (RAs) operating under the HPCAA[125], namely the New Zealand Psychologists Board (NZPB), the Dental Council of New Zealand (DCNZ) and the Medical Council of New Zealand (MCNZ) and I would like to thank them all for their contribution to my research. The interviews commence with NZPB as it was the foundation of the research and solely for this reason it is the comparative base against which the others are analysed. There is no intended weighting in using the NZPB as the comparative base.

II *Methodology*

When selecting the interviewees the writer considered the following factors in the first instance whilst the other RAs dealt with mental health. The only other RA that specifically addressed mental health was the Psychotherapists Board of Aotearoa New Zealand (PBANZ). When research assistance was requested PBANZ advised that they were one of the smallest Responsible Authorities and the only group of professionals to be regulated after the introduction of the Health Practitioners Competence Assurance Act 2003 (HPCAA). As a result their complaint history is minimal and advised they would not be able to add much value to the research. For this reason the Psychotherapists Board was not included in the research.

The writer then looked at other Boards who were of a comparable size and experience to the New Zealand Psychologists Board (NZPB) and who were willing to participate. Therefore the Medical Council of New Zealand (MCNZ) and the Dental Council of New Zealand (DCNZ) were included in the study. Other RAs could have been included in the research were it not for limits of time and space.

[125] Health Practitioners Competence Assurance Act 2003.

The interviews contained a number of pre-determined questions[126] but also included some off the cuff questions to clarify the understanding of certain aspects of the process or understanding of the legislation. The writer interviewed one or more staff or associates from each RA from which the discussions below are derived. Each person interviewed agreed to be identified by organisation rather than individually for the most part so the interviewees are unnamed. The exception to this was the Medical Council where the CEO, Philip Pigou, kindly allowed me to interview him regarding the process used by the Council. The Registrar, David Dunbar, was interviewed not only on the legal technical components of the process, but also on his understanding of the Act based on his involvement with the Ministry of Health (MoH) in the early creation of the Act and his experience of the Act in practice during his work with the MCNZ for the last 10 years. His familiarity with the Act has further been developed through his writing of the text for "The Laws of New Zealand - Health Practitioners"[127].

The writer notes that all the interviewees are passionate about their work and are all acutely focused on their role in public protection, in the best ways possible.

The writer recognises that the RAs do meet on a regular basis for a discussion but the RAs agreed that having a written record for comparative purposes might facilitate future discussions.

III *Roadmap*

This chapter looks at an analysis of the statistical reporting of each of the Boards to check for trends, similarities and any useful information that may be gleaned. The chapter then provides an overview of the complaints process for each of the three RAs by way of a flowchart with explanations. There then follows an analysis of areas within the process that were identified as either differences or issues identified in Part 1. Finally, there is a record of the discussions about the HPCAA legislation.

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[126] Approved by the Human Ethics Committee (0000021853).

[127] David Dunbar *The Laws of New Zealand: Health Practitioners - Reissue 1* (LexisNexis NZ, Wellington, 2015).

IV *A Brief Overview of Terms used in this section*

The term "Responsible Authority"(RA) as discussed above is derived from the legislation but is frequently used interchangeably with the term "Regulatory Authority", Board or Council and is taken to mean the same thing. Each type of Health Practitioner is affiliated with a RA in their area of practice. There are 16 of these RAs governing 22 health professions.

Each RA has a permanent staff who run their offices. The staff, in the collective, are known as the Secretariat. Each RA has a Registrar, who performs a variety of roles including a statutory role with delegations as set out in the legislation. The remainder of the staff varies in title and by job description from RA to RA but each Secretariat ultimately performs the same functions.

The Health and Disability Commissioner (HDC), operating under a different Act,[128] is an organisation intersecting with the RAs as the HDC represents consumer rights, deals with consumer complaints and promulgates the HDC Code of Health and Disability Services Consumers' Rights Regulation 1996 and by law[129] the RAs are required to refer complaints to them.

There is frequent reference to a Professional Conduct Committee (PCC) which is embodied in the legislation but the various RAs have other committees they use with a variety of names which will be used in the context they arise.

There is also reference to the Health Practitioners Disciplinary Tribunal (HPDT or the Tribunal). This is discussed later but in short, it is the Tribunal to which all RAs prefer charges and is responsible for the administration of justice at a higher level than within the RA, but still falling under the auspices of the Act as discussed in chapter 5.

Other frequently used acronyms are for the District Health Boards (DHBs) and the Ministry of Health (MoH).

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[128] Health and Disability Commissioner Act 1994.

[129] Above n 121, s64(1).

For this section any reference to "the Act" is a reference to the HPCAA[130].

The reader is also reminded to bear in mind that within the legislation there are two tracks for complaints, those that relate to competence issues and those that relate to conduct issues. This affects the passage of a complaint through the process and thus the description of the process endeavours to show the two tracks.

V *The Health and Disability Commissioner (HDC)*

This organisation needs some explanation as it is frequently referred to in discussion with the RAs as legislation requires all complaints affecting a health consumer, received by the RAs, to be referred to the HDC[131].

The Health and Disability Commissioner Act was enacted in October 1994, prior to the HPCAA. The Act created the Office of the Commissioner - with the role of promoting and protecting the rights of health and disability services consumers, and facilitating the fair, simple, speedy, and efficient resolution of complaints - with a national network of independent advocates, under the Director of Advocacy, and an independent prosecutor, the Director of Proceedings[132].

The Office also promulgated regulations that created a code of consumer rights that applies to all providers of health and disability services. The code sets out ten rights, including the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to services of an appropriate standard, to give informed consent, and to complain.

The complaint mechanisms under the Health and Disability Commissioner Act have become the primary vehicle for dealing with complaints about the quality of health care and disability services in New Zealand. Due to the number of complaints the Office deals with, the Office offers a number of services that can be accessed to assist the consumer including the assistance of an advocate who, beyond assisting with ensuring the complaint is properly composed and evidenced, the advocate can also be required to see

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[130] Above n 121.

[131] Above n 121, s64(1).

[132] "Health and Disability Commissioner" <http://www.hdc.org.nz/>.

if a resolution can be obtained by agreement between the complainant and the practitioner[133].

VI *Statistical Information*

This section relates to information gathered from the RAs' Annual Reports over a period of time. This allows for the comparisons between the RAs. Having said that I also recognise some of the limitations in this method. For example, in the initial annual reports the data was not recorded in the same way as it was in the latter 5 years. So some of the data sets could not be obtained from a review of the Annual Reports (ARs).

RAs data collection on complaints also varied somewhat, from those who considered all notifications to others where only the formal complaint was counted. In places it was necessary to add the competence notifications to the conduct complaints in order to achieve a comparable figure and in other instances this was sometimes just not available. For example in the 2010 year of the DCNZ AR only the formal complaints of conduct notifications were counted whereas MCNZ had mostly the competence notifications counted. Because of these limitations the total number of complaints is less useful across the RAs but still useful.

A glaring example of this limitation caused by the different definitions and recording of complaints is seen by the huge increase reflected in the DCNZ complaints in 2015 in comparison to previous years. When questioned DCNZ advised it was because they were recording what constituted a complaint differently rather than any workforce issue.

[133] Health and Disability Commissioner Act 1994, s42.

Figure 1: Statistics for RAs collected from the Annual Reports

Statistics for RAs collected from the Annual Reports

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
NZPB APC holders	1625	1732	1826	1897	2092	2093	2165	2293	2398	2527
DCNZ APC holders	NA	3399	3681	3448	3574	3689	3771	3821	4008	4176
MCNZ APC holders	11398	11854	12152	12493	12644	13488	13874	14150	14381	14677
NZPB complaints	NA	27	30	25	45	31	46	35	57	62
DCNZ complaints	61	48	72	73	21**	51	61	58	65	146
MCNZ complaints	35*	38*	62*	42*	46*	199	180	210	219	124
NZPB referrals to Comptence Review	NA	1	1	1	NA	4	4	3	4	4
DCNZ referrals to Comptence Review (excluding IRC category)	3	0	0	1	2	8	2	8	7	10
MCNZ referrals to Comptence Review	19	18	38	29	21	23	21	30	41	16
NZPB referrals to PCC	NA	13	6	4	9	3	5	6	6	11
DCNZ referrals to PCC	NA	2	NA	NA	0	7	6	23	10	4
MCNZ referrals to PCC	6	14	19	21	23	12	9	31	20	27
NZPB referrals to HPDT	NA	0	2	4	4	0	0	2	0	2
DCNZ referrals to HPDT	NA	0	0	0	1	0	4	10	4	4
MCNZ referrals to HPDT	NA	NA	NA	NA	13	0	0	4	6	9

NA - indicates that there was no information available to the author for this period either because I did not have access to the Annual Report (2006) or the data was not located in the AR of that period

* report only included referrals for competence in AR

** in this year the report did not include the total complaints, on the competence notifications

Information gathered from the chart confirms that there has been a steady increase in practitioners holding an Annual Practising Certificate for all the RAs. It should be noted that this figure was used as it was the number in common across the ARs whereas some also showed the total number of persons on the registrar which could easily increase the amount by a third again but these people are not practising and so while they could be subject to complaints, it could give a false impression and therefore was not included.

There is also an increase in complaints across the RAs over time, which supports the claims that there is an increasing number of complaints to be dealt with, although the author does note an anomaly in the number of complaints for MCNZ in 2015 (reason unknown). Interestingly, however, is the fact that there is not a similar steady incline in referrals to competence review, PCC or HPDT. One could speculate about the reasons for this, i.e. it could be as simple as the fact that while more people are willing to complain there is not necessarily any more inappropriate conduct or lack of competence than existed in the past. Or could it relate to limitations being placed on the formal processes for reasons like resource availability, but without further investigation it is not possible to reach a conclusion.

It was also noted that the figures used above for referral to competence review, PCC or HPDT, are where possible, just the new notifications in the calendar year in order to achieve a comparable figure. This does not show however, that a number of cases carry over from year to year. So while figures show 20 new referrals, the RA may still be managing about 60 complaint related processes in any one year.

The DCNZ competence figures are those that are used for the competence review to make it comparable to the other RAs but DCNZ also uses and reports on Individual Recertification Programmes that are used only by DCNZ but are part of their competence process.

Figure 2: Calculations for RAs using figures collected from the Annual Reports in Figure 1.

Calculations for RAs based on figures collected from the Annual Reports

	2007	2008	2009	2010	2011	2012	2013	2014	2015
NZPB % of complaints to APC	1.56	1.64	1.32	2.15	1.48	2.12	1.53	2.38	2.45
DCNZ % of complaints to APC	1.41	1.96	2.12	0.59	1.38	1.62	1.52	1.62	3.50
MCNZ % of complaints to APC	0.32	0.01	0.34	0.36	1.48	1.30	1.48	1.52	0.84
NZPB % of Competence Reviews to complaints	3.70	3.33	4.00	NC	12.90	8.70	8.57	7.02	6.45
DCNZ % of Competence Reviews to complaints	0.00	0.00	1.37	NC	15.69	3.28	13.79	10.77	6.85
MCNZ % of Competence Reviews to complaints	NC	NC	NC	NC	11.56	11.67	14.29	18.72	12.90
NZPB % of PCCs to complaints	48.15	20.00	16.00	20.00	9.68	10.87	17.14	10.53	17.74
DCNZ % of PCCs to complaints	4.17	NC	NC	NC	13.73	9.84	39.66	15.38	2.74
MCNZ % of PCCs to complaints	NC	NC	NC	NC	0.00	0.00	1.90	2.74	7.26
NZPB % of HPDT cases to complaints	0.00	6.67	16.00	8.89	0.00	0.00	5.71	0.00	3.23
DCNZ % of HPDT cases to complaints	0.00	0.00	0.00	NC	0.00	6.56	17.24	6.15	2.74
MCNZ % of HPDT cases to complaints	NC	NC	NC	NC	0.00	0.00	1.90	2.74	7.26

NC - Not calculated due to unreliable data figure from first chart

In this figure the first set of calculations support the assertion that psychologists receive more complaints per capita than the other professions.

The second set of calculations shows that NZPB does not reflect numbers that are statistically different from the other RAs in terms of the amount of complaints that are referred to a competence review proportionately.

However, the third set relating to the number of complaints referred to a PCC, NZPB is somewhat comparable with DCNZ, although NZPB has a slightly higher frequency

overall. In contrast MCNZ reflects a very low proportion, this may be because of the number of complaints overall being received by MCNZ as they have a larger membership but it could potentially indicate something in the process used by MCNZ but that would require further research.

The final set of calculations relates to the number of cases going on the highest level of adjudication with the HPDT. The figures reflect similar figures across the RAs but the concern with that is that in relative terms NZPB has a much lower practising professional base than MCNZ, which ideally means that NZPB should reflect lower figures. As it does not this means proportionally NZPB is still taking more cases through to this level than the other RAs. This supports the assertion made elsewhere that psychologists are the most complained about profession and supports the desire for additional support by way of an early alternative dispute resolution process.

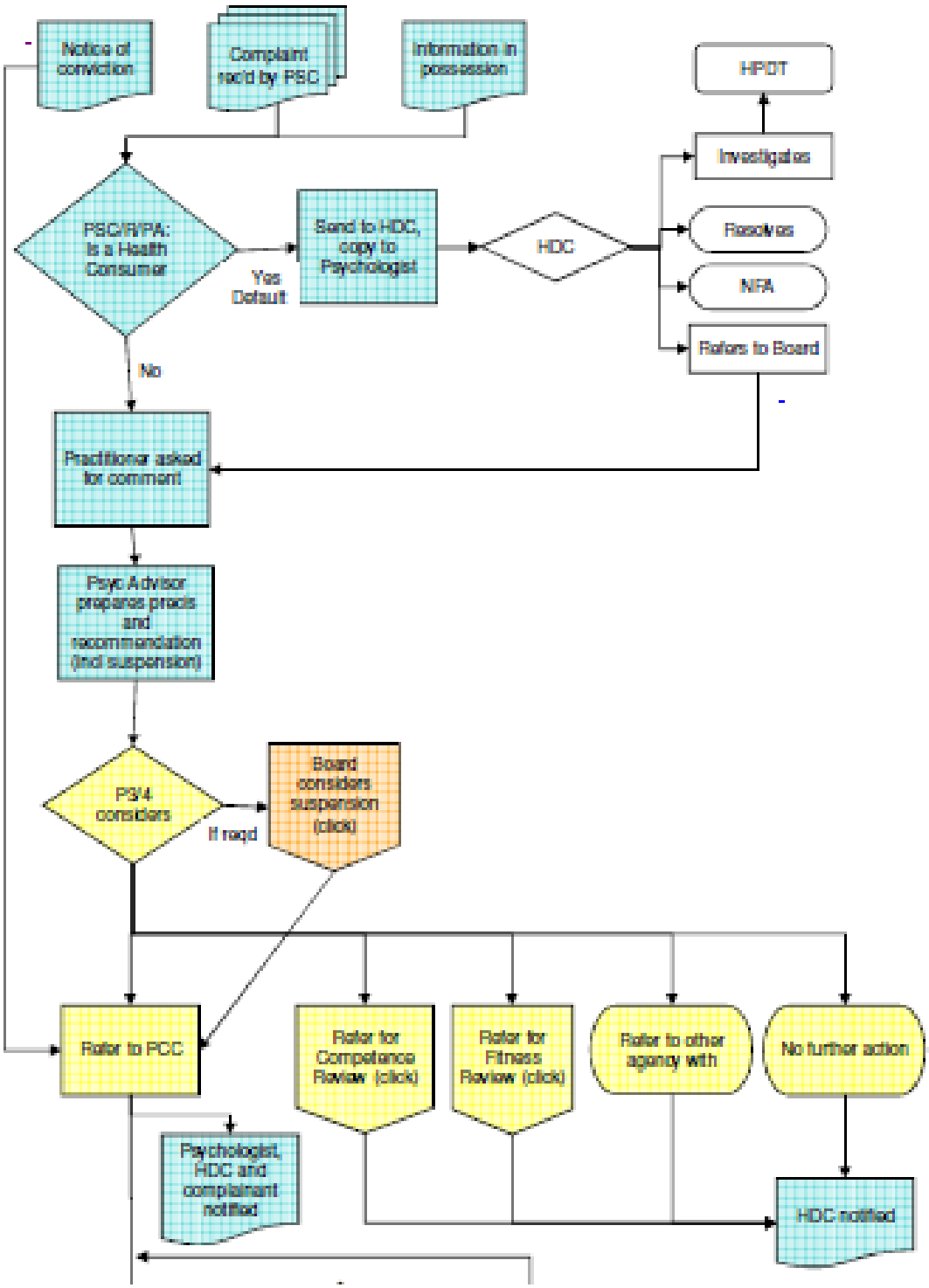
VII *New Zealand Psychologists Board (NZPB)*

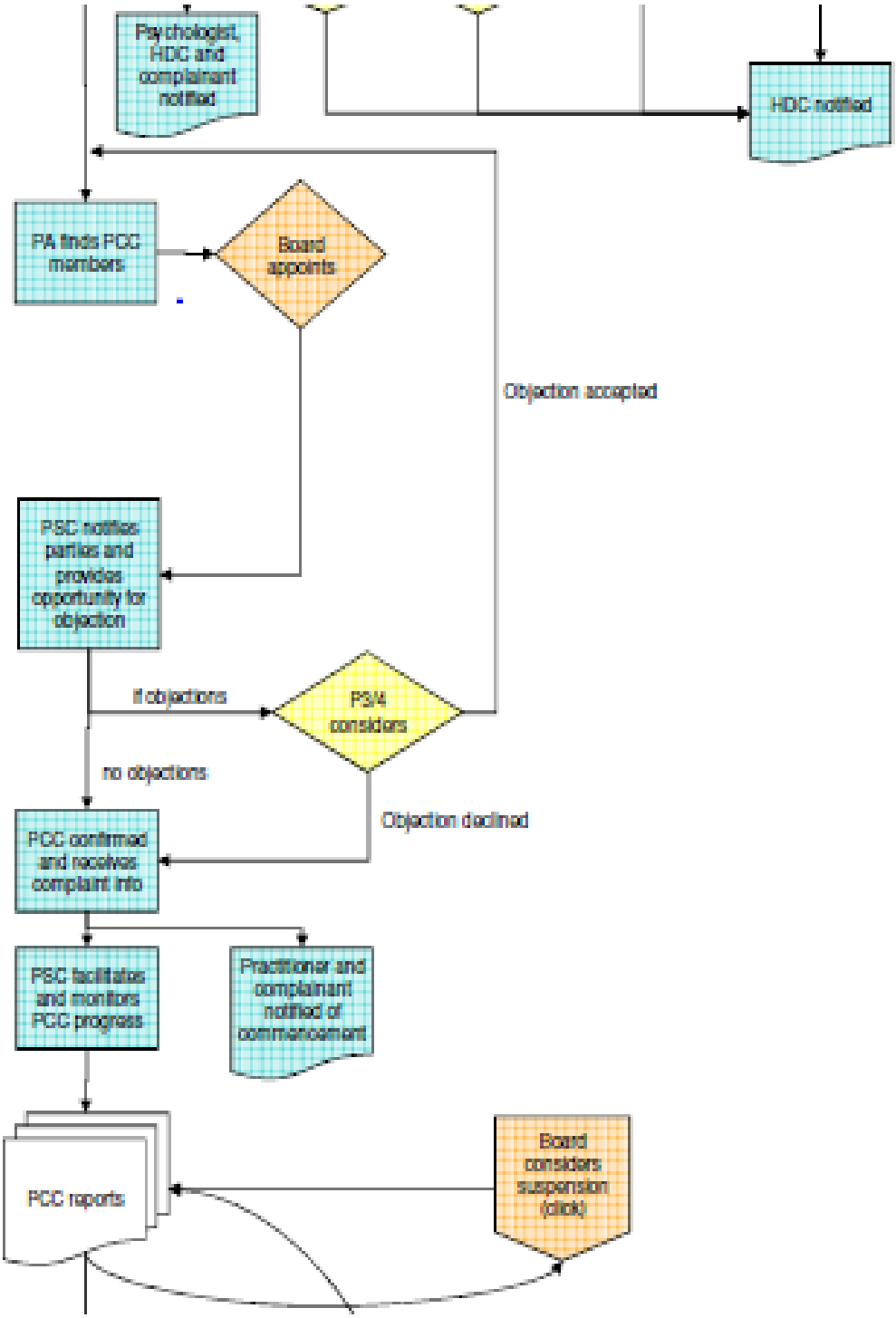
The New Zealand Psychologists Board (NZPB) regulates psychologists. It should be noted that nearly 50% of psychologists are technically included in the complaints process by virtue of registration although the actual practitioners have little or nothing to do with health as such e.g. educational psychologists, industrial and organisational psychologists etc.

