FEWER CHARGES ARE BEING LAID IN THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL: SHOULD WE BE CONCERNED?

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Since the Cartwright Report was produced 27 years ago, it has become accepted that the needs of patients should be at the centre of our health system – including when things go wrong. This article examines professional disciplinary charges laid against doctors in the Health Practitioners Disciplinary Tribunal, and compares them with those laid in its predecessor organisation, the Medical Practitioners Disciplinary Tribunal. It concludes that fewer charges, particularly charges that relate to clinical misconduct, are coming before the Tribunal, and discusses the implications of this change. The article questions whether this evolving practice could undermine some of the purposes of the Tribunal and lead to a less patient-focused system.

I INTRODUCTION

"The focus of attention must shift from the doctor to the patient."[1] The Health and Disability Commissioner "is committed to a consumer centred and engaged system".[2]

For better or worse, professional discipline is an essential (but not uncontroversial) component of a well-functioning patient-centred health system. This article investigates the role of professional discipline in supporting the competence of doctors[3] in New Zealand – in particular asking whether

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1 *Report of the Committee of Inquiry Into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and Into Other Related Matters* (July 1988) [*The Cartwright Report*] at 176.

2 "The Commissioner" Health & Disability Commissioner <www.hdc.org.nz>.

3 The term "doctors" (rather than "medical practitioners") is used throughout this article.

the laudable focus on "learning not lynching, resolution not retribution"[4] has shifted the balance too far towards the focus on rehabilitation of doctors at the expense of leaving clinically incompetent doctors in practice?

The research set out in this article was undertaken to investigate anecdotal evidence that fewer charges are being laid against doctors in the Health Practitioners Disciplinary Tribunal (HPDT) compared with its predecessor organisation, the Medical Practitioners Disciplinary Tribunal (MPDT), and further that the nature of the charges being laid has changed.

A review of all charges against doctors laid before both tribunals since the MPDT was established determined that fewer charges are being laid, and of the charges laid, fewer are clinical in nature. The research then investigated whether this change was being driven by a change in the charging practice of the Director of Proceedings or the Professional Conduct Committees. It was found that both sets of prosecuting authorities had shifted their practice. In order to assess what was happening to the clinical charges, all 369 Health and Disability Commissioner (Commissioner) Investigations relating to doctors from 2003 to 24 May 2015 were examined, and the recommendations of the Commissioner recorded and analysed.

Part II discusses the background to the Health Practitioners Competence Assurance Act 2003. Part III describes how a complaint can become a charge in the HPDT. Part IV shows how the HPDT is based on the MPDT. Parts V and VI suggest the threshold to lay a charge has been raised and that the proportion of clinical charges being laid is reduced. Part VII sets out the results of a detailed analysis of what happens to complaints made about doctors to the Commissioner.

Parts VIII and IX respectively discuss the purpose of the HPDT and whether that purpose is being undermined.

Parts X and XI pose some broader questions about the overall disciplinary system. Part X locates the discussion in a patient-centred context. Part XI asks whether the changing charging practice is having a negative impact. The place of competence reviews as an alternative to disciplinary proceedings is discussed in Part XII. Matters of transparency are raised in Part XIII and some conclusions drawn in Part XIV.

II BACKGROUND

Under the Medical Practitioners Act 1968 all complaints about doctors were received by either the Medical Practitioners Disciplinary Committee or the Medical Council of New Zealand (Medical Council).[5] An initial assessment was made of the complaint and depending on the seriousness it was then dealt with by one of three disciplinary bodies. The most serious allegations were heard by the

4 Ron Paterson, Health and Disability Commissioner "Inquiries into health care: learning or lynching?" (Nordmeyer Lecture, Wellington School of Medicine, University of Otago, 17 September 2008).

5 Medical Practitioners Act 1968, ss 42A and 55.

Medical Council (disgraceful conduct) and the least serious were heard by the Divisional Disciplinary Committees (conduct unbecoming a medical practitioner). The Medical Practitioners Disciplinary Committee had jurisdiction to hear cases of alleged professional misconduct and conduct unbecoming.[6] The majority of complaints were dealt with by the Medical Practitioners Disciplinary Committee.

The disciplinary bodies were made up entirely of doctors until 1983 when one lay member was added to each panel. The hearings were held in private and the complainant had no right of appeal to the courts.[7] This led to members of the public making claims like "the medical old boy network is conspiratorially playing judge and jury to protect the profession".[8]

The 1988 Cartwright Report (Report) investigated gynaecologist Herbert Green's "Unfortunate Experiment" on over 100 women. The findings of the Report forced a change in the thinking about patient-doctor relationships and recommended more independence in the way in which complaints were investigated and doctors disciplined.[9] Parliament responded to the Report by enacting the Health and Disability Commissioner Act 1994 and the Medical Practitioners Act 1995.

The Health and Disability Commissioner Act 1994 established the Commissioner who developed a Code of Health and Disability Consumers Rights (the Code)[10] and became the "gate keeper" of complaints against health practitioners. The Medical Practitioners Act 1995 disestablished the complaint and disciplinary regimes of the Medical Practitioners Act 1968. It established a new system of competence review for doctors, administered by the Medical Council and created the MPDT. The MPDT only had jurisdiction over doctors.

These new competence reviews were designed to be a confidential, educative and rehabilitative approach to incompetence. The ability to review doctor's competence was welcomed by the Medical Council with some trepidation, noting that the disciplinary system was not a satisfactory method of reviewing a doctor's whole practice. Although the new recertification and competence provisions of the legislation appeared threatening, the Medical Council expressed confidence that the public and the profession would benefit.[11]

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6 David Collins *Medical Law in New Zealand* (Brookers, Wellington, 1992) at ch 8.

7 DB Collins and CA Brown "The impact of the Cartwright Report upon the regulation, discipline and accountability of doctors in New Zealand" (2009) 16 J Law Med 595 at 601.

8 Cate Brett "Dr Who?: A medical conspiracy of silence" *North and South* (New Zealand, October 1994) at 55.

9 *The Cartwright Report*, above n 1.

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

11 Medical Council of New Zealand *Annual Report 1995* at 6.

The new competence review system enabled the Medical Council to undertake a competence review of any doctor, either of its own initiative or after a recommendation of the Commissioner.[12] If after reviewing a doctor's practice, the Medical Council considered that the doctor failed to meet the required standard of competence, it was required to make one or more of the following orders, that:[13]

- the doctor undertake a competence programme;
- one or more conditions be included on the doctor's scope of practice;
- the doctor sit an examination or undertake an assessment specified in the order; or
- the doctor be counselled or assisted by one or more nominated persons.

If the Medical Council had serious concerns about the doctor's practice it could order the doctor's scope of practice be altered or the practising certificate be suspended.[14] The outcome of a performance assessment was not public information, unless it led to restrictions, conditions or suspension of the doctor's practice, in which case it was published on the Medical Council's website under the doctor's registration details. It should be noted, however, that if a doctor entered into a "voluntary agreement" to have conditions placed on their practice, this was not made public.

The implementation of both the Health and Disability Commissioner Act 1994 and the Medical Practitioners Act 1995 led to a four-fold reduction in the number of doctor complaints proceeding to discipline. In 1994, about 85 doctors faced disciplinary charges; by 1997, this had reduced to fewer than 20. The number of doctors facing charges from 1997 until 2003 varied over the years between about nine and 20.[15]

A finding by the Commissioner that a doctor had breached the Code was a censure in itself and avoided the need for more formal disciplinary findings. In addition, the "Commissioner's complaints resolution process [sought] to resolve complaints at the lowest appropriate level, [which] … contributed to a dramatic decline in the number of doctors facing disciplinary charges".[16] Further, less serious complaints could be considered by the Medical Council under the competence system thereby further reducing the need for discipline.[17]