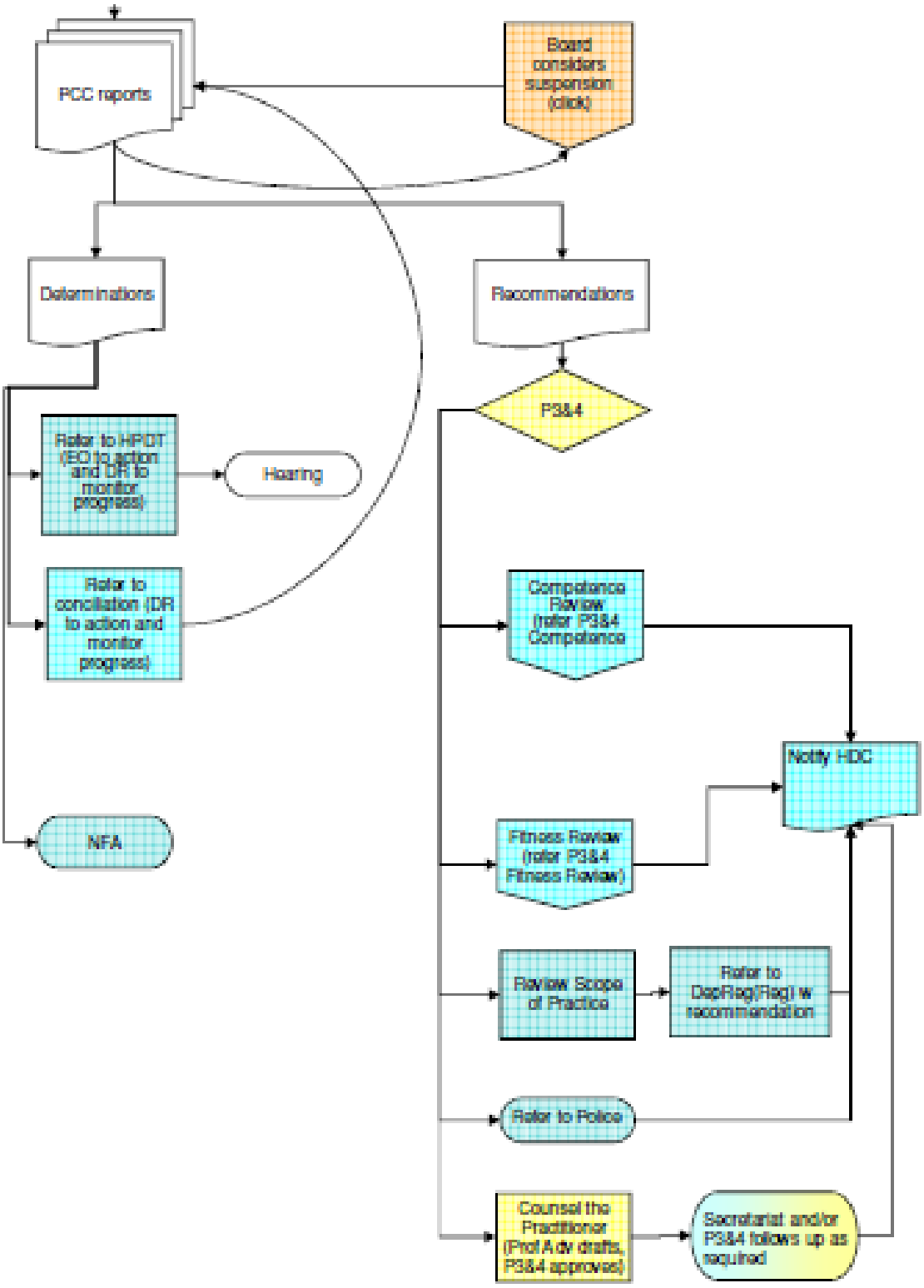
The following flowchart, to be read from the top down, briefly summarises the process that is followed by the NZPB when a complaint is received[134].

[134] Kindly provided by the New Zealand Psychologists Board.

COMPLAINTS


Notice of conviction
Complaint recd by PSC
Information in possession
HPDT
Investigates
PSC/R/PA: Is a Health Consumer
Yes Default
Send to HDC, copy to Psychologist
HDC
Resolves
NFA
Refers to Board
No
Practitioner asked for comment
Psyc Advisor prepares precis and recommendation (incl suspension)
PS/4 considers
If reqd
Board considers suspension (click)
Refer to PCC
Refer for Competence Review (click)
Refer for Fitness Review (click)
Refer to other agency with
No further action
Psychologist, HDC and complainant notified
HDC notified


Psychologist, HDC and complainant notified
HDC notified
PA finds PCC members
Board appoints
Objection accepted
PSC notifies parties and provides opportunity for objection
If objections
PSA considers
no objections
Objection declined
PCC confirmed and receives complaint info
PSC facilitates and monitors PCC progress
Practitioner and complainant notified of commencement
PCC reports
Board considers suspension (click)


PCC reports
Board considers suspension (clock)
Determinations
Recommendations
P3&4
Refer to HPDT (EC to action and DR to monitor progress)
Hearing
Refer to conciliation (DR to action and monitor progress)
Competence Review (refer P3&4 Competence
Notify HDC
NFA
Fitness Review (refer P3&4 Fitness Review)
Review Scope of Practice
Refer to Dep/Reg/Regl w recommendation
Refer to Police
Counsel the Practitioner (Prof Adv drafts, P3&4 approves)
Secretariat and/or P3&4 follows up as required

A Commentary - Stepping through the process

1 The complaint

The process outlined in the flowchart starts at the top. The complaint can be brought by anybody. If the complainant meets the definition of **health consumer** i.e. "includes any person on or in respect of whom any health care procedure is carried out"[135], then the complaint must also be referred to HDC[136].

A complaint can be received from somebody or it can come as a notice of conviction from the Courts. A complaint can actually come through a more subtle gateway called "information in (the RA's) possession"[137]. When a complaint is received it goes to the professional standards coordinator. The co-ordinator and the psychology advisor check to see if the complaint affects a health consumer for referral to HDC. The complaint may be sent by the complainant to either the NZPB or HDC. Similarly, complaints received by the HDC will be notified to the RA[138].

Complaints may also be received about psychologists working in the Family Court. Such complaints are dealt with slightly differently because they also affect another agency. Family Court complaints comprise nearly 40% of all complaints received by the NZPB. When a complaint of this nature is received, it is not only sent to the HDC who invariably refer it back to NZPB but also the NZPB has a protocol with the Court for how these complaints will be managed. The Family Court will refer the complaint to the Judge involved in the case for an opinion as to whether the complaint ought to be pursued. This information is included in the decision-making process.

Complaints are also received from patients within DHBs. In such cases the complainants are advised in the first instance to consider using the DHB complaints process, to work out some resolution directly with the psychologist, or with the assistance of the psychologist's supervisor or employer. If that does not bring resolution then a formal complaint can be made. The hope is that these systems have some opportunity for reconciliation and a complaint would only go to NZPB if there is no resolution.

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[135] Health and Disability Commissioner Act 1994, s2.

[136] Health Practitioners Competence Assurance Act 2003, s64(1).

[137] Above n 132, s68(3).

[138] Health and Disability Commissioner Act 1994, s42(1) mirrored in Health Practitioners Competence Assurance Act 2003, s66.

There are also complaints from DHBs about their own psychologists and these usually occur when they terminate their employment and they want to inform NZPB as to why that occurred. The DHB concerned is obligated to inform NZPB if the matter relates to competence, and may inform about other matters. However, DHBs are really poor at doing this. NZPB frequently hears of cases that it was not informed of because the DHB negotiated an exit with a confidentiality clause. This, in NZPBs opinion (based on legal advice), is unlawful. Sometimes the psychology advisor at the DHB says "I am ethically bound to do something about this" and they send in a complaint or competence notification.

2 Referral to the HDC

Once a complaint is received and if it alleges that the practice or conduct of a psychologist has affected a "health consumer" it is sent to the HDC as per the legislation. This process may take some time but HDC does “refer” only a portion to NZPB, indicating it thinks there is some merit to the complaint and NZPB should have a close look at it. The majority of complaints are returned without formal referral, leaving NZPB to decide whether to continue. Occasionally the HDC will take on an important case, where for example there has been an egregious violation of boundaries (e.g. sex with the client or theft from the client).

If a complaint also contains matters that relate to competence, the NZPB may consider that aspect while the conduct is being considered by the HDC.

The author noted that, for example, the Psychotherapists Board website advised complainants to contact the HDC in the first instance. When comment was sought on this point, the NZPB responded that it had not gone in that direction because it felt that its job was to protect the public and making them go to the HDC may feel to the complainant like the NZPB was putting up barriers. The NZPB likes the complainants to feel heard from the first instance and believes it sends a message to the public saying that it does take complaints seriously, and while the complaint may have to go to HDC, it will quite likely come back to the NZPB.

The NZPB indicated that they thought perhaps that other RAs may rely on HDC no further action decisions and while this might assist in managing complaint numbers, NZPB considered it would not be doing its job of protecting the public if it did not consider pursuing the matter further. The complainant was usually asked if they wanted NZPB to follow up on the complaint. It was noted that 9 times out of 10 the complainant agreed and NZPB subsequently continued the complaints process.

3 Consideration by the NZPB

Once the above steps have occurred and the Psychology Advisor has received the complaint, a response from the psychologist, potentially a Family Court Judge's decision and any comments from the HDC which indicates how seriously they view the situation, then the Advisor would prepare a précis of the information. This summary document containing the highlights of the reports would be attached to the front of the documents and sent to the P3&4 Committee for consideration.

The P3&4 Committee is a sub-committee of the Board tasked with dealing with complaints. The name P3&4 refers to Parts 3 and 4 of the Act which contain the competence and conduct complaints legislation. The committee comprises 7 people, 3 of whom are from the Secretariat - the Registrar as Chair, the Psychology Advisor who has 30 years of experience in the profession and the Professional Standards Coordinator, who is also a lay person, 3 Board members nominated for appointment by the Board but appointed by the Registrar, and one external expert.

The committee can recommend to the Board that the practitioner is suspended while further investigation is completed. It was noted that suspension is very rare. The Committee then decides the direction for the complaint. The Committee may decide that no further action (NFA) is required, which occurs in the majority of cases. This decision is effectively saying that the complaint does not reach a threshold, or that for some reason it could not be fairly investigated (for example where there is no reliable evidence that could corroborate the complainant’s allegations). There was, however, some comment on how this threshold needed to be better defined. Part of the decision is based on factors such as: how bad was the behaviour/injury or whether the public interest was sufficient to justify a full investigation.

The Committee may also refer the complaint to another agency (e.g. the Privacy Commissioner), but noted that this happened very rarely; or it can refer the psychologist for a fitness review (where the psychologist has health issues); or a competence review (if the complaint relates to matters of competency).

The Competence Review for competence matters is carried out by a panel of two psychologists who are peers in the practitioner's area of practice. Their role is to determine whether or not the practitioner is fully competent and, if they identify deficiencies, to recommend a plan for rehabilitation.

The final option for conduct matters is a referral to a Professional Conduct Committee (PCC). NZPB noted that it was currently working with a lawyer to clarify the threshold for referring a complaint to a PCC. NZPB noted that it would be unsustainable to send every conduct complaint to PCC, as a PCC case costs (on average) about $25,000 and, with an average of 40 complaints received a year, the process would become prohibitively expensive.

4 Professional Conduct Committee (PCC)

A PCC is an independent body which reports to the NZPB. A PCC comprises 3 people, two psychologists in the appropriate scope of practice with extensive experience, and a layperson, drawn from a pool of about 30-40 people. The Board adds new people to the pool as required. PCC members are volunteers, who usually also have full-time jobs but who are willing to contribute to the profession in this way above their regular work. Members commitments can impact on the process in the form of time delays. The PCC process can take from 2 months up to 2 years, with the majority taking less than 6 months.

The appointment of PCC members has recently changed (February 2016) with the addition of a new role in the form of a "Psychology Advisor - Accreditation and Investigation". The Psychology Advisor will now be Chair of almost all PCCs which will result in more consistency, more speed and efficiency because she will carry out all organisational and recording functions. The Advisor brings extensive experience to the

role having previously served on PCCs, the Board, and having worked in the profession for a long time

A PCC decides what questions to ask and whom to interview in its investigation of a complaint. The NZPB provides guidelines for psychologists who are undergoing an investigation, for PCC members, for the complainants, and for support people for the complainant.

The complainant and/or the psychologist can object to the PCC's composition, which the Board will consider. However, the Board is not required to make any changes.

PCCs can choose to, and mostly do, use a legal advisor. The NZPB maintains a list of lawyers recommended for this role. It should be noted that the lawyer who advises the PCC cannot go on to prosecute at the HPDT so there is a separate list of prosecutors from which the PCC can select should it decide to lay charges at the HPDT.

At the end of its investigation, a PCC sends its report to the Board. That report contains determinations and/or recommendations. If the PCC determines the matter is to go the HPDT, then they work with a prosecutor to lay a charge. If the PCC makes recommendations, then the P3&4 Committee considers them and decides which, if any, will be actioned. The determinations are binding and can include no further action, referral to the HPDT or referral for conciliation (only used once).

A PCC's recommendations might include that the practitioner is referred for a competence or fitness review, or that his or her scope of practice be reviewed (which may require that one or more conditions be placed on their scope). Recommendations can also include referral to the Police or that the Board counsel the practitioner. While it was noted that there was some debate about what 'counsel' means, it is usually understood as some written advice on what the practitioner should be doing.

Recommendations often include a competence review and are used in combination with other recommendations or determinations. An example given was a PCC report which determined that two complaint aspects should be referred to the HPDT. The report also recommended that one aspect should go to a fitness review as it concerned a person's

fitness to practise. The fourth aspect of the complaint warranted no further investigation. This use of creative combinations to address complaints is considered very beneficial. It was noted however, that if there is a determination of "no further action" (NFA) then there cannot be any recommendations because they are mutually exclusive.

5 Referral to the HPDT

When a PCC makes a determination to lay charges with the HPDT, the PCC effectively become the prosecution. The complainant has mostly stepped out of the process by this stage but often becomes the main witness for the prosecution.

B Recognition of obligations under the Treaty of Waitangi

NZPB is strongly committed to biculturalism both in terms of the standards set around cultural competence, and also in its processes. If there is a clear cultural component to a complaint, in terms of people involved or issues involved, then bicultural obligations can be built into the process. An example is a case that went to a PCC and where the PCC Chair was Pakeha and both the layperson and other peer psychologist were Māori. All were very experienced and highly regarded in their communities. The PCC agreed to meet on the practitioner's home Marae, enabling him to have culturally appropriate support.

The NZPB encourages biculturalism at all stages of the complaints process, including at the P3&4 level when making decisions. If the committee needs a cultural expert, it can reach out to (for example) a Board member who is Māori and seek advice as to any particular cultural aspects the committee may need to consider.

NZPB also tries to recognise other cultures. At PCC level people are welcome to bring a support person to any meeting with the PCC. Such meetings do not occur at P3&4 level for fear of encroaching into PCC territory, but for other interactions it can be built into the process.

It appears that the HPDT does not routinely extend bicultural considerations quite as far. On one occasion for example, the HPDT acknowledged that everybody on the panel was Pakeha and its only nod to biculturalism was to ask if the (Māori) practitioner wanted to do a karakia.

VIII *The Dental Council of New Zealand (DCNZ)*

The Dental Council (DCNZ) effectively has the registration and oversight of dental related professions, gathered together in legislation for management purposes. These are dentists, dental specialists, dental therapists, dental hygienists, clinical dental technicians, dental technicians, and orthodontic auxiliaries. For the purpose of this thesis all these professionals will be referred to generically as dentists, and the writer intends no offence to the other qualifications.