The Health Practitioners Competence Assurance Act 2003 was heavily based on the Medical Practitioners Act 1995. The processes of registration, competence, complaints and discipline which

12 Collins and Brown, above n 7, at 602.

13 This is repeated in the Health Practitioners Competence Assurance Act 2003, s 38(1).

14 This is repeated in Health Practitioners Competence Assurance Act 2003, s 39.

15 Health and Disability Commissioner *Annual Report for the year ended 30 June 2003* (E17, 2003) at 2.

16 Health and Disability Commissioner *Annual Report for the year ended 30 June 2001* (E17, 2001) at 5.

17 Collins and Brown, above n 7.

were established under the Medical Practitioners Act 1995 were extended to apply to all registered health practitioners not just doctors.

III HOW A COMPLAINT CAN TURN INTO A CHARGE IN THE HPDT

Any person can complain to the Commissioner alleging that any action of a provider is or appears to be in breach of the Code.[18] The Commissioner may choose from a number of actions as set out in the flow chart below; one of which is to investigate the complaint. If a breach of the Code is established, the complaint may be referred to the Director of Proceedings. The Director of Proceedings will then review the matter and decide whether or not to lay a charge with the HPDT. Occasionally, the Director of Proceedings may resolve the matter without the need to lay a charge, although this is more likely to happen when a case could go before the Human Rights Review Tribunal than the HPDT.

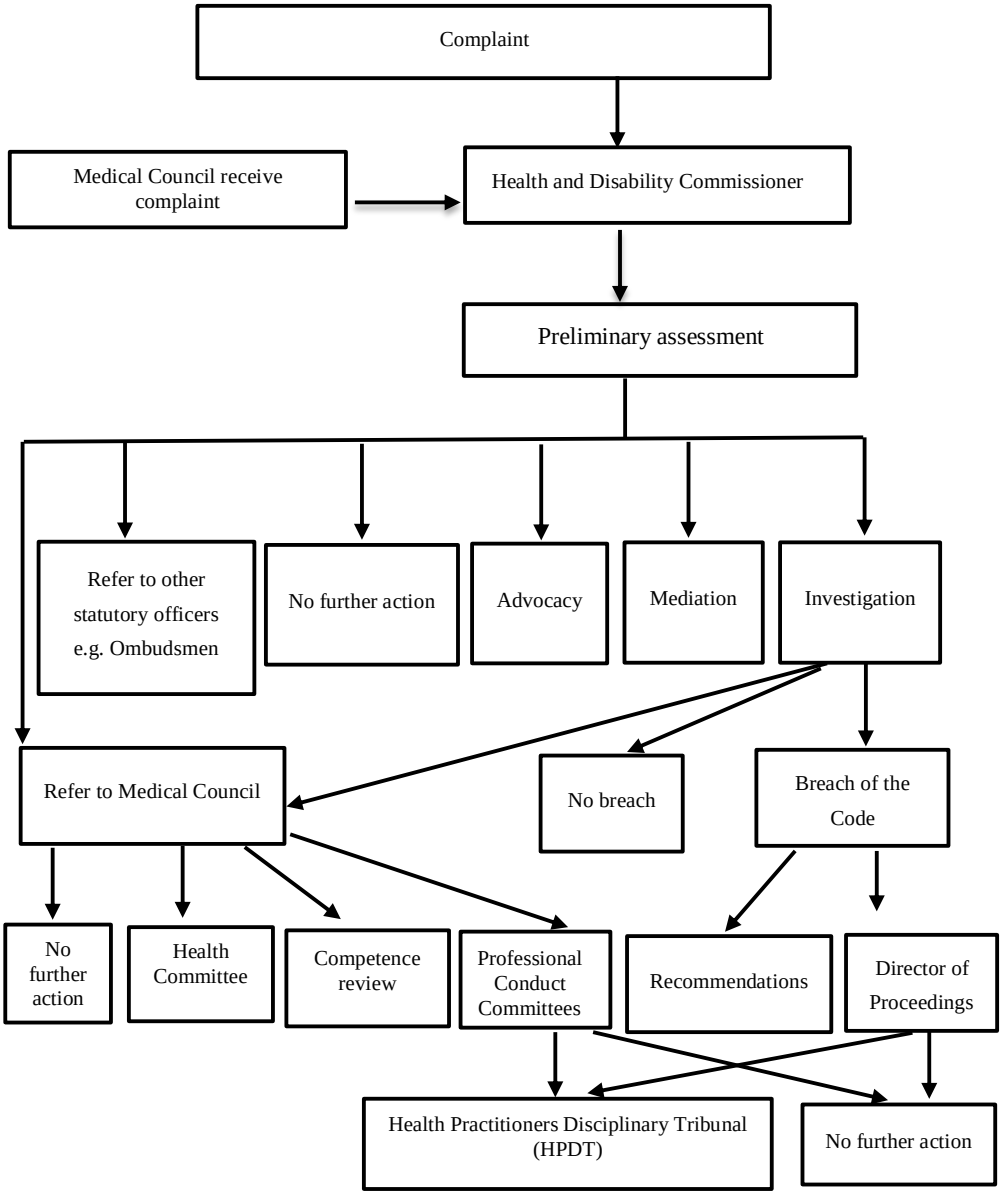
If a complaint is made to the Medical Council about the practice or conduct of a doctor in relation to a patient, the Medical Council must forward the complaint to the Commissioner for an initial assessment.[19] The Commissioner may then refer the complaint back to the Medical Council either prior to or after an investigation. The Medical Council, after considering the complaint, decides on the appropriate course of action from the four possibilities set out in Figure 1 below; one of which is to refer the complaint to a Professional Conduct Committee, which may then lay a charge with the HPDT.[20]