A Commentary - Stepping through the Process

1 The Complaint

Complaints may be received by way of referral from HDC, from ACC, from an employer, one practitioner about another which is not mandatory. Complaints from the general public are recorded but the complaint is referred to HDC and while HDC investigates no further action is taken by DCNZ beyond informing the complainant that the complaint has been referred to HDC. HDC may investigate the complaint itself but for the most part, the complaint is referred back to DCNZ.

It was noted that patients must find it confusing to know who to complain to and how the processes work.

2 Referral to HDC

Legally all complaints relating to a consumer are referred to the HDC. When complaint enquiries are received, the response is to indicate to the member of the public that HDC is an avenue for complaint but they are welcome to send a notification to DCNZ in writing

and are advised that the process from there would be that DCNZ refers the complaint to the HDC.

DCNZ will only investigate a case referred back to it by the HDC. DCNZ will not investigate until HDC refers back to DCNZ. While it is possible to wait for up to 18 months or 2 years for a complaint to be referred back to DCNZ from HDC, the timeframe may also be as little as three months.

If HDC determines that no further action is required, then DCNZ will not investigate further. The reasons given for this are firstly because HDC has already investigated and found no further action so nothing more is required; and secondly because HDC has not referred the complaint back to DCNZ.

If the complaint comprises two parts, i.e. part competence and part conduct then DCNZ would discuss the matter with HDC. It was noted that the majority of complaints were referred back by HDC and at that point the competence and conduct components would be investigated.

3 Referral to other agencies

Generally there are no referrals to other agencies. The DCNZ does consult with other agencies e.g. the Privacy Commissioner when setting standards to ensure that the standard complies with their legislation. DCNZ however, would advise the Privacy Commissioner should such a failure of the standard be found through the PCC.

4 Consideration by the Council

On receipt of a complaint, including those referred back by HDC, the Council would look at nature of the complaint and if the complaint has substance, referral would be made to the Professional Advisor (PA) who visits the practice to determine the validity of the complaint and course of action. This assessment is known as a s36 enquiry in which PA assesses the practitioner by the standards set by DCNZ, which has legal compliance requirements for working in New Zealand. For example, if a complaint concerns clinical

issues, the PA would consider the clinical standards set for entry to the profession e.g. cross-infection practice standards. The s36 enquiry also assesses whether the practitioner has worked within the ethical framework and within the standards for practice, whether they be clinical competencies or the practice standards for working. As a result of the initial assessment, the PA writes a report which goes to the next monthly Council meeting.

The Council then determines, based on the complaint received and the PA's report, whether no further action (NFA) is required, or if further action is required, the Council determines whether it requires an individual recertification process (IRP), a competence review (IRC) or if it is a conduct issue for a PCC. The other determination that can be made is that the complaint relates to a health issue, in which case a process is used to decide how to manage those physical or mental health issues which gave rise to the complaint.

Once that decision is made, for example in the case of a competency matter, then DCNZ will form an IRC committee, comprising two peers and a layperson. DCNZ would then ascertain the availability of potential committee members, and confirm or make changes to recommended members. The DCNZ determines the date when the competence committee can conduct the review of the practitioner. Based on their investigations the Committee prepares a report.

The timeframe for the process, depending on when the complaint is received is from 1 to 3 months to the committee, depending on the nature of the complaint and the availability of the committee and practitioner. Consideration by the Council has an average timeframe of 5 months from notification to decision.

5 Competence Review

There are two arms of the competence review process, the first being individual recertification programme(IRP) and the second being individual competence review(IRC). The first arm checks if the practitioner has been maintaining their professional competency training requirements. If not then the practitioner is advised by the Council what programmes they are required to undertake to reach the competency and

training levels required. This is the individual recertification programme, which is not used by the other RAs interviewed.

The second arm, IRC, occurs if a review by the Council determines that the practitioner is not competent based on the complaint, response and report prepared by the professional advisor. The competence review is more a review by a group of peers who determine what level of training needs to be undertaken for competency to be achieved. This may include having to complete around two years of university study. Although there are no charges laid in this process, it is felt that the process impacts the core reputation of a practitioner and therefore certain natural justice steps need to be taken before making a proposal for training. These steps include people having the right to be heard and any other legal factors that need to be considered. The process is in contrast to the PCC where the practitioner gets a lawyer and potentially the Tribunal as an independent party who considers the matter as in a Court situation. The need for confidentiality in this process is high because the practitioner's reputation is at stake. While it may take five months to complete through the competency review process, the committee report may find that the practitioner has undertaken normal standard practice.

For example, while a person may have experienced extreme pain, the practitioner is found to have used appropriate methods and to be completely competent with contemporary practice. The only finding may be that while the practitioner is competent and the work was competent, the practitioner could have communicated with the patient better. The outcome in this case becomes an advisory about communication and not a matter of competence.

It should be noted that there is a separate process to deal with health issues. Practitioners can become unwell, suffer from depression or be affected by life circumstances. In such circumstances the aim is to wrap a health monitoring programme around them to ensure that they are safe to keep working , and are monitored to make sure they remain safe.

6 Professional Conduct Committee (PCC)

The legislation is followed in that the Council will consider whether the complaint relates to a matter of conduct. If the Council deems the complaint to concern conduct, the legislation requires an independent PCC to be established. The Council appoints two peers and lay member as the PCC.

After appointment, the PCC conducts an investigation. The PCC is provided with all the information already collected by DCNZ, including interviews with the complainant, the practitioner, going into the practice and talking to other employees of the practice. The PCC is entitled to legal counsel and who works independently to determine whether to lay charges with the Tribunal. It was noted that by the time the complaint reached PCC level, the complainant was generally no longer involved in the process. The Council has no interaction with the PCC other than funding the PCC. It was noted that the DCNZ was aware that other RAs run their PCCs but that they had received legal advice which interprets the legislation as intending that the PCC be independent from the Council and attributed the difference to interpretation of the legislation.

Once the PCC has completed the process the report is received by the Council and notes the decision as to whether there is NFA, further education required or whether charges will be laid with the Tribunal. The Council has no influence with the PCC as it is an independent body.

The PCC report would also be recorded against the practitioner and appended to the practitioner's file. If any remediation or suspension recommended, that is carried out by the Council. If the PCC recommends a referral to the Tribunal, then the PCC lays charges. If the charges are upheld there are certain procedures to be followed including publishing the information on the website.

B Recognition of obligations under the Treaty of Waitangi

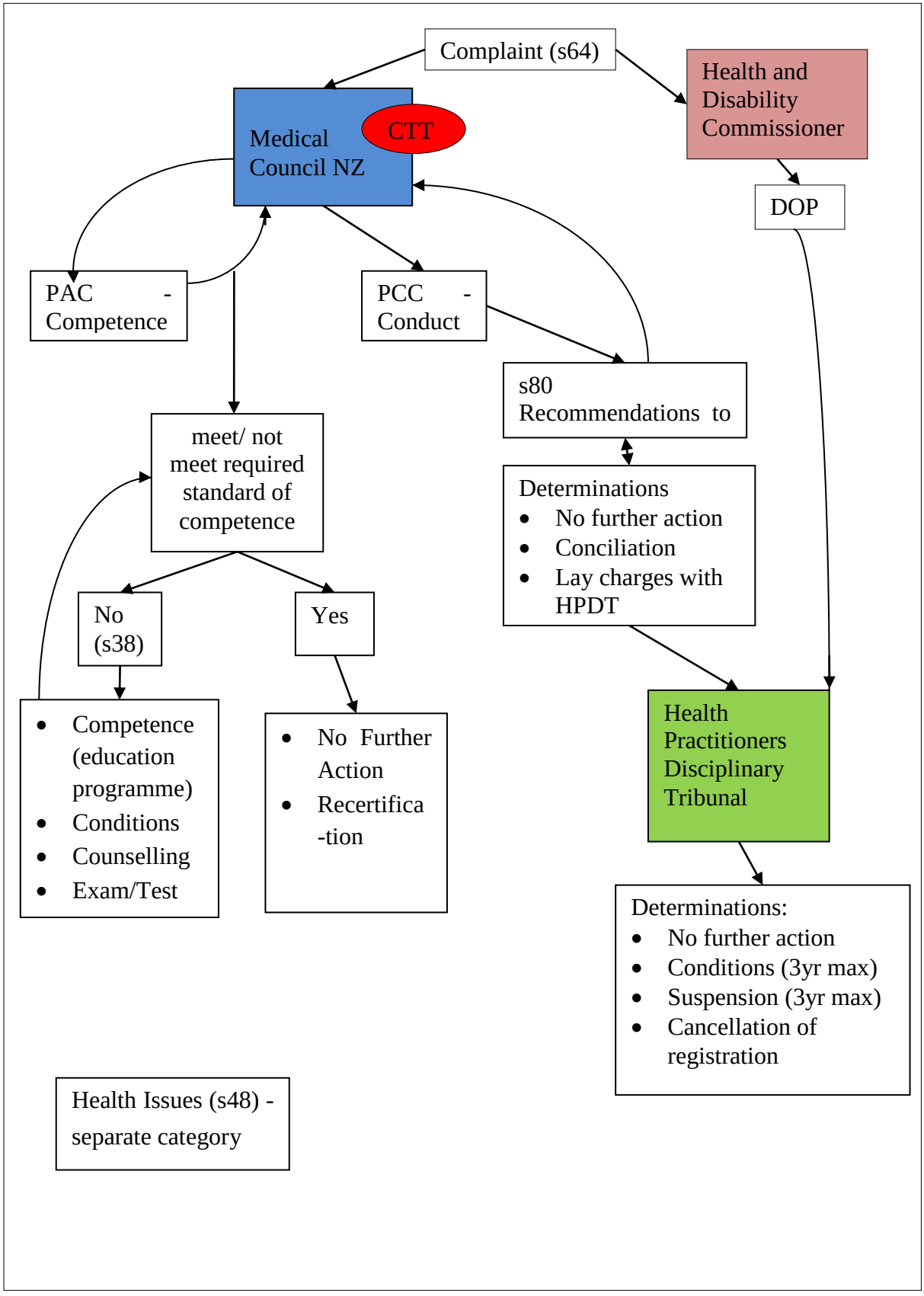
DCNZ noted that, while the legislation allows for recognition of Treaty obligations, more work could be done in that area. DCNZ thought that, as statutory bodies, most of the

RAs have recognised from a cultural perspective the requirements under the Treaty of Waitangi and, like DCNZ, have a cultural competence standard. However, DCNZ felt that the cultural competence standard needed to be expanded to recognise the diversity of New Zealand. DCNZ recognises this as an area where further work is required.

IX *The Medical Council of New Zealand (MCNZ)*

The Medical Council (MCNZ) is responsible for the registration and oversight of doctors who may specialise in various scopes of practice overseen by vocational colleges.

The following flowchart sets out the complaints process for doctors:


Complaint (s64)
Health and Disability Commissioner
Medical Council NZ
CTT
DOP
PAC - Competence
PCC - Conduct
s80 Recommendations to
meet/ not meet required standard of competence
Determinations
No further action
Conciliation
Lay charges with HPDT
No (s38)
Yes
Competence (education programme)
Conditions
Counselling
Exam/Test
No Further Action
Recertification
Health Practitioners Disciplinary Tribunal
Determinations:
No further action
Conditions (3yr max)
Suspension (3yr max)
Cancellation of registration
Health Issues (s48) - separate category

A Commentary - Stepping through the process

1 The Complaint

Upon receipt of a complaint, a determination is made if the complaint meets the test set out in s64, that is, whenever the responsible authority receives a complaint alleging that the practice or conduct of a doctor or health professional in relation to a health consumer, then the complaint must be referred to the HDC. There is no discretion. While some complaints clearly fall into that category, other complaints raise questions about a doctor's wider competence rather than a specific complaint of an individual patient. MCNZ deals with those complaints directly.

If a complaint contains components of both aspects i.e. partial conduct and partial competence or any other aspects (this depends on the case) then the complaint is referred to HDC who would generally refer it back. Where the evidence suggests possible competence issues, MCNZ may consider both a referral to HDC and a competence review because they are quite different processes.

2 Referral to HDC

The role of the HDC is to look at any complaint which relates to the treatment diagnoses, or care between the practitioner and patient. Anyone can make a complaint. When that happens HDC has first jurisdiction, and MCNZ may or may not get the information at the same time. If MCNZ receives the complaint first, then the complaint is referred to HDC, who will advise if an investigation is taking place, as this places some restrictions on what MCNZ can do. Under Part 3 of the Act MCNZ can look at the doctor's competence performance or health under s48 whether or not HDC is investigating. In terms of Part 4 of the Act, which relates to conduct, MCNZ can only consider a professional conduct investigation if the HDC is not investigating or has ceased its investigation. MCNZ may also choose to impose conditions on the doctor or limit the scope of practice until HDC has completed its investigation. Restriction is often done by way of voluntary undertakings between the Council and the doctor. This occurs after the process of gathering information and assessment of whether there is any risk to the patient or public that needs to be managed quickly. In a situation posing potential risk, MCNZ will make contact with the doctor and/or his or her lawyer and negotiate restraints or conditions

which manage the risk or even that the doctor relinquishes their Practising Certificate for a period of time until a more formal assessment can be undertaken.

If the HDC determines no further action is required, MCNZ may still investigate as the two use different thresholds. HDC considers the rights of consumers based on the code of consumer rights, which may be the only document of its kind in the world. However, MCNZ considers whether there is a wider ethical issue which needs to be considered by a PCC. On a few occasions when HDC has investigated, found the doctor in breach and asked the doctor to apologise, that is the end of the matter. Where there is a finding, MCNZ would almost certainly not undertake a PCC because it would be a double jeopardy situation. If HDC does not take action, then it is not perceived as double jeopardy for MCNZ to do so.

3 Consideration by the Council

Part of the process before the complaint comes before the Council is for the complaint to be considered by the Complaints Triage Team (CTT).

CTT meets weekly and every complaint, notification, and information received goes to that team. The team includes the CEO, the Registrar and various other senior staff within Council and also the Chair and Deputy Chair of the Council. CTT considers the information received, generally including the original complaint and response from the doctor and uses that information to make a decision as to how serious the complaint is, what the risk (if any) is to the public and also whether there is a wider competence or conduct issue. This can occur as early as one to two weeks after receiving the complaint.

There is no legislative mandate nor exclusion for CTT, rather it operates as a triage process for complaints or notifications. The Act states that, when a notification of complaint is received, then MCNZ must make an inquiry and may refer the matter for a review of competence under s36 and "promptly after receiving a notice of the kind in s34, must make inquiries and may review competence". CTT has Terms of Reference which have been approved by the full Council. The Registrar has a number of delegations under the Act, including to make certain enquiries and to make certain decisions. CTT does not stop complaints from progressing, but is more of an intermediary process for determining what further information might be required and how risk is managed ahead of Council being able to consider any case formally. The Registrar's delegations include:

to make enquiries, to issue a s35 notice which indicates to the wider community a doctor poses a risk of harm. Formally, CTT is described as an advisory group to the Registrar to assist in exercising those delegations, determine how soon a matter should be drawn to Council attention, discontinue an inquiry or await HDC's decision-making process. CTT's role does not compromise Council's decision-making capacity, but rather assists Council in its processes. The authority for CTT is now contained in clause 17 in the third schedule of the Act which authorises the Council to give the Registrar further delegations.

To ensure that CTT is not perceived to have more authority than it does, CTT is based not only on the legal framework which works, but also on how that framework interfaces with policy and delegations to achieve the desired purposes of CTT. CTT decisions can also be reviewed by the full Council.

4 Performance Assessment Committee (PAC)

PAC is the committee which deals with competence issues under Part 3 of the Act. There are a range of powers under Part 3 to deal with competency. Often information regarding competence is received from a peer or a colleague of the doctor, a response from the doctor is obtained and then MCNZ weighs up the information. Sometimes a professional inquiry is completed before consideration of more formal action. This inquiry would involve an independent colleague of the doctor. If the inquiry concerns a surgeon, then a surgeon or whichever particular field of the practitioner, who would go and spend a half day with that doctor. The inquiry would cover the doctor's personal issues, what the doctor is doing in terms of their professional development, and review the clinical notes before reporting back to the Council. The report provided gives a fuller picture in terms of the competence of the doctor and from that report the Council decides whether to make a full assessment .

A full assessment would be undertaken by a PAC which comprises a three-person panel. The panel will go into the practice and assess the doctor in the workplace. This would be conducted over a one to two day period using two doctors in the same scope of practice and one layperson. The PAC would use a range of assessment tools including feedback from other colleagues and peers and possibly patients depending on a number of factors. The review would include a range of questions, interviews tests etc. to measure how a doctor is performing.

Depending on the PAC's findings, which are reported back to the Council, there is a range of possible actions which can be taken against the doctor. MCNZ can put in place a competence programme for re-education, conditions on the doctor's scope of practice, counselling of the doctor, or an exam or assessment for the doctor to sit. There are no regulatory disciplinary outcomes for competence, although it might affect some practitioners as such. It is not the same as going through a conduct investigation which can lead to formal discipline measures including censure, cancellation of registration or a fine.

The PAC process may differ from other RAs who use a different process to review competence.

5 Professional Conduct Committee (PCC)

The PCC's role is to investigate conduct. It should be noted that assessment and investigation are quite important distinctions. Examples of investigation of conduct would be a doctor who had sexual relations with a patient, mis-prescribing drugs to themselves, family, or to gangs. The PCC, comprising of two doctors and a lay person, effectively investigates and assesses whether the doctor's behaviour is consistent with the ethics and standards set by MCNZ. A breach would result in a PCC being held and the complainant and the doctor would be interviewed, with the PCC make recommendations on the outcome. The PCC can decide to recommend certain actions to the Council i.e. that it counsel the doctor, or that Council restrict the scope of practice or in serious cases the PCC will lay charges with the HPDT. If the doctor was found guilty of professional misconduct it could lead to a fine and costs and maybe censure or cancellation of registration.

B Recognition of obligations under the Treaty of Waitangi

The legislation allows for recognition of bicultural interests with the minimum requirement for the RA to set standards of cultural competence. This has been a challenging area for the RA since the Act came into force in 2003. MCNZ had its first cultural competence standard in place by 2006. There was a perception that the

profession found it difficult trying to determine how to assess a doctor in terms of cultural competence.

MCNZ also recognises that it is now insufficient to have only bicultural competence but that multicultural competence is essential. MCNZ is currently considering this area, although the main focus at this time is addressing issues around health equity or health inequity. MCNZ is working with other organisations in the health sector in terms of how to improve health equity, especially as cultural inequity is linked to health inequity.

X *The Health Practitioners Disciplinary Tribunal (HPDT)*

The Health Practitioners Disciplinary Tribunal (the Tribunal) hears and determines disciplinary proceedings brought against health practitioners. The Tribunal comprises a chairperson, two deputy chairpersons, and a panel comprising laypersons and health practitioners. All members of the Tribunal are appointed by the Minister of Health. When the Tribunal sits to hear and determine a charge, it comprises five people: the Chairperson or one of the deputy chairpersons; a lay person appointed from the panel; three health professionals appointed from the panel and who are professional peers of the health practitioner who is the subject of the hearing

The decisions made by the Tribunal allow for more punitive actions to be taken against an offending health practitioner than are available to the PCC. These actions are found in s101 of the Act and include cancellation of registration, fines, suspension for up to 3 years, censure, and costs.

A Statistical Analysis

The decisions and statistics provided by the Tribunal allow for reflection on the efficacy of the PCC work as the decision to bring charges against a practitioner is that of the PCC. The statistics[139] reflected the following:

[139] "Tribunal's Statistics - All Professions" <http://www.hpdt.org.nz/Default.aspx?tabid=86>.

Summary for All Professions												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Summary of charges since 2004
Charges received	27	22	35	31	34	36	33	32	49	40	61	422
Number of Practitioners charged	27	22	32	31	31	27	31	29	40	34	32	350
Guilty - Professional Misconduct	22	15	20	21	24	28	22	24	38	24	20	255
Guilty - Conviction	3	5	11	4	8	5	10	6	7	8	8	75
Not Guilty - PMC	1	1	3	3	1			2	3	3	1	19
Not Guilty - Conviction	1				1							5
Not Guilty on appeal				1		1						2
Withdrawn		1	1	2		2			1	3		
Struck Out												
Stayed							1					1
Not Completed	0	0	0	0	0	0	0	0	0	2	32	60

A review of the statistics shows that the vast majority of practitioners charged are found guilty of professional misconduct or of a conviction. This indicates that the charges being laid by the PCCs before the HPDT are appropriate and there is suitable evidence to sustain the cases. The conclusion that can be arrived at is that the RAs are performing well in their investigation of complaints and that appropriate charges are being laid. It also means that if a practitioner is not guilty of any misconduct, it is likely that they will be cleared before it proceeds beyond a PCC investigation. It could also be concluded that only the most serious cases of misconduct with sufficient evidence are being referred to the Tribunal however, it is not possible to determine if any other cases should have been referred to the HPDT.

The chart also reflects a steady increase in the number of charges being laid. This may reflect either more experience in the PCCs in laying appropriate charges, that multiple charges are being laid against offending practitioners, or that consumers are becoming more knowledgeable in what they are complaining about. Without more information it is difficult to reach a conclusion on the causal factors of this increase. The difference in charges received in comparison to the number of practitioners charged reflects the fact that multiple charges can be brought against a single practitioner. Therefore no statistically significant conclusion can be drawn as the number of practitioners charged

has remained reasonably steady over the last 5 years. The exception is for 2013. Prior to 2014 the resolution rate for cases reflected that the cases were heard and finalised within the year the charge was laid. The "not completed" in 2015 merely reflects the fact that the cases have not been finalised for statistical purposes when the statistics were produced, rather than that the cases had not yet been heard.

B Interview

An interview was conducted with a psychologist who has served on both PCCs and HPDT. The purpose of this interview was to determine if the PCC process flowed well into the HPDT and to learn from the experiences of the psychologist in both these forums.

1 Training

The psychologist noted that PCC members have a wealth of experience in their field and while there is some training, the quality of the PCC depended on the experience of the members within the PCC process. He contrasted that with the fact that the Tribunal Chair or one of the Deputy Chairs sit on all cases so that there was always a wealth of experience available and some consistency brought to each HPDT case. He considered this the preferable option. It was also noted that the Chair/ Deputy Chairs are practising barristers so the legal aspects are also addressed with particular reference to the observation of natural justice.

The Tribunal brings together all the panel members from all the Tribunal groups for training every 2 years for a one-day programme and the psychologist said that, while this training covered the key points and issues of process, each year there was a specific focus item of relevance which was helpful clarifying issues. For example, this year there was a particular focus on penalties - how they are applied, how decisions are made as to which penalties to include etc. and a session about the issues around name suppression. The training therefore also addressed the legal issues that the Tribunal has to manage, given by people who are experienced in the topic discussed.

The psychologist noted that skills are also improved effectively by on the job training as the HPDT Chairs are very skilled communicators. The Chair's role provides the legal

framework and guidance which is consistent for each case. He noted that he had learnt a great deal about the process just sitting on the Tribunal, as well as psychological issues. Of the two processes, he felt more supported at the HPDT. He thought that PCCs are slightly disadvantaged because they are a much smaller group. The psychologist then also acknowledged that the legal implications at Tribunal level are very serious and therefore it was appropriate that the HPDT was more formal in its process.

In terms of recommendations for the PCC the psychologist suggested from his experiences, that PCC members receive more training beyond the process to include legal issues, and that when the PCC is convened a person who has lots of PCC experience be teamed with another of lesser experience, and that it might be possible to use experienced people as a resource to mentor newcomers to the process.

An example was given of a previous HPDT hearing, wherein it was necessary to address many small charges but no clear connection indicative of a larger problem. He said it was not clear exactly what the real issue was, and given how taxing and long the resulting HPDT hearing was, posing the question that if the PCC had different guidance it may have filtered the charges differently or structured them differently. He suggested that it would be helpful for PCC members to attend some HPDT hearings, which are generally open to the public, as he had learnt a lot from the process and thought that they would too.

The perceived benefits of attending HPDT hearings would be that PCC members would understand how their report is used, what the lawyer does with the points raised in the report and the charges outlined in the report. It may assist them to make clearer charges in terms of importance or prioritising and the required support for a charge going forward, in terms of substance and evidence to support it to ensure it was worth the time and effort to pursue it. He noted that, of the HPDT hearings he attended, almost 50% of charges had fallen away because there was insufficient evidence.

Most people on the Tribunal had already been on PCCs, so they appreciated the difficulties with the PCC process, knowing from the profession's point of view that the practitioner has stepped over a line but not how to appropriately reflect that in charges. He was not sure however, that the appreciation went both ways.

2 Charges

The psychologist suggested that these multi-charge cases indicated perhaps that there was some confusion regarding the nature of the complaint in terms of competence and conduct. Some of the charges dealt with both misconduct and some sort of negligence and incompetence. Where there was any confusion about which section of the Act was appropriate, then the PCC appeared to err on the side of caution and charged on both sections. He says this is not a criticism because he is also sometimes confused as to where something correctly belongs and even reading legal precedents about what constitutes incompetence or unprofessional conduct, has not clarified the situation for him. Fortunately he says lawyers have a better handle on the distinctions, or are more willing to draw a line in the sand and so provide invaluable advice to the PCC.

He recognised the need for a framework so that there is at least some consistency but acknowledged that this is difficult given the fact that there is little consistency across the health professions. He referenced as an example an issue discussed at training - that for psychologists there is no statute of limitations on having a sexual relationship with an ex-patient but for other professions it may be acceptable after the patient has been discharged for say 2 years. He queried whether these rules need to be consistent for all health practitioners and noted these variations made training across the spectrum difficult as acceptable conduct varies according to professional group.

3 The subjective nature of psychology and the difficulties in adjudicating

The psychology profession, within health, is slightly different from other professions. Psychology uses a number of theories to support practice and talking therapies[140], which have a different level of intimacy with a client than say a dentist. This would indicate the need for variances in the approach to rules and adjudication. For example in response to the initial complaint the psychologist needs to write an extensive response detailing not only the notes taken, but also the reasons that the approach was taken with this particular client in this particular circumstance rather than another approach. The approach taken and theory used is subjective both as to the client and as to the psychologist. Whereas for example a dentist can be judged on their notes and x-rays, this could not be replicated in psychology.

[140] Carl R. Rogers "A Theory of Therapy, Personality, and Interpersonal Relationships, as developed in Client-Centred Frameworks" in ed. Koch Sigmund *Psychology: A Study of a Science; Study 1, Volume 3: Formulations of the Person and Social Context* (McGraw-Hill, New York,1959) 154-256.

In the case of psychology, you can refer to the psychologist's notes. If there are no or limited notes, then that could be seen as a problem as the complaint can turn on the quality of note taking. If there are extensive notes then it becomes more of a subjective judgment about whether the psychologist's work was appropriate. This is partly a function of the nature of the relationship between the psychologist and the client. He notes that what he does with each client depends on the client and how he is feeling that day and how he responds, the approach taken to a similar issue would be different for different clients.

There are also different levels of intimacy. He used the example of talking to somebody about their abuse experience over a long period of time in comparison to doing a gynecological exam, even though both are intimate and open to abuse. It would be hard to say that the one could be more abusive than the other. It is just abusive but differently if not done adequately. This illustrates how difficult it is to present a case for psychologists at the HPDT because so much is based on opinion rather than obvious error, e.g. extracting the wrong tooth. He also notes that half of psychologists are not really health practitioners per se or not working in health as such, so while the registration authority covers the whole profession, only half of the profession comfortably fits within the current complaints regime, although it is applied to all psychologists.

C Bicultural Interests in the HPDT and PCC

It was noted that it is difficult to maintain bicultural interests at this level. The psychologist referred to a Tribunal case where the psychologist was Māori but there were no Māori sitting on that Tribunal. While it would be useful to have that capacity, he noted that there was a danger in having a "token Māori" who has to do everything as they become the authority whereas all the Tribunal should take some responsibility for taking care of cultural recognition. He felt that the Tribunal does have perspective and capacity for dealing with cultural issues, but there would be opportunities for improvement.

He noted that at PCC level if the complaint is about a Māori psychologist, then there would normally be a Māori psychologist on the PCC or alternatively that they would receive some cultural advice.

The Treaty is bicultural and while there is a need to recognise multiculturalism, there is a special obligation to biculturalism. Biculturalism is everybody's responsibility, not just that of Māori. All members of the Tribunal or PCC need to be familiar with Māori models of psychology practice, relating and social structures.

XI *Issues raised in interviews with regard to the Complaints Process*

A Introduction

This section looks at some of the discussions held with the NZPB, DCNZ and MCNZ in terms of the issues identified in Part 1. When the interview questions were proposed for ethical approval, these issues had not yet been clearly identified so not all of the RAs commented on all of the issues. In some cases it was not an issue for them or had not been raised in their process.

B Role of the Responsible Authority

The interviewer asked how the RAs positioned itself on a continuum of zero being public protection and 10 being the promotion of the profession, to see how the RAs perceived the service that they were providing.

NZPB put its rating as 0.1 as public protection is paramount. However, in order to do well at protecting the public, the psychologists need to be on board, hence not completely 0. NZPB is clear that its role is not to protect psychologists, but to protect the public, and it recommends that psychologists engage a lawyer during the complaints process.

DCNZ's legal understanding of complaints is that its purpose is providing the public with an avenue to use when they have received a service not up to standard or they have been

treated in a way that is not ethical or cultural. On the continuum they selected not quite zero as the protection of the public is not its exclusive focus. Public protection is the DCNZ's main focus and the standards it sets form the threshold standards for public safety. However, the DCNZ understands that in order to succeed in protecting the public, it is necessary to ensure the profession understands the standards to be adhered to. Therefore part of its role includes educating psychologist in order that they comply with the standards. DCNZ enables practitioners to achieve ethical frameworks, which consist of five ethical standards[141] supported by a number of professional standards. If practitioners meet all the professional standards, then by default they will have achieved an ethical standard.

MCNZ again selected an option somewhere between zero and one. MCNZ recognises that improvement of the quality of the profession supports public protection, and that the improvement of the quality of the profession is a wider strategy that MCNZ has adopted. In an operational sense, with an individual doctor, then the option would be zero.

Comment: All the RAs are focused on their role in regard to public protection. It is reassuring to discover how true they are being to the intent of the legislation and the goal that was set for them.

C Time taken

The average time taken to complete a case varied over the RAs mostly because of their processes and the type of practice. Each case had a different schedule depending on the complexity of the case and the availability of personnel and even on how long it might take to be considered by the HDC.

The HDC mostly referred the case back to the RA which could be a fairly quick process, up to about 3 months, If, however, a decision was made to investigate the matter themselves, then the process could take around 18 months to two years.

[141] "Standards Framework » Dental Council" <http://www.dcnz.org.nz/i-practise-in-new-zealand/standards-framework/>.

NZPB could potentially consider a matter including a PCC hearing, in an 18 month to three year period. The reason for the psychologists' complaints about the length of time could in some part be influenced by the fact that the complaint had gone through the HDC process first. Further time was added by the NZPB processes, which if you assumed it was a complex case which needed full investigation by both HDC and NZPB, the process could potentially take three years. NZPB, however, notes that the process can be simultaneous in some cases where there is an overlap with the HDC. A notification of complaint may be made which has different components i.e. conduct is seen as simply a bad act or misconduct but the complaint may also include some competency issues or ongoing indications that the practitioner is not practising competently.

For matters under HDC investigation, NZPB does nothing further under Part 4 of the Act. However, if the complaint includes competence issues, then Part 3 of the Act is invoked so that NZPB can consider competence at the same time. NZPB offered this as one reason why they prefer to receive complaints directly, rather than via HDC.

DCNZ advised that from the time of receipt of a complaint, after the complaint had been referred by the HDC, the complaint would likely be considered and completed in approximately four months, not including orders as some training programmes could take 2 years. If there was no referral from HDC, then DCNZ would not consider the complaint. The reason for this relatively quick process is because the investigation can be undertaken by visiting a practice and reading the notes with the evidence being more tangible. The case can be heard relatively easily.

MCNZ also recognised that the time a case spent with HDC would add to the time required for the process to be completed. MCNZ suggested that cases generally took a year and a half with HDC and a further six-eight months with MCNZ. MCNZ agreed the timeframe for the process needed to be flexible otherwise there would be greater delays. MCNZ regarded the main factor in complaint management timing as being the HDC. A significant proportion of complaints are dealt with by HDC and if a full investigation was undertaken, then the time frame could be anything up to two years, which MCNZ admitted seemed a long time. However, MCNZ also recognised that part of the delay could be, at least in the medical world, attributed to complicated processes. Lawyers arguing points of process actually led to delays in the consideration and outcome of a particular complaint. MCNZ noted that the more formal the process, the more likely

there would be a delay, but the use of voluntary undertakings for example, does speed the process along.

HPDT - it was noted by the psychologist that sometimes there is around a 3year time period between the index event and the matter coming to a hearing. He noted that the timing for PCCs was difficult because PCC members are volunteers. The matter then had to be scheduled for a hearing. It was noted that length of timing makes it difficult because people come before the Tribunal and can say that they have had three years to reflect on the error of their ways and that they have made changes to their practice/ lives. Despite that, the Tribunal still has to rule on something that happened then and not on what is currently happening. Lawyers sometimes present information about the intervening time at sentencing for sanctions and penalties. However, the Tribunal does not seek that information and it is difficult to know how to interpret the alleged changes. The psychologist went on to reflect that "justice delayed is justice denied"[142] but that it was in the interests of everybody to have fair process even if it took longer.

The psychologist also gave an example of delays in the process caused by scheduling and resources. If for example, a Tribunal hearing runs overtime, then another day has to be scheduled which could take two to three months due to availability issues. While for the psychologist the complaint is the most important thing in their personal and professional lives, for the people on the Tribunal it is one more thing in their calendar, and with due respect to the lawyers, another day in the office. Improving the speed of the process would probably require increased resourcing to cater for more hearings. Balanced against that is the huge cost of hearings and having days where nothing is scheduled to accommodate changes to hearings added to those costs. The psychologist thought that it "*must be horrible when you are notified about a complaint and you know it is going to take years to resolve. Especially if there is some restriction on your practice certificate and you can't work*".

Comment: While an argument can be made about delayed justice in these situations, this is should be balanced against the potentially ponderous process to preserve natural justice. The only question that can realistically be offered to advanced the argument is whether it is in the public interest to have speedy justice or to have a thorough process that protects everybody's interests. The answer then becomes clear in the best interests to

[142] Attributed to William E. Gladstone, unverified.

protect the public., All the parties should seek to improve the process so as not to cause unnecessary delay.

D The Complainant

NZPB routinely considers non-health consumer related complaints. NZPB also considers motivation and whether a complaint might be frivolous and/or vexatious.

DCNZ does not find it necessary to define the complainant.

MCNZ does not find it necessary to define the complainant. MCNZ makes no meaningful distinction as to whatever form the complaint takes if it requires action. The complaint might concern the competence or conduct or behaviour of any doctor. There is a variety of complainants and complaints i.e. employers complaining about doctors giving medical certificates, complaints from ACC clients who do not like a report that an Occupational Physician has given and ACC changing client's benefit. Complaints are also received about clinical care or unethical behaviour. Medsafe also provides information. There is no limit to the category of people who could complain or send information.

1 Frivolous and Vexatious Complainants

NZPB has received legal advice that there is a very high threshold for the legal terms "vexatious and frivolous". NZPB does not receive many complaints of this type. In one case, however, a complainant brought a complaint against six psychologists in one matter. The complainant made it clear on a number of occasions and advised five of the psychologists, that the reason she has brought a complaint against them was to 'get' the one psychologist. The complainant even told the psychologists that if they helped her, she would either not bring or drop the complaint against them. This seemed to be an abuse of process and as such vexatious. NZPB thought it likely that a number of these complaints should be disregarded and that it was unfortunate because such behaviour cast

doubt on the central complaint even though NZPB thought it likely that the complainant probably did have reason for the original complaint.

NZPB will almost always initially accept a complaint, but once the psychologist has responded and it is considered at the P3&4 committee level, they may deem the complaint to be frivolous or vexatious.

MCNZ recognises that there are occasionally vexatious and litigious complainants, and note that it is not always easy to determine straight away exactly what the situation is. Further information received enables MCNZ to identify a complaint of this nature. MCNZ notes that complaints can be difficult to assess especially if the patient has a mental health background, thereby making it difficult to distinguish the complainant's perception of a real concern and whether the complainant is sufficiently cognitive to understand that actually there was a concern. This made it difficult to decide in advance whether the complaint was frivolous or vexatious.

ACC cases were offered as another example. While ACC has a robust process for ACC claimants to appeal against ACC decisions, a number of complaints received were from an ACC complainant who did not like the doctor's report about their physical injuries. Complaints were then made to the Council. The doctor may have had a valid reason for the opinion in the report and that is what MCNZ would consider as well as how professionally the doctor treated the complainant. MCNZ does not comment on or judge ACC decisions, so there are some grey areas in that type of complaint.

The frivolous/ vexatious litigant may result from the Council deciding to take no further action. One of the protections against this is that the complainant would go through the HDC in the first instance before going to MCNZ. However, that would not always stop the complainant going to the MCNZ as well. In some situations MCNZ has had a complainant continue to correspond with the Council when they are not happy that the Council has determined to take NFA. MCNZ has been known to advise the complainant that they will not enter into any further correspondence with them. CTT has a reserve capacity to take the matter before the full Council for consideration to ensure the Council feels comfortable that CTT has made the right decision particularly in regard to a complainant of this nature. Council gets a regular schedule of CTT decisions on how to manage the complaint and if there is doubt, then Council can see the complaint.

Comment: From descriptions of the process and the way that the RAs operate, it appears that RAs do not limit complainants and are not able at the first instance to weed out unnecessary complaints before the practitioner is required to respond. This is appropriate as there is a risk of endangering access to justice for the public if any limitations were placed on the complainant or complaints. However, this adds a heavy burden both on the RAs in terms of workload and on practitioners in terms of the number of complaints where they are required to respond, even though the grounds for the complaint have little substance. It is clear that the RAs are doing their best to minimise the amount of work the practitioner has to do in response to unnecessary complaints through the use of extra committees and investigation teams who endeavour to decide quickly on the substance of a complaint and whether any further action is required.

E Nature of the complaint

None of the RAs limit the nature of the complaint, the only requirement being that there has been a breach of the professional standards or ethics.

F Withdrawing complaints

NZPB allows the withdrawal of a complaint at any point in the process but once sufficient information has been obtained to commence the process, then the complaint may proceed even without the complainant. NZPB noted that the PCC has the power to compel complainants to co-operate with the process but that that option had never been used. The reason given for continuing a complaint without the complainant is that while the complainant may withdraw for any number of reasons, the complaint still requires investigation to ensure that public protection is maintained.

MCNZ considered the two contexts in which a complainant withdraws. With regard to competence, the complainant would have provided enough information for MCNZ to commence a process even if the complainant withdraws. If the complainant withdrew the complaint before any action, then MCNZ will not pursue the matter. However, once MCNZ has the information and has asked the doctor to respond, then withdrawal of the

complaint would not stop the process. The process does not require the complainant's involvement, just for someone to have said what happened and that it happened to them in the form of the initial complaint information. In doing so MCNZ knows a threshold has been met and that there is enough verified information to put to the doctor to seek a response. Withdrawal of a complaint can be frustrating because MCNZ cannot ask the complainant for further information. However in most cases, unless they withdrew at an early stage, MCNZ would have an information base that it could take further.

If the complaint relates to conduct, then the complainant would have given information to HDC and that would suffice to commence the process. However, there are occasions where a complainant has talked about conduct at a consultation but withdrew the complaint after that. This could cause difficulties as CTT may have already given some consideration as to whether the matter should be referred to a professional conduct committee. This has occurred and inhibited the process for a time but the case progressed on the strength of other verification of the circumstances. If the conduct complaint was based on information that was personal to the complainant, then that would cause frustration. Some PCCs have been discontinued when the complainant was not willing to engage. If the Council decides that the information already provided suggests that there was inappropriate conduct or an issue that compromised safety, the PCC is charged with establishing whether there is a prima face case to proceed to charge. The PCC has a semi-judicial role and has broad powers under legislation to subpoena information. If the complainant withdraws at the point at which PCC has been initiated, the PCC can compel the complainant to provide information. Essentially the complainant has been tipped into a semi-judicial process which they are obliged to proceed with. Ultimately if the complainant refused to supply any further information, there would probably be sufficient information before the PCC to pursue the question despite the frustration caused by the complainant not providing more information.

Comment: Initially I was concerned that the PCC or any similar committee became both the complainant, in the absence of a complainant through withdrawal, and the investigation quasi-judicial body which judged a practitioner. However, with further information, I was reassured that the process at that stage no longer required the presence of a complainant as the investigation was into the practitioner on the basis of the original complaint information. The complainant was not the accuser, as in an adversarial process, but rather the process was inquisitorial and therefore the absence of a complainant was not necessarily a breach of natural justice.

The second concern following on from this discussion was whether the public understood the fact that once they were in the process they could be subpoenaed. I was reassured to learn that all the RAs used a light hand in the process and generally never used these powers. However, it was good to know that the power was there for cases where it was deemed necessary.

G Limits to investigations or complaints

NZPB found that more of an issue than complaint withdrawals, was that people could not be stopped from submitting and re-submitting multiple times about a complaint and that that often drew the process out. While NZPB asks complainants not to add to the complaint after a certain point, they still do, resulting in NZPB having to go back to the beginning of the process to ensure fair process.

MCNZ also said that while they asked people not to keep adding to the complaint, MCNZ could not stop it happening.

Comment: I sympathise with both the RAs and practitioners who find this ever expanding type of complaint to be time-consuming and impractical. On the other hand, the purpose of the RA is public protection and while the public can be problematic to deal with, in terms of their understanding, education and eloquence, I understand the need to leave the complaint open-ended should the member of the public decide on further disclosure, especially if another aspect of the complaint might only become apparent to them later.

H The Practitioner's response - reasonable demands on the practitioner?

NZPB advised that when the practitioner is asked for comment, the guidelines show that NZPB accepts the same submissions that were made to HDC. NZPB had amended this process in response to complaints from psychologists about how many authorities they

had to respond to regarding one complaint. NZPB acknowledged that psychologists generally wanted to, at least, amend the submissions from those given to the HDC, but that the response did not have to be brand new. The response was however, important because it is the first opportunity for the psychologist to give their side of the story which is often quite eye-opening because until then NZPB has only heard the complainant's side of the story.

There was some discussion of the requirements of that initial response to the complaint and while NZPB advises psychologists that they do not have to provide a full response at the first stage, they generally do. The psychologist will have a chance to talk to the PCC (if one is convened), so that they do not need to provide all the information at the screening stage but need to give enough information for the P3&4 committee to decide which direction the complaint should take. Psychologists generally err on the side of caution and give everything, even supporting documents which could come later as any initial reference to them is taken at face value that they exist.

DCNZ investigates the complaint at the practice and so that practitioners are not required to send a response. The complaint is shared with the practitioner and sometimes they respond in writing. Generally because dental records are electronic, the records would be provided by email. The Professional Advisor (PA) would use that information along with the complaint to determine if the PA needed to visit the practice to undertake s36 enquiries to understand more by observing what is being done. Such competence enquiries may result in no further action or an educative requirement. A complaint originating from a consumer would still go to HDC. If the HDC determines no further action is required, then DCNZ does not do anything further with the complaint.

MCNZ expects the doctor to respond to allegations in a complaint and from there the CTT can decide a number of different actions. MCNZ can decide to take no action at all, which would be the end of the issue. MCNZ may issue what is colloquially called an "education letter" but which is effectively a warning that the doctor's performance was not good and that, while no action is being taken this time, it is necessary to improve performance in the future. If it happens again it might be looked at more seriously. The CTT decision can occur before the complaint is sent to HDC, although generally HDC will already have the complaint and referred it back to MCNZ. Another option is that MCNZ will refer the complaint to HDC but will consider the competence issues

concurrently or slightly after the complaint goes to HDC as the principle is that there is dual jurisdiction to a point. The doctor can send the same response to both HDC and MCNZ.

MCNZ can also seek a specific response to particular questions that relate to safety aspects of the doctor's practice rather than on the investigation. These questions may address what needs to be done in the interim while the HDC investigation is in progress or may just ask what the doctor has given to HDC and what progress is being made. MCNZ usually has specific questions that are asked and the HDC response may not necessarily cover all that MCNZ requires.

Comment: This response requirement has been recognised by NZPB particularly as an issue for psychologists in a way that is different from other professionals because of the nature of "talking therapies". NZPB has done its best to minimise the workload for psychologists in agreeing to take the same response as given to HDC and not requiring supporting documentation in the first instance.

I Fear of complaint affecting work

NZPB recognises the sensitivity of psychologists to the complaints process and how it might affect their workload as the work is usually referred on the basis of the psychologist's reputation. NZPB agreed that it was unfortunate how the system works but noted that practitioners only see cases that make it into publications which occurs at the end of the process. NZPB reminded practitioners that they do not see all competence related complaints or those sent to fitness reviews, and that NZPB may work with a psychologist for two to three years with training or treatment in the hope that the psychologist can safely return to practising. The privacy levels of competence reviews are such that not even the complainant is told anything beyond that the practitioner has been referred to a competence review and will get some help with the practice. This means that most of the rehabilitative work done by NZPB is unseen by practitioners and never makes the headlines.

Comment: It is extremely difficult to measure the impact of a complaint on a person's work in objective terms. Without a doubt there is fear, embarrassment and other implications but another study would be required to measure the impact on employment opportunities. NZPB was keen that psychologists be considered innocent until found guilty if a complaint was brought, especially in the early stages of the process.

J Fair Process

For the most part, the RAs were all of the opinion that the process was kept as fair as possible with due consideration to natural justice. One of the methods that all relied on was the use of legal advice in the process.

1 The use of legal advice by practitioners

NZPB noted that psychologists almost always bring a lawyer into the process. This was in part because many hold Professional Indemnity Insurance. NZPB noted that some psychologists were self-represented but that the process often went badly -- at least in the later stages -- for those who did not utilise a lawyer. More recently, perhaps the last 2 - 3 years, psychologists have also been using lawyers during competence reviews. This has led to some difficulties as the lawyers were challenging the competence process as if it was a conduct process and challenging every single step whereas the purpose of the competence review is for NZPB to sit down with the psychologist to identify any competence issues and how to fix those issues. The lawyers in such instances are limiting the questions and the process to the point where it is not possible to get to a productive conversation. This approach wasted time, money and emotional effort, illustrated in a recent example where it all become too much for the psychologist who then left the country.

While lawyers cannot be excluded from the competence process, NZPB has been proactive in organising meetings with lawyers from the two EPA schemes and having regular annual meetings to talk about how NZPB are running processes. If lawyers have concerns, then those concerns can be discussed at the meetings instead of turning each competence review into a battleground. The lawyers have been very helpful so it is hoped that there will never be a repeat of the above illustration. Hopefully lawyers now

understand that NZPB is genuinely pursuing a rehabilitative outcome and is not using competence review as a back road to punishment.

NZPB notes that there are a number of suitable lawyers in this field, and those who worked for the indemnity programmes were generally well qualified and familiar with the process, and when those lawyers were involved the process worked well. Issues still occur if the practitioner consulted a local lawyer without expertise in the process who misunderstands the Act or process but this is remedied by discussion.

DCNZ noted that some practitioners used legal advice to respond to a complaint, and while there appear to be more people taking up legal advice, generally few use a lawyer in the process. Some go through the process and never engage a lawyer. A greater number of practitioners each year are engaging a lawyer. Usually, when practitioners receive advice that DCNZ is operating within the Act, that is sufficient for unaided practitioners to go through the process. However with the use of the professional indemnity scheme, more practitioners are supplied with a lawyer and therefore it is becoming more common.

The use of a lawyer can be helpful if that lawyer understands the Act but often the lawyer engaged does not understand the process. In comparison DCNZ is completely conversant with the Act and sometimes finds lawyers pointing people in a direction that just is never going to work, this causes the practitioner a great deal of difficulty in the process. At other times the lawyer acting for practitioner holds DCNZ to account, and keeps the process honest which is beneficial.

DCNZ does not recommend using a lawyer for the competence process because it adds to the cost of the process for the practitioner. Added to that is the cost of their remediation if that is the outcome. Often the practitioners who use a lawyer in this process are those who lack insight into themselves, how they deliver care and the issues they may or may not have. Practitioners with insight generally do not use lawyers in the competence process because they agree that DCNZ has given them a fair assessment.

MCNZ noted that doctors generally obtain legal advice as soon as Council gets involved. Some senior staff at MCNZ are lawyers themselves and are happy for other lawyers to be

involved in the process although sometimes delays in the process are caused by the doctor's or their lawyer's own actions rather than by the actions of MCNZ. Delays in the process should not always be attributed to the RA because it may well be the doctor or their lawyer causing the delay.

MCNZ's view was that lawyers were generally unnecessary for complainants because MCNZ is used to dealing with complainants at different levels. However, any complainant who wanted a lawyer would still be treated the same. Staff who handle complaints spend a lot of time explaining the process to people before the complainant decides to proceed. MCNZ is therefore skilled at making sure the complainant is advised of the process.

Generally speaking, for most doctors for whom it is the first complaint, it is useful for them to have a lawyer MCNZ often recommends that the doctor obtains representation because:
(1) Lawyers know the MCNZ process and MCNZ can sometimes have a discussion with the lawyer as to the best way to work through the initial steps;
(2) The lawyer will understand what MCNZ wants in terms of what the concerns are about. MCNZ can also liaise with the lawyer about the CTT options and discuss the risk of harm and come to some accommodation as to what Council can receive by way of insurance; and
(3) For a doctor who has received a complaint there is often a much bigger picture that they need to deal with, for example the HDC is involved, ACC may be involved, the DHB is on their case. So it is useful for the doctor in managing all those competing demands and processes to have a lawyer as the liaison person who can manage the process.

MCNZ's philosophy is that good legal representation helps both a doctor and MCNZ in so far as the lawyer also makes sure that Council does not act outside its authority or does not act prematurely without all the information. It is reasonable to have lawyers protecting the integrity of the process.

Comment: While it could be argued that the use of lawyers may delay the process, this argument is offset against the value provided by the lawyers in the processes in terms of

efficiencies while still observing all the rules of natural justice. The lawyers however, must be fully conversant with the processes under the Act and the differences between civil and criminal law. I support the specialist training of lawyers working in this area.

2 The use of legal advice by the RAs

NZPB also uses its own lawyers in the process. For example the P3&4 Committee may obtain legal advice, particularly for cases that are not straightforward or that have not been seen before. PCCs are also entitled to obtain legal advice, and routinely appoint a legal advisor.

The psychologist interviewed, said he recommended that PCCs use legal advice. He contrasted the benefits of some PCC cases where there was good legal support obtained early in the process, to other cases where legal advice was not accessed early enough or it was difficult to obtain legal advice in a timely fashion because the lawyer was busy. The psychologist noted that, while none of the PCCs he was involved in had no legal support, some relatively straight-forward cases had advice in the form of a preliminary conversation. After most of PCC work was done, the report would then be sent to the lawyer for final checking and to see if any issues had been missed. If the case was more complex then the PCC was in regular contact with lawyers.

The psychologist said that he was aware of the meaning of natural justice and the need for it in the PCC process, but since his experience with the HPDT he realised that it was not applied with the same rigor a lawyer would apply natural justice. He described his experience with lawyers through the HPDT process, noting that their focus and concern that natural justice is observed is taken to the ultimate degree, e.g. with any new information obtained in ensuring all parties have the information, all parties have time to consider it, all parties have time to respond. This makes the process very slow. He admits that when he was at PCC level he was not as aware of how "fine grained" the application of natural justice could be. He notes that it probably would not have made any difference in the PCC cases he was involved with, but did bear in mind there would be grounds for challenging the PCC if natural justice was not observed.

MCNZ allows for the PCC to consult legal advice and they generally do consult a lawyer.

K Independence of the PCC

As mentioned above, NZPB has recently appointed a new role of Professional Advisor - Accreditation and Investigation, who will chair PCCs. This raised in the interviewer's mind the question of the independence of the PCC from the Board.

The legislation states that " A professional conduct committee may regulate its procedure as it thinks fit."[143] This section gives one the impression that the PCC is independent from the NZPB but further reading of the legislation allows: [144]

> The authority may, if in any particular case it considers it appropriate to do so, appoint, under subsection (1), a health practitioner or, as the case requires, a layperson who is a member of the authority.

Thus the legislation does allow for the RA to appoint a practitioner who is a member of the Board to the PCC. This allows for the Board's new appointment even though it might be perceived as reducing the independence of the PCC.

The psychologist spoken to earlier noted that the PCC is such a critical process that he felt that it was hard to get enough training on the process. He noted that this created a reliance on the PCC Chair having experience and that it was difficult if there was not that much experience given that the PCC is such a small group. The PCC also relied a great deal on NZPB helping and supporting the process to a certain degree, although they cannot interfere in the process. He recommended that, when PCC members are selected, it would be useful to have a senior experienced person paired with a less experienced person to work together, and that legal advice becomes more important if less experienced.

This psychologist makes a strong argument regarding the approach taken by NZPB even though at the time of interview he was unaware that this new appointment was being made. Earlier discussions with psychologists also revealed that they were never that

[143] HPCAA, s72(1).

[144] Section 71(2).

confident of the independence of the PCC and so this new appointment is unlikely to damage any perceptions of independence.

Comment: The new appointment's effect on independence is well compensated by the expected effects of having a dedicated Chair who brings a wealth of experience as well as having the time to facilitate efficiencies in the PCC process. Psychologists would prefer a quicker process due to these efficiencies over any perceived loss of independence of the PCC. The focus on efficiency is important because one of the key complaints expressed by psychologists is the length of the process, albeit that I recognise the difficulties experienced by NZPB and psychologists due to the subjective nature of the "talking therapies". The only argument that some psychologists will no doubt raise is that the person appointed to the role, and therefore Chair, is a clinical psychologist and may perceive a degree of loss in terms of peer review.

Overall however, ultimately most psychologists would prefer the benefits of timely justice and that will outweigh the loss of some independence and peer review.

MCNZ considers the PCC as independent from the Council in terms of decision making and collection and consideration of the evidence, whilst acknowledging that there is a connection with the Council. The PCC are connected to the Council in so far as the Council sets up the PCC and considers any recommendations from the PCC. MCNZ is also involved in the actual investigation itself, provides some training and provides the PCC with a list of legal advisors and a panel of prosecutors to choose from if they decide to take the case to the HPDT. MCNZ does not get closely involved in any of the PCC's decision making or investigation thereby maintaining a measure of independence.

L Early Intervention/ Dispute Resolution

NZPB feels confined by the fact that there is no early intervention process in the legislation. Legal advice indicated that the legislation does not allow for early dispute resolution processes. Consideration was given to whether enough flexibility exists in the legislation to allow for early dispute resolution and the matter is still being explored. In

both reviews of the Act by the MoH in 2008[145] and 2012[146], NZPB has requested an amendment to allow for reconciliation in the first instance based on the Alberta legislation.[147]

Part of the legal advice received was that the legislation specifically allows for conciliation at PCC level and therefore to have it earlier in the process might usurp the powers of the PCC. However, since conciliation is a PCC power, the author argues that the intent of Parliament must have been to allow for conciliation, so while it is not in the right place at this time it is not outside of the purview of the legislation. In the interim, NZPB encourages people to try mediation, either independently, through the workplace or with HDC if the matter is conducive to that sort of approach.

NZPB notes that the PCCs do not use conciliation generally as it is too late in the process to be helpful. NZPB has arranged one unsuccessful conciliation in the 10 years that it has been available in the legislation.

NZPB has also considered some of the objections to the RA doing mediation and whether that process needs to be separate from the complaints process. NZPB believes that the process would be manageable referencing the approach taken in Alberta where the secretariat is structured in a manner that allows one side to receive complaints and the other to conduct a discussion/ mediation off the record. This gives NZPB and practitioner a chance to provide what the complainant actually wants (e.g. an apology or that the practitioner recognises the hurt and does something to fix it) and to resolve, if possible, a mutually agreeable outcome. The signed mediation agreement can then be referred back to the other side of the Board with the complaint resolved.

Over a period of some years NZPB has been actively seeking ways to include conciliation early in the process both in discussion with lawyers and other Boards as there has to be some way that an early dispute resolution process can be introduced. NZPB recognises that, with the possible exception of Family Court complainants, most complainants just want recognition of what has happened and an apology, which at this

[145] "Review of the Health Practitioners Competence Assurance Act 2003 Report to the Minister of Health by the Director-General of Health", above n 110.
[146] Above n 110.
[147] Health Professions Act RSA 2000 c H-7, Chapter H-7.

time they are not getting anywhere in the process. Quite reasonably by the time the matter reaches PCC level, the practitioners have lawyers who do not allow the practitioner to say anything that may be open to being interpreted as an admission of guilt.

NZPB anticipates that any form of conciliation such as mediation would be confidential anything discussed at conciliation not be allowed in the judicial process if the complaint should proceed.

The psychologist recognised and agreed with the HDC advice about the importance of apology and how so many issues can be resolved by people talking together, often a sincere apology and a plan for how people are going to prevent it from happening again suffices. He commended conciliation but wondered if it was an appropriate role for the Board, concurrent with their regular responsibilities. He further considered that contracting the process out to an independent mediation agency might be preferable but agreed that conciliation in the first instance was a much preferred option because it would probably cost less than a full PCC process. He also said that the PCC, while inquisitorial, does not facilitate conciliation.

DCNZ recognises some value for an early dispute resolution process especially as many complaints related to the charges made by dentists rather than the actual procedure. This matter has been addressed through the NZ Dental Association offering a dispute resolution service for dental costs. The Association is acutely aware of what the charge rates are across the profession and can use that information to help mediate a resolution which is generally successful.

An early disputes resolution for any competence or conduct matter would probably not be of any benefit because DCNZ would still need to undertake the investigation to ascertain whether the conduct or competence standards are met or where the practitioner is not meeting the standards.

MCNZ use the CTT process to provide early screening and resolution of complaints. CTT meets weekly and every complaint, notification and information received goes to that team, who consider the complaint information provided including the doctor's

response. A decision is made as to how serious the complaint is, what the risk is (if any) to the public and also whether there is a wider competence or conduct issue which may need to be addressed. This process commences as early as one to two weeks after receiving the complaint and there may be no further action taken. The promptness of the CTT process could be considered similar to an early intervention process.

MCNZ recognises that the HDC Act has a provision for early dispute resolution but points out the HDC's role is different from MCNZ in that the MCNZ assesses competence, health or conduct by way of investigation that leads to two specific outcomes – recommendations or prosecutions. MCNZ considers that with the difference in roles the HDC process is the appropriate place for that early dispute resolution process and the legislative provisions suitably sit within the HDC Act.

Philosophically, MCNZ believes that dispute resolution is a matter for advocacy whereas MCNZ's role is to consider issues of conduct or competence. The difficulty is fundamentally in what Council wants to achieve. The complainant being happy is not the sought after outcome, but rather that the Council and by extension the public, is satisfied that the doctor is safe to practise. MCNZ is concerned that early dispute resolution could compromise the process as getting an agreement could be counter-productive because, if MCNZ accepted a resolution between the doctor and patient, there could still be outstanding issues regarding actual competence or conduct. MCNZ is not persuaded that early dispute resolution fits conceptually within the terms of the Act given its mission.

HDC has a dispute resolution service that is part of its advocacy process and so the issue is within its remit.

Comment: This is obviously a controversial topic. I agree that a conciliation process may appear to compromise the investigation and public protection roles of the RA. There is certainly a tension between the RAs public protection role and the resolution of a dispute between two parties.

NZPB suggests that the issue can be dealt with using "Chinese walls" as was used in Alberta, Canada[148]. Other suggestions received included outsourcing the dispute resolution to the Associations, like the consumer mediation offered by the NZ Dental

[148] This information was acquired from staff at NZPB at interview.

Association for cost concerns[149], or to an independent mediation specialist service. Outsourcing may indeed increase the independence of the process but raises questions as to the burden of cost for the process. Bearing in mind that the RA is funded largely by the annual practice fees paid by registrants, finding additional funding for a mediation service may increase the costs. However, it could be argued that mediation may be a cheaper solution than a full PCC, although limited by the fact that the Board would still be required to do PCCs where complaints related to matters of conduct in breach of the standards. Mediation would not obviate the need for Board processes currently operating.

Serious consideration also needs to be given to how the early dispute resolution process would work in practice, whether mediation is the medium to be used or some other form of discussion. The questions of confidentiality and the information available to NZPB would need to be carefully considered. NZPB indicated that it would prefer that the form of early dispute resolution is not prescribed by legislation but rather, consistent with the rest of the Act, the process could be an option within the framework. This means that those RAs needing this type of process could use the option and those that find it unnecessary do not need to use that section.

The NZPB and psychologists' arguments in desiring an early dispute resolution process are compelling, one main reason being the benefits of conciliation as a therapeutic process. The role of a psychologist mainly focuses on healing and integration of the psyche, although there are also many other aspects. However any wounding done by a psychologist is seen as especially problematic. A delicate and careful process is required to manage such a situation in a way that could be defined as therapeutic.

NZPB and psychologists are justified in arguing that the practice of their profession is much more subjective than other professions currently covered by the Act. "Talking therapies" rely on ever-changing research, theories and concepts which are used in any number of combinations to assist clients. Often however, psychologists report that the reason for the complaint is a misunderstanding by the client of the process or methodology that the psychologist is using. For example there can be difficulties with transference and counter-transference. These complaints would be better resolved

[149] "About NZDA" <https://www.nzda.org.nz/pub/index.php?id=4&no_cache=1>.

through neutral discussion facilitated by people who are familiar with the theories and concepts of psychology.

The issue remains that the complainant may feel ganged-up on by psychologists if more enter the conciliation process. While this could be ameliorated by the use of a mediator who is not a psychologist, there may still be some argument that such a mediator may not sufficiently grasp the concepts so as to be useful to the process. Having said that, the NZPB has used a legal mediator in the past with some success in other matters. Like most processes when they are introduced, these issues would need to be considered on merit and dependent on the people used and their levels of experience. Any teething issues could be worked out until a suitable process was in place.

The main hurdle to the use of early dispute resolution is the conflict with public interest. The question then becomes one of whether the public interest in general supersedes the public interest of the individual. Can the public to be protected on an individual basis versus collectively. An analogy can be made with vaccination - if enough individuals are protected then there is a herd immunity (general public interest). Perhaps the tension in the role of the RAs could be flexible enough to accommodate resolution without compromising public protection. Psychologists would have to invest in the process both in terms of how it happened as well as financially. The level of buy-in to such a scheme would require further research.

After reflecting on the arguments, I support the RAs having the ability to include an early resolution process. This should be provided for in the Act but in practice, would have to be managed in such a way that it did not compromise public safety and that the profession supported the process.

M Therapeutic Jurisprudence[150]

NZPB agrees that there is some therapeutic jurisprudence included in the process in so far as most of the outcomes of the process, until Tribunal level, are more rehabilitative than

[150] See also the discussion of Therapeutic Jurisprudence in chapter 3, Part IV.

punitive. However, NZPB points out that true therapeutic jurisprudence, and what NZPB desires, is where the process heals both sides, rehabilitating the practitioner if they are sub-par and healing wounds caused to the complainant.

NZPB could see this happening within the current system and thinks it would work. The only qualification is for Family Court complainants whom NZPB describe as different, to quote an interviewee "*they often come looking for blood and they want it now, they want the person out of the profession. Chances are they have lost a custody battle or something and are seriously wounded by the time it gets to us*". NZPB recognises the need for punitive measures in some cases and sees the place for those with the Tribunal. The Tribunal has a limited range of outcomes available in the legislation but they are fairly punitive. NZPB acknowledges that generally cases that get as far as the Tribunal generally warrant some punishment for conduct.

Therapeutic jurisprudence cannot fairly be used to describe the outcomes in the competence review and fitness areas because although they are mostly rehabilitative for the practitioner there is no direct benefit for the complainant. NZPB also acknowledges that some of the outcomes may appear punitive to a practitioner, giving as an example a person who is nearing retirement and who receives a competence review outcome for retraining. In that situation realistically it is not worth their while retraining that late in their career. It is also possible that a person, for a health reason, may never again be fit to practise as a psychologist even with support, in which case the NZPB outcome may not be therapeutic.

NZPB would like to be able to do more for the complainant/notifier. At this stage NZPB can be helpful and friendly but cannot hold the hand of either the complainant or the psychologist in the process as that is not its role. NZPB gives consideration as to how there could be more support for people in the process, how it can provide better information and a better time in the process. Feedback is retained and is gradually being built into documents which support the process. NZPB recognises the validity of complainant concerns regarding their involvement in the process, the length of time it takes and the emotional energy required but at the same time has to balance that with the knowledge that, if it described the worst case scenario to every complainant at the beginning, it would be likely that the complainant would not make any complaint or could validly say that NZPB was deliberately putting up hurdles to making a complaint.

NZPB has to find the fine balance between being honest and transparent without scaring people so much that they do not want to get involved in the complaints process. It would not help NZPB protect the public if people found the process too hard. This supports the argument for early dispute resolution as it could build in something therapeutic at the early stages of the process and more people may be willing to engage in the process.

DCNZ described New Zealand as lucky in terms of the legislation which allowed for such a rehabilitative focus, especially with reference to competence issues. The rehabilitative focus was seen as better than in most other jurisdictions which do not have such a remediation component and complaints more frequently conclude with practitioners being struck off the registry. DCNZ admits that practitioners can slip below the standards required but education can bring them back up to standard so that they can continue working in the profession that they trained in. DCNZ sees this as hugely positive whereas on the conduct side beyond the rehabilitative aspects there are appropriate punitive measures for things like bringing the profession into disrepute or acting fraudulently. DCNZ considers that the legislation is well-balanced in this regard.

MCNZ took a similar view to DCNZs in so far as acknowledging that competence issues have an educative rehabilitative focus without any punitive elements. However, MCNZ considers conditions or suspension where there is a real risk and there is no other way to get the doctor to act in a way that is going to be safe for the public despite the competence review, which may be described as punitive.

In terms of conduct issues the focus on therapeutic jurisprudence is more muted as there are some potentially rehabilitative elements, for example where the doctor would benefit from counselling around the requirements or standards of being a doctor. There is also a threshold where the PCC may determine that the breach of standards is such that there also needs to be punitive action and that is usually achieved by way of charge to the HPDT for prosecution.

Comment: Perhaps NZPB is more keenly sensitised to the needs of complainants and practitioners due to the nature of psychology. From a psychologist's viewpoint it is easy to recognise some limitations in the use of therapeutic jurisprudence in the complaints process due to NZPBs role as public protector. Sensibly NZPB offers as a solution, a

collaboration of therapeutic jurisdiction in an early dispute resolution process. It is worth considering therapeutic jurisprudence for both the complainant and the practitioner as within the role of NZPB as it may result in individual protection which in turn may lead to a greater level of public protection.

I support NZPB considering this matter further within its processes. NZPB, due to the knowledge range of the profession, may be well placed to be the subject of a trial of such measures.

XII *Issues raised in interviews in regard to legislation*

All interviewees were asked, if they could change the legislation what recommendations they would make. Most chose some of the more pressing issues and said that anything else they thought necessary was more in the way of minor tweaks to the legislation. All three RAs expressed satisfaction with the legislation as a whole.

A NZPB

NZPB regards the purpose of legislation and protection of the public as its mantra. Public safety is both the purpose and focus of the work done and that should not be changed in the legislation. Overall the Act works reasonably well and it is a huge improvement on the old Psychologists Act 1981. NZPB perceives that it is restricted more by what is not in the Act than by what is.

Ideally NZPB would like to add sections relating to mechanisms for early alternative dispute resolution (ADR), not pinning the RA to any one form of ADR but having the flexibility to pursue whichever method would work. NZPB needs a legislative directive to offer ADR before it would consider providing an early resolution service.

There are a number of other small technical changes that have also been included in the review submissions. For example, in a couple of places threshold languages are not ideal. One section talks about "risk of serious harm" and elsewhere as a "serious risk of harm" which are two very different thresholds. Using two different thresholds, as they currently appear in the legislation it does not really make sense.

B DCNZ

Again DCNZ was happy overall with the legislative process but noted that the Act has a mandatory requirement for conduct issues to go to PCC. DCNZ thought this placed an unnecessarily high cost on regulation. E.g. a conviction must be put before a PCC but it would be good if the Council had the option of putting it to a PCC. An explanation was given by reference to a practitioner who had a drink driving charge. There are some instances where the practitioner had been charged but with the benefit of further information it determined that the practitioner was only just over the legal limit. The practitioner may have been on the Register for years without a notification, and in the Court summarisation around the charge, MCNZ would get all the information required to understand what happened. It may have been a mere moment when the practitioner misjudged the limit and was just over, and the matter had gone through the Court and been dealt with there. The question should be whether the Council needs to adopt a health monitoring programme, rather than a referral to a PCC.

It would be helpful referrals to PCC occurred at a threshold level, or perhaps described in the legislation as a "may", because the practitioner has already been punished through the Courts. There is still a notification on the practitioner's file, but realistically that practitioner, if it was an accident that they were over the limit, would probably curtail their own behaviour without going through the cost of putting together a PCC to investigate a matter that has already gone through the Court system. DCNZ acknowledges that the practitioner has brought the profession into disrepute. However there is a difference between those who are accidentally just over the limit and those where the practitioner is well over the limit and may be a repeat offender. Minor infractions are often accidental and further action is not of any benefit unless there is a habitual issue. Regardless, the Act requires them all to go through PCC.

A further change that DCNZ would like to make is a way for the public to understand that the complaint mechanism is the HDC as HDC is the consumer complaint body to which they should go first. DCNZ considers that further public education about the roles of HDC and DCNZ in the complaints process would be helpful as then the public would know who to complain to first, how the organisations intersect and what to expect of the process.

Having said that, it may cause a bottleneck of complaints going to HDC for the complaints process. DCNZ considers that patients are getting more savvy and willing to complain than previously and that there has been a steady rise in complaints. DCNZ recommends that more resources are made available to clear the bottlenecks as, if there is a complaint and where possibly a competence issue exists, that complaint may sit with HDC for 18 months - 2 years before it is referred back to DCNZ. That is a long time for a practitioner to continue practising if, when investigated the practitioner was found to be not competent. DCNZ recommends a form of joint triaging with HDC so that together the consumer complaint can be determined as to whether it is likely to be referred to the RA for investigation and whether there are any safe practice issues that need immediate attention.

DCNZ advised that they have a good relationship with HDC and so anecdotally some of that exchange of information is already happening but not in any formal way. If DCNZ has concerns it would be talking to HDC. To date, it has worked without the process being formalised but there may be some benefit in having a formalised arrangement, perhaps like a Memorandum of Understanding.

DCNZs experience internationally is that people are envious of our legislation because it allows for remediation. While remediation can be a challenge to manage, not so much for small basis remediation which is fairly easy, but if the remediation is of a larger nature, for example those created by the grandfathering provisions derived by the RAs when considering applications for practicing certificates under the then new Act[151], then it is not so easy to maintain a programme over a couple of years, in conjunction with the university. However that is what the Act requires so that is what is done. DCNZ sees the legislation as fair to the practitioner and certainly it works well for the public because the

[151] Health Practitioners Competence Assurance Act 2003, ss 26 & 27.

Act enables DCNZ to restrict the work of a practitioner until the practitioner is safe to practise.

DCNZ has identified another arena in which it is seeking public support and that is through the HDC forum which is used to engage the public in the manner of a working advisory group to assist when DCNZ is establishing standards. This would be in addition to the ordinary groups consulted by DCNZ in the process. For example, the orthodontic working group has as a consultant a person from the Office of the Children's Commissioner because braces tend to be used with children in the majority of cases. Another example is where information and assistance was sought from the Privacy Commissioner in balancing the two pieces of legislation to consider the privacy of the practitioner's information in fitness review situations. All working groups always have a lay person as a member of the working group representing the view of the public, but it is one person and using the forum is an extension of this idea. There is perceived benefit in having the views of a consumer group on standards and the implications of that standard on the consumer. This will also be beneficial for the public from an educative point of view.

DCNZ also sees as part of its role to promote DCNZ through public education, beyond the standards for example, but in areas where there are not sufficient complaints to drive a standard, but there is still need for a tool in the form of a brochure/ information sheet for education or communication to the public around certain practices e.g. understanding orthodontic treatment as parent/guardian/child. These are a soft regulatory response but that alone might be what is needed. DCNZ sees this type of response within the purview of the legislation. DCNZ aims to have a response proportionate to the risk, so if there is little to indicate harm for example via competence cases or there is no evidence to indicate there is harm, then a soft response is appropriate especially if DCNZ has been receiving a number of telephone enquiries about the issue. This proactive measure could reduce the risk of future complaints.

DCNZ regards the legislation as enabling, with many levers within it that DCNZ can use, rather than overly prescriptive legislation with which other jurisdictions have to contend. There are some parts of the legislation that are quite prescriptive at an operational level, but the intent is assurance of competence and the response in legislation is levered against the level of risk.

C MCNZ

MCNZ considered that there is no need for many changes to the legislation. Most of the Act works quite well for MCNZ although there are some minor adjustments that could be made that would be helpful.

1 Immediate suspension

MCNZ has recognized that in the legislation where there is provision for immediate suspension of a doctor whose practice is impaired due to ill health with some conditions that flow from that e.g. assessment of the doctor within a prescribed period. MCNZ considers that to be appropriate but there is no similar provision for conduct or competence issues with regard to immediate suspension. The current process around putting in place conditions and suspensions under s39 (competence) and s69 (conduct) can take too long. The reason for this is that the suspension/condition could be put to the Council at one meeting and the Council will order an assessment or be referred to PCC. The Council must then advise the practitioner and seek feedback on the proposed additional action around conditions or suspensions. The earliest that it can be put in place is by the next Council meeting when the Council has received a response from the doctor to those proposals, so at best it would take two months for Council to put suspension or conditions into place after a matter is raised.

In really egregious cases the Council should be able to unilaterally impose suspension or place conditions, not unlike s48 which allows the Council to immediately place conditions or suspensions pending an assessment of fitness. This however, must be balanced by the use of time restrictions i.e. like the s48 allowance of 20 days for assessment.

At this time the Registrar uses delegated powers to apply s35 (relating to a notification of risk of harm) as leverage in negotiations with the lawyer or practitioner as to some sort of agreement or voluntary undertaking around the doctor's practice to reassure the Council that there is no risk of harm in the meantime.

The incentive for the doctor to agree to the voluntary undertaking is that, if they do not agree, the Registrar has the capacity to issue a notice to inform certain agencies that there is a risk of harm from the practitioner. The greater incentive for the doctor is that by coming to an accommodation with CTT and the Registrar early in the process, the practitioner can front foot whether Council needs to make a consideration of conditions and suspension and may not in fact have any conditions imposed. MCNZ has a sense that, while this is an interim measure, it is mostly private and so in some situations Council wants to be able to react more quickly to manage the risk of harm. A legislative solution would be helpful although Council can work around it if necessary by way of teleconference taking into account scheduling difficulties for people when there is already a two monthly meeting scheduled.

The type of case that MCNZ anticipates immediate suspension applying to would be those that have a high risk to the public e.g. a doctor accused of sexually assaulting patients or where a doctor's competence is so at question and the doctor has no insight into their situation. In such cases there should be an ability to issue an immediate suspension while still offering some level of protection for the doctor in terms of a restricted time for immediate assessment or investigation to consider the complaint.

2 Harm

As also identified by NZPB there could be greater clarity within the Act regarding the definitions of 'risk of serious harm' or 'serious risk of harm'. For example section 35 of the Act talks about 'risk of harm' that has to be considered by the Council and if there is 'risk of harm', then the Council needs to advise the Director-General of Health, HDC, ACC, any employer etc.

A discussion on the use of various thresholds of 'risk of harm' within the Act would be useful. MCNZ had previously prepared guidelines as to the interpretations of 'risk of harm' which was also used by other RAs. This guideline was a relatively clumsy definition and has been updated, but MCNZ recognises that the term is not defined in the Act, not easily defined in case law, and thought that a consensus decision and common

definition for 'risk of harm' could be developed as a guideline in collaboration with the other RAs.

In consideration of amendments to the Act, there should also be some discussion regarding the reference for conduct complaints in s69 as it does not refer to risk of serious harm. In contrast the reference to competence reviews under s36, and s39, any risk of serious harm perceived can be addressed through the placement of conditions or suspension. When a matter is referred to PCC under s68, or under s69, then consideration can be given as to whether the alleged conduct reaches the threshold of inappropriate which is when MCNZ can use conditions or suspension. In practice the outcomes are the same but the Act uses different thresholds. The differing phraseology can also lead to different interpretation of the elements required for the threshold to be met. Legislators should consider reconciling the language in s39 and s69 so that there is more consistency between those two decision-making processes.

3 Wilful Incompetence

MCNZ has considered whether there is a need to be able to judge cases where MCNZ wants to be able to more explicitly say that a practitioner's competence can reach a level where they are essentially knowingly practising incompetently, a wilful incompetence. And in cases like this, wilful incompetence should be considered as a matter of conduct. MCNZ was not able to say how this could be framed in the legislation but perhaps a clause could be introduced that stated that where people are so incompetent and practising at such a poor level they are deemed to be knowingly doing so and that such cases are considered a conduct matter.

4 Other

Other issues identified but not requiring urgent addressing included the capacity to remove people from the register more quickly than is currently possible. This would apply to those who have just quietly stopped their involvement but not officially asked to be removed. There is currently quite a process to be followed in these cases to check if a doctor wishes to come off the register or not.

Another inconsistency in the Act is that people are able to make notifications to the Council about health concerns about a doctor with an immunity from civil liability if they do so in good faith, in s45(6). There is a similar provision in s34 for concerns regarding competence, protection for complainants in good faith. There is no similar statement under the Act for immunities afforded to a person who may raise an issue about conduct. There have been occasions where MCNZ has had people come forward who would like to discuss a conduct concern but are worried about being sued. MCNZ has not determined that this has been a major issue but it could be a potential improvement to the Act.

Chapter 7 The Administration of the Lawyers and Conveyancers Act 2006

I *Introduction*

The second part of the interview study considered a profession outside of the HPCAA in order to see how another professional body is legislated and operates its complaints process. A comparison could then be made with the RAs. The New Zealand Law Society (Law Society) was selected because it has recently changed its legislation and there have been some innovations to the process that are of interest to the Health RAs.

Complaints against lawyers are dealt with by the Law Society's Lawyers Complaints Service as provided for in the Lawyers and Conveyancers Act[152] (the Act). Some complaints may concern an alleged breach of the Lawyers and Conveyancers (Lawyers: Conduct and Client Care) Rules 2008 (the Rules).

The Rules are analogous to the Standards set by the RAs in terms of how they are used to assess the practice of the profession, but for lawyers the rules are binding although they are not an exhaustive statement of the conduct expected of lawyers. It is also noted that the Act applies to both lawyers and conveyancers and there is a Society for each. For the purposes of this research, the Law Society only was included.

II *The Complaints process for lawyers*

The Act permits anyone to make a complaint about a lawyer. The Law Society provides brochures for the public outlining how to make a complaint, how to access the 0800 number to discuss the making of a complaint. These are provided free of charge to community law centres and citizens advice bureaus. The client care information that lawyers must provide to their clients must inform a client about their internal complaints process and the Lawyers Complaints Service The Law Society has provided guidance on effective internal complaints processes for law firms. The information given to the client, along with a letter of engagement, could include details of a resolution process for

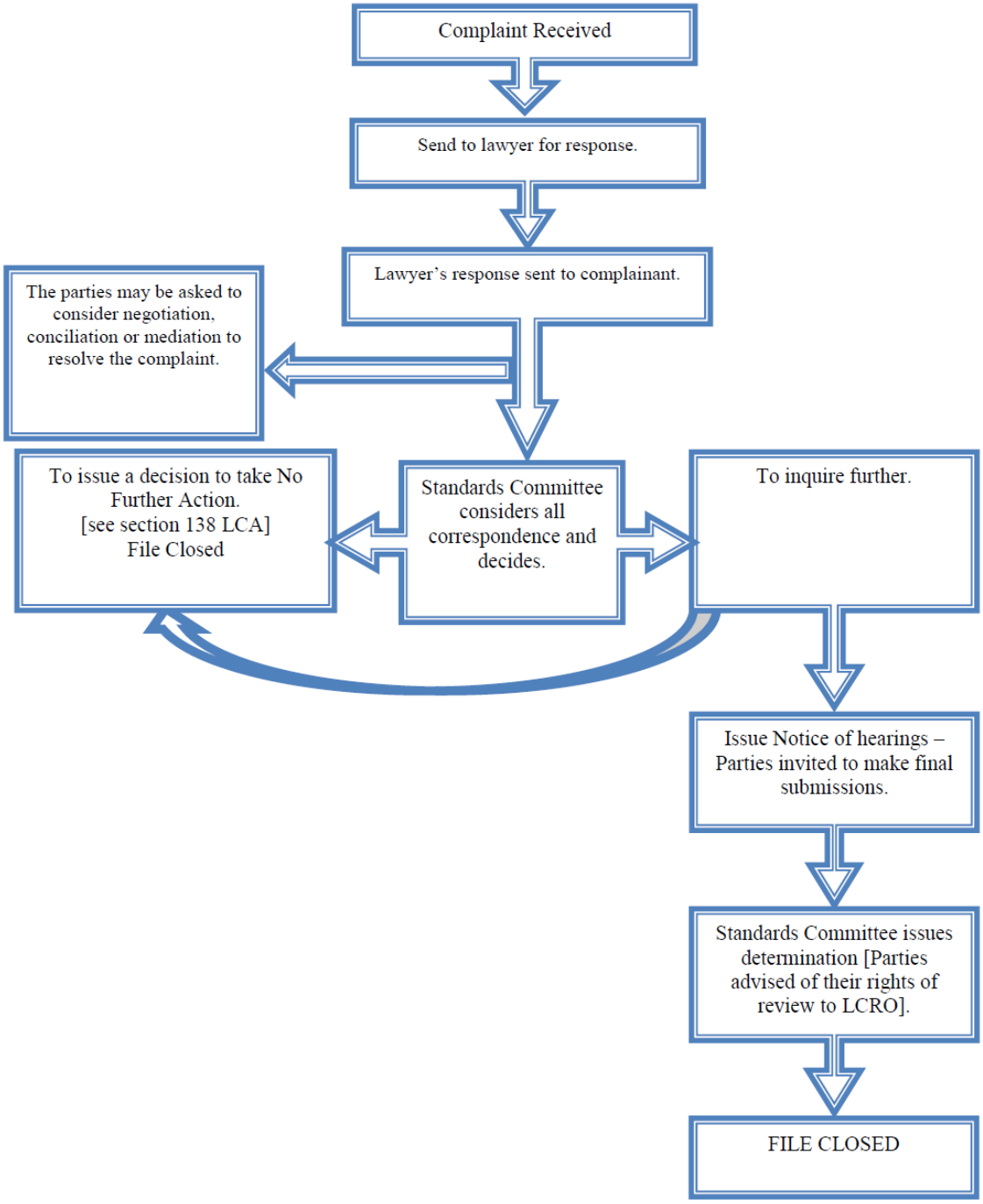
[152] Lawyers and Conveyancers Act 2006.

complaints within the firm. Should the client not want to use this opportunity, the client can lodge a formal complaint.

The Lawyers Complaints Service (LCS) offers a variety of avenues for contact, including calling an 0800 number and the website. The website offers two options, the first being lodging a formal complaint when a person is sure of what they wish to complain about. There is also a concerns form whereby a complainant can record a concern about a lawyer. They will be contacted by a staff member of the Law Society for discussion to either address that concern, or potentially advance the concern into the complaints process. The person may be referred back to the law firm's internal complaints procedure.

The following flowchart[153] sets out the complaints process for those in the legal profession:

[153] Kindly supplied by the Law Society.


Complaint Received
Send to lawyer for response.
Lawyer's response sent to complainant.
The parties may be asked to consider negotiation, conciliation or mediation to resolve the complaint.
To issue a decision to take No Further Action.
[see section 138 LCA]
File Closed
Standards Committee considers all correspondence and decides.
To inquire further.
Issue Notice of hearings – Parties invited to make final submissions.
Standards Committee issues determination [Parties advised of their rights of review to LCRO].
FILE CLOSED

A Stepping through the process

Complainants are referred to the website which describes[154] the Law Society's Complaint Service. There is no differentiation made between competence and conduct related matters. Complaints may also be about costs.

1 Early Resolution Service (ERS)

All complaints are received centrally and are triaged on a daily basis for either referral to the Early Resolution Service or the standard track process. Senior experienced Law Society staff make up the triage panel.

If a complaint does not raise serious concerns and is considered to be minor in nature, the complaint is referred to an ERS Standards Committee. ERS deals with approximately 40 percent of complaints. The matter will be placed on the agenda for the next meeting of the ERS committee. Currently, ERS committees are made up of four lawyers and two lay members (but may have up to seven lawyer members). The ERS has two committees which meet week about. The ERS committee may decide that a complaint should not be accepted for ERS and referred to the standard track process, that the complaint requires no further action, or refer the matter for resolution by negotiation. If resolution is reached, then that resolution is referred back to the ERS committee and may become the decision of the committee. If no further action is decided upon, the complainant and lawyer are both advised of the finding by telephone and offered an opportunity to respond.

The ERS system effectively fast tracks minor matters through the complaints system, the process taking on average 38 days to complete in comparison with the standard track which can take up to 221 days on average. The benefit of this process is that it manages both parties' expectations with the added benefit of a quicker outcome. Evaluation feedback indicates that there is a direct correlation between the speed of the process and people's satisfaction with the process.

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[154] "How your complaint is processed - NZ Law Society" <http://www.lawsociety.org.nz/for-the-community/lawyers-complaints-service/How-your-complaint-is-processed>.

2 Standard Track Process

There are 24 Standards Committees (SCs) (including the two ERS SCs), based in Law Society branches around New Zealand. The standard track SCs deal with those complaints not considered suitable for the ERS process. These SCs usually meet monthly over the lunch break. They meet by teleconference to deal with urgent issues.

The SCs comprises between seven lawyer members and two lay members as a maximum or two lawyers with one lay member as a minimum. Lawyers who serve on the Committees are volunteers although lay members do receive a small stipend. The legal volunteers are senior lawyers who are appointed by the Board and may serve terms of up to nine years. Although some SCs are specialist generally the SCs deal with all areas of law and there is usually at least one lawyer who has practised in the same field as the subject matter of the complaint.

Approximately 87 percent of complaints results in a finding of no further action. If the complaint is sufficiently serious, the complaint is referred to the New Zealand Lawyers and Conveyancers Disciplinary Tribunal (Tribunal). A SC may find that there was unsatisfactory conduct but matters involving suspected misconduct must be referred to the Tribunal A breach of the Rules or Act may result in a finding of unsatisfactory conduct. However not every breach of a rule is necessarily unsatisfactory conduct as it depends on all the facts being taken into account.

If the SC determines that the lawyer's conduct was unsatisfactory, it may make orders which include censure, compensation, an apology, amend fees charged, award costs against the lawyer, require the lawyer to rectify the situation, undertake education, open their practice for inspection or pay a fine[155]. The issue of compensation warrants mention because the SC must show a nexus between the complaint and any award of compensation, similar to damages and there must be a level of reasoning behind the compensation. The SC can award up to $25,000 in compensation and up to $15,000 in fines. The SC can use any combination of these orders.

[155] Lawyers and Conveyancers Act 2006, s 156

A single complaint of incompetence may not be enough to be classified as unsatisfactory conduct If however there is serial incompetence then it may be found to be unsatisfactory conduct or may be referred to the Tribunal[156].

3 Review

A lawyer or complainant who is dissatisfied with the decision of the Standards Committee can have the decision reviewed by the Legal Complaints Review Officer (LCRO) which is administered by the Ministry of Justice.

The LCRO can make any Order a Standards Committee can make, including confirming, reversing or modifying the Standards Committee's decision. The LCRO can also refer a matter to the Tribunal or back to the SC for reconsideration. Some decisions made by the LCRO are anonymised and are publically available on the LCRO website.

4 New Zealand Lawyers and Conveyancers Disciplinary Tribunal (the Tribunal)

The Tribunal operates under the auspices of the Tribunals Unit of the Ministry of Justice. The Tribunal panel comprises a chair, deputy chair and lay people, appointed by the Governor-General on the recommendation of MOJ, as well as 15 lawyers who have been appointed by the Law Society.

If the Tribunal finds that there has been unsatisfactory conduct or misconduct, the Tribunal can make any order that is made by a SC. The Tribunal can make an order for strike off or suspension of a lawyer for up to three years.

5 Judicial Review

Any of the Tribunal's decisions may be appealed to the High Court. Having lawyers on the SCs is advantageous to the profession, in comparison to other professions, given lawyers are more aware of legal processes such as natural justice.

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[156] Above in 150, s 152.

B Comparison on points of interest between the Law Society and Health Professions (NZPB, DCNZ, MCNZ) complaints process

NZPB was the first to note that a big difference between the legal profession and the health professions is that the legal profession has its representative and regulatory body within the same organisation. Although there are other representative bodies for lawyers such as the NZ Bar Association and ADLS. NZPB had always been advised by lawyers and had assisted in previous regulatory roles where the first task was splitting the collegial body and the regulatory body. The advice has always been that an RA cannot convince the public that it is there to protect them if the RA also protects the profession. Having said that, NZPB recognised that the Law Society had very good early resolution processes.

The Law Society acknowledges its dual role. The paramount aim of the Act[157] is for the protection of the consumer and this is taken into account by the Lawyers Complaints Service in regards to complaints. It is in the interest of the profession itself as well as consumers of legal services to have those lawyers who fall below the threshold of acceptable standards disciplined in an appropriate manner.

This section discusses other differences using the same framework determined in chapter 1 regarding the complaints process issues summary under Hypothesis 1 in order to consider those issues.

1 Time taken

The ERS process takes approximately 38 days and the standard track process takes 221 days. The short process is closer in time to the four months averaged by DCNZ, although bearing in mind that there could have been a 3-18 month process prior to that with HDC. Similarly, MCNZ reported an average of 18 months for its standard process, similar to the standard track Law Society process, in contrast to the 18 month - 3 year standard process for psychologists. A process similar to the ERS is used by most health professions e.g. MCNZ's triage process, NZPB's Parts 3&4 committee.

[157] Lawyers and Conveyancers Act 2006.

The main difference is in the ERS telephone resolution service offered by the Law Society which is not used by NZPB and to a far lesser degree by MCNZ. This may be a method that could speed up the process. I do not interpret the reconciliation offered by Law Society at this stage as the type desired by NZPB and psychologists who appear to prefer that the parties were able to meet and discuss the issues under an alternative dispute resolution process offered by NZPB.

The negotiation process is included in the legislation (s143) which permits any standards committee to give a direction that the parties to a complaint explore the possibility of resolving the complaint by negotiation, conciliation or mediation. However, a committee cannot insist that the parties undertake resolution.

The HPCAA[158] does not give a similar obligation or have any similar provisions so at this stage is would not be possible to introduce such a process. This is a consideration for amendment of the HPCAA if such a process was desired. I would support such a process because it would improve the administration of justice, improve consumer satisfaction, therapeutic jurisprudence without resulting in a significant loss of public protection.

2 Type of complainant e.g. litigious, vexatious etc.

The Law Society receives complaints from ”any person”(s132), similarly to the RAs, without needing to consider the type of consumer i.e. health consumer for referral to HDC.

The Law Society advised that it uses the term vexatious very sparingly and that a complaint may be vexatious but not a complainant. This is similar to the RAs.

3 Type or nature of the complaint - includes inappropriate and unlimited complaints

The Law Society advises that on occasions complaints may be widened from the initial complaint lodged If this occurs the Law Society always ensures that the process of

[158] Health Practitioners Competence Assurance Act 2003.

natural justice is followed, giving all the parties time to consider and respond to any new issues raised.

This is similar to the comments made by the RAs with the exception that because of the early resolution service, it appears not to add much in the way of delays to the process.

In the same way as the RAs, if a complaint is withdrawn once in the system, the complaint and the withdrawal will go to the SC who can either take no further action on that basis of if the matter is serious it may commence an own motion complaint and continue the complaint.

4 Therapeutic jurisprudence

The Law Society believes that the quicker a resolution or decision is reached, the more satisfaction there is for both parties.

Lawyers previously interviewed indicated a high level of satisfaction with their complaints process so there is merit in this approach.

5 Fear of complaint affecting work

The Law Society was not engaged for a comment on this section. It may be a concern for lawyers but quick resolution would assist in limiting fear of the complaint affecting work.

6 Early intervention - discernment and/or mediation

The Law Society has both the 0800 number, the concerns process and ERS standards committees which deal with minor complaints.
The benefits of the early intervention process in both segments have been recognised and will be a recommendation.

7 Double jeopardy

This is not an issue for the Law Society because there are no other bodies where it is required to refer complaints to.

8 Unfair process including procedural issues and legal process issues

The Standards Committees are made up of lawyers who are used to dealing with legal procedural issues. On rare occasions a committee may seek legal advice.

The Law Society noted that on occasions a lawyers insurer may become involved in the process which might delay matters but it generally was not an issue.

The Law Society is slightly different from the RAs in terms of the use of legal advice as the majority of the committee members as well as those that are being complained about are lawyers in their own right, therefore access to additional advice is not that common.

9 Natural justice

The Law Society considered that having lawyers involved in the process kept natural justice at the forefront of the process which is often reflected in how decisions stand up to later scrutiny and judicial review.

10 Limits to the investigation or complaint

No comment sought.

11 Excessive/ unreasonable demands on practitioners

Lawyers whose complaints are referred to standard track are requested to make a response to the complaint in writing. Trust account Inspectors are able to visit law firms that operate trust accounts, review files and provide a report.

For Lawyers, like MCNZ and DCNZ, matters are more tangible and can be more easily investigated. This supports the argument that psychologists may need a slightly different approach in the initial stages of the process.

C Changes in Legislation

When the Law Society was asked if it would make any changes to its Act, it noted there would be no major changes contemplated in Part 7 of the Act which deals with complaints and discipline apart from some minor tweaking. One change would concern preventing complaints being made against lawyers who are making decisions in the course of performing their duties on the SCs unless there was an allegation of bad faith.

D Bicultural Interests

The Lawyers Complaints Service appears to be accessible and complaints are received from many diverse complainants.

There does not appear to be any specific focus on bicultural issues beyond the requirements to treat clients with respect and courtesy and without discrimination[159].

[159] Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care) Rules 2008, r3.1.

Chapter 8 Final Recommendations and Conclusion

I *Introduction*

Each section of this thesis considered the issues identified in the first chapter. These were derived from the comments about the complaints process for psychologists and other issues noted along the way. The research put forward three hypotheses and considered the issues as to whether they arose from the process or the legislation or both. There were a number of issues applicable to both process and legislation but were categorised as one or the other in order to facilitate discussion. This chapter, therefore, considers any recommendations that can be made arising from those discussions.

II *Hypothesis 1 - Process*

A Time taken

Time taken was the most identified issue with the average time to completion for a case varying over the RAs mostly because of their processes and the type of practice. Each case had a different schedule depending on the complexity of the case and the availability of personnel and even on how long it might take to be considered by the HDC.

The HDC varied in time from three months for referrals, to 18 months to two years for decisions which would be in addition to any timeframe from the RAs. NZPB averaged between 18 months to a three-year period. DCNZ averaged four months on account of the fact that it investigated tangible practice and it did not consider any complaints that were not specifically referred from HDC. MCNZ averaged six to eight months for completion but could be up to 18 months on the standard track, this would be in addition to the time taken by HDC. Referrals to HPDT would incur further time. Law Society takes 38 days on average using ERS and 221 days on the standard track.

At face value, the NZPB complaints process takes the longest. The reasons of complexity of the case, the subjective nature of psychology and the complexities in investigating these matters are offered in explanation. Remediation is proposed currently in terms of a dedicated staff member on the PCCs and the introduction of an early

resolution service. I support the proposals, especially an early resolution service incorporating the telephone resolution service as used by Law Society. NZPB should continue to focus on reducing the average time taken to complete the complaints process. This is definitely a process issue, excepting the early resolution, rather than something that needs remedying through legislation.

B Type of complainant e.g. litigious, vexatious etc.

The complainant is defined in the legislation. The use of the terms vexatious and frivolous is interpreted to have a very high threshold. The RAs do not receive many of these complaints. The complaint is difficult to determine as vexatious in the first instance especially if the patient has a mental health background, making it difficult to distinguish between the complainant's perception of a real concern and whether the complainant is sufficiently cogent to understand that actually there was a concern. One of the protections against this type of complaint is that the complainant would go through the HDC in the first instance before going to the RAs. However, that would not always stop the complainant going to the RAs as well.

Minimal recognition of vexatious complainants is appropriate as there is a risk of endangering access to justice for the public by way of limitations placed on the complainant or complaints. However, this does burden RAs and practitioners in terms of workload. The RAs are doing their best to minimise the amount of work the practitioner has to do in response to unnecessary complaints through the use of any measures that assist the efficiency of the process.

C Type or nature of the complaint - includes inappropriate /unlimited complaints and withdrawals

None of the RAs limits the nature of the complaint, the only requirement being that there has been a breach of the professional standards or ethics. The RAs cannot stop people from adding to their complaint as it would thwart natural justice, which they are required to observe.

All RAs allow for the withdrawal of the complaint during the process, the RA may in some cases still proceed if sufficient information has been received.

I do not support any amendment to these processes for the sake of efficiency as they meet important natural justice requirements.

D Therapeutic jurisprudence

New Zealand is fortunate in terms of the legislation which allows for a rehabilitative focus, more so than other jurisdictions. There is some therapeutic jurisprudence included in the process in so far as most of the outcomes of the process, until Tribunal level, are more rehabilitative than punitive. However, NZPB would like to be able to do more for the complainant as it notes that true therapeutic jurisprudence (TJ) occurs when the process heals both sides, rehabilitating the practitioner if they are sub-par and healing wounds to the complainant.

The Law Society advised that the quicker a resolution or decision is reached, the more satisfaction there is for both parties, which may be the best way to improve TJ. Quicker resolution could be supported in an early dispute resolution service as is used by Law Society. It is worth considering therapeutic jurisprudence for both the complainant and the practitioner as within the role of the RAs it may result in individual protection, which in turn may lead to a greater level of public protection.

NZPB should consider this matter further within its processes. NZPB, due to the knowledge range of the profession, may be well placed to be the subject of a trial of such measures.

I support NZPB considering this matter further within its processes. NZPB, due to the knowledge range of the profession, may be well placed to be the subject of a trial of such measures.

E Fear of complaint affecting work i.e. workforce issues

NZPB recognises the sensitivity of psychologists to the complaints process and how it might affect their workload as the work is usually referred on the basis of the

psychologist's reputation. It is difficult to measure the impact of a complaint on a person's work in objective terms. Without a doubt there is fear, embarrassment and other implications but another study would be required to measure the impact on employment opportunities. NZPB was keen that psychologists be considered innocent until found guilty if a complaint was lodged, especially in the early stages of the process. Quick resolution of complaints would assist in limiting fear of the complaint affecting work.

F Unfair process including procedural issues and legal process issues - natural justice

The RAs were all of the opinion that the process was kept as fair as possible with due consideration to natural justice. One method all relied upon was the use of legal advice in the process and the legal advisors of practitioners keeping the RAs accountable in terms of natural justice.

RAs, in general, support the use of lawyers and I recommend that psychologists use an appropriately trained lawyer in the process, not only to ensure natural justice but also to assist in managing all the parties. However, delays in the process caused by the health practitioner or their lawyer should also be minimised to ensure swifter justice. I support specialist training of lawyers working in this area.

G Independence of the PCC

PCC independence is legislated but in practice the RA has considerable involvement in setting up a PCC and processing the decisions of the PCC. The RAs do not get closely involved in any of the PCC's decision making or investigation thereby maintaining a measure of independence.

NZPB has recently established a new role of Professional Advisor - Accreditations and Investigations, who will chair PCCs and who is part of the Secretariat. This raised in the interviewer’s mind the question of the independence of the PCC from the Board.

The effect of the appointment on independence is well compensated for by the expected effects of having a dedicated Chair who brings a wealth of experience as well as having the time to facilitate efficiencies in the PCC process. Psychologists would prefer a

quicker process due to efficiencies over any perceived loss of independence of the PCC. The focus on efficiencies is important because one of the key complaints expressed by psychologists is the time taken to process complaints. There may be a degree of loss in terms of peer review as the appointee is a clinical psychologist.

Overall however, most psychologists prefer the benefits of timely justice and that will outweigh the loss of some independence and peer review and so support this change.

H Limits to the investigation or complaint

An issue recognised by the RAs was that people could not be stopped from submitting about a complaint resulting in the process being drawn out, if the RA was observing the principles of natural justice. While RAs usually asked people not to keep adding to the complaint, it could not stop it happening.

I sympathise with both the RAs and practitioners who find this ever expanding type of complaint to be time-consuming and impractical. Dealing with the public can be problematic. However, it appears necessary to justice to allow for further disclosures, especially if another aspect of the complaint might only become apparent to the complainant during the process. Despite the delays and inconvenience, I do not support any limitations on complaints.

I Excessive/ unreasonable demands on psychologists

The demand on psychologists in response to complaints was recognised and NZPB advised that it accepts the same submissions that were made to HDC. NZPB acknowledged the limitations with this as the standards being considered were different. For this reason, it was accepted that psychologists generally provide a full response at the first stage. Concerns were raised that, while psychologists were advised the information was only required for determination by the P3&4 committee as to which direction the complaint should take, the response was also the basis of the decision by the PCC. This is not an issue for DCNZ due to its tangible nature, investigation process and the use of electronic records. MCNZ generally seeks a response to questions rather than the complaint in general which helped facilitate the process.

This response requirement has been recognised by NZPB as an issue for psychologists in a way that is different from other professionals because of the nature of "talking therapies". NZPB has taken steps to minimise the workload for psychologists in agreeing to take the same response as given to HDC and not requiring supporting documentation in the first instance. However, I recommend that NZPB continues to keep this issue as a focus and seek alternative means to reduce this workload where possible.

III *Hypothesis 2 - Legislation*

A Complainants

New Zealand, like the other jurisdictions, has a broad scope to accept complaints from a variety of complainants but lacks the mandatory reporting requirements of any of the other jurisdictions. This may appear as an easier legislative approach but in practice, the reporting is likely to be similar whether it is mandatory or not. Further research would be required to comment on this conclusively.

I do not find it feasible to suggest that the legislation is amended in any way to prevent certain types of complainants, due to the public protection function of the legislation. Accessibility is an important principle of justice.

B Time frame for complaints - statute of limitations

There is no limitation in the legislation on when a complaint might be brought. Currently this is an area that is interpreted by practice within the process in order to have access to documentation and witness recollection. This lack of guidance in terms of time frame could be addressed either through an amendment to the legislation or via a best practice standard collectively agreed upon by the RAs. The consensus standard would be easier to achieve than a change in legislation.

C Grounds for complaints and limitations on the scope of complaint

Grounds for complaints are similar across the Acts both in the types of complaints that can be received as well as the purpose of protection of the public. The function of public protection argues against a limitation on the scope of complaint. This issue is not

sufficiently problematic to warrant a change of legislation that outweighs the public protection function. I recommend no further action.

D Double jeopardy and multiple authorities for referral of complaints

Practitioners under the HPCAA complain that there is double jeopardy for complaints that are heard by both the HDC and the RA. A similar double jeopardy appears in the Australian Act and may arise in practice in other jurisdictions. It is the intention of Parliament to support consumer protection that creates this situation.

While legally the concept of double jeopardy is undesirable, in this case, it serves a worthwhile purpose in consumer protection. Despite the issues with legality, it should remain as it has been constructed in the legislation. I hold this view bearing in mind that the RAs are aware of issues in this area and should take as many steps as possible to mitigate the impact of double jeopardy.

E Natural justice

The HPCAA includes provisions for natural justice so the concerns raised in chapter 1 must relate to the practice rather than legislation. The legislation allows that PCCs may use lawyers. The PCC process should involve at least one lawyer, either representing the practitioner or advising the PCC and as part of the process, that lawyer should be specifically tasked to ensure that natural justice principles are observed.

While the PCC guidelines reference natural justice, the training for PCC members should also include a session on natural justice. I also commend the suggestion that PCC members consider attending some HPDT hearings to see how their processes work and observe natural justice principles being applied in that setting.

F No boundaries to complaint e.g. unlimited complaints and withdrawal of complaints

This is not referenced in any of the Acts and the issue must have arisen in other jurisdictions. The absence of any inclusion in any of the Acts indicates that Parliament recognises that limiting complaints would act against consumer protection and the withdrawal of complaints would better be addressed as a process issue rather than

something that needs to be addressed in legislation. It could be argued that natural justice should compensate for any shortcomings in the lack of boundaries of the complaint with regards to the process. I recommend that this issue, in part, be addressed through increased awareness of the process for withdrawal of complaints.

G Process time limitations in the Act

None of the Acts prescribe a set time frame in which a case must be addressed. The reason for this is likely because the time varies according to the complexity of the case and unpredictable external forces. The issue of delays in justice for psychologists is very pressing and one remedy would be to include more time frames within the legislation.

The disadvantages of this inclusion however, are that it would make the legislation much more prescriptive (i.e. not framework) and that it still would not take into account varying factors arising out of professional practice. This issue might better be remedied by process steps including potentially introducing KPIs or targets for time management of cases.

H Early intervention process or alternative dispute resolution

The Law Society has both the early telephone resolution service and the ERS committees which deal with minor complaints. I support such a process for psychologists because it would improve the administration of justice, improve consumer satisfaction and, allow for therapeutic jurisprudence without resulting in a significant loss of public protection. The benefits of these processes are clear and I support the inclusion of similar provisions in the HPCAA

I also support an amendment to the Act in similar terms to the Canadian Act in order to allow for earlier alternative dispute resolution processes. Parliament is not averse to these types of sections allowing for early resolution. This issue should be pursued by NZPB with regard to the MOH reviews.

This is not a "live issue" for the other RAs spoken to and this may be because of the nature of psychology. However, since the HPCAA is framework legislation, such amendments, if included in the Act, the provisions would not necessarily be used by all the RAs.

In the interim, complainants and practitioners should be encouraged to use whatever services are available such as resolution processes in the workplace or those offered by HDC.

The RAs should consider whether the proposed legislative amendments should include outsourcing the resolution process, or not. This would require more research as to costs and support from practitioners.

I also recognise the conceptual difficulties with having a consumer protection focus and adjudicating between parties. Philosophically, it could be argued that there are fundamental issues in the contrast of these two processes and outcomes. There may be occasions where a resolution is counter-productive because, if the RA accepted a resolution between the practitioner and patient, there could still be outstanding issues regarding actual competence or conduct. Many other regulatory bodies, including HDC, have dispute resolution within their remit and so it is possible in this arena.

There is a tension between RAs' public protection role and the resolution of a dispute between two parties but the benefits of a resolution service will outweigh any potential conflict in outcomes sought, especially if the process is managed carefully.

More research would be required to comment on the best process to be used, potential buy-in to the process by practitioners and cost management.

I support RAs having the ability to include an early resolution process, by way of provisions in the Act. However, in practice, the process would have to be managed in such a way that it did not compromise public safety and that the profession supported the process.

I Excessive demands on organisations

The Act does not reference any demands on RAs or any other organisations involved in the process. This was discussed above when the Act was proposed with reference to self-funding difficulties for smaller organisations. The author is mindful that further changes to the Act e.g. in an early intervention process may result in further costs for the

RAs and more burden in terms of workload. Any changes to the legislation should be considered in light of its demand.

J Changes in legislation

When RAs were questioned, a number of legislative amendments, relevant to the complaints process, were raised. Without canvassing all amendments, in review I support all the amendments discussed as for the most part the amendments are minor in nature. The process of amending the legislation has been particularly slow but hopefully the MoH is successful in making alterations to the Bill following the reviews and that the Bill comes before Parliament in the not too distant future.

IV *Conclusion*

The final consideration and recommendations to address the issues raised prove that there are issues in both the complaints process and legislation that can be addressed. Overall, the RAs were mostly responsive to process issues and generally satisfied with the legislation. There are parts of the legislation that tie the hands of the RAs and cannot be changed e.g. double jeopardy, no boundaries to complaints, complainants, grounds for complaint and limitations on the scope of the complaint but these exist in order to maintain consumer protection, which is seen as outweighing the other arguments.

The only issues of importance remaining for psychologists and which should be addressed with some urgency, are the time taken for the complaints process to progress, with particular note of potential delays at HDC level and with the NZPB, and the introduction of an early resolution process which may alleviate some of the delays and onerous obligations felt by psychologists.

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