18 Health and Disability Commissioner Act 1994, s 31.

19 Health Practitioners Competence Assurance Act 2003, s 64.

20 Professional Conduct Committees also lay charges when the doctor has been convicted of an offence that reflects adversely on his or her fitness to practise, but these do not come through the complaints process.

Figure 1: How a Complaint can become a Charge in the HPDT[21]



21 This is heavily based on a flow chart from the Psychotherapists Board of Aotearoa New Zealand website: "Making a Complaint" Psychotherapists Board of Aotearoa New Zealand <www.pbanz.org.nz>.

IV HPDT BASED ON MPDT

The Health Practitioners Competence Assurance Act 2003 created a new disciplinary tribunal, the HPDT,[22] to replace the MPDT. The HPDT has jurisdiction for professional discipline over 21 different health professions registered with 17 different responsible authorities.[23]

The legislation relating to the HPDT was heavily based on pt 8 of the Medical Practitioners Act 1995 which established the MPDT.

Charges in the HPDT were from the same two prosecuting authorities as the MPDT; the only difference being that the equivalent of a Professional Conduct Committee in the HPDT was called a Complaints Assessment Committee in the MPDT. The membership of both committees was the same: two doctors[24] and one lay member.[25]

Like the MPDT, the composition of the Tribunal panel for the HPDT was five members:

- a legal practitioner as chair;
- three members from the same profession as the health professional who is charged;[26] and
- a lay member.

Many of the MPDT members, including the chair, became HPDT members on establishment of the HPDT.

There is very little difference between the Health Practitioners Competence Assurance Act 2003 and the Medical Practitioners Act 1995 when considering the grounds on which a doctor can be disciplined. The only significant difference is a single charge of professional misconduct in the HPDT[27] replaced a hierarchy of three offences in the MPDT.[28]

There is no evidence in Hansard relating to the Health Practitioners Competence Assurance Act 2003 that Parliament intended there should be a higher threshold for a charge to be established

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22 Health Practitioners Competence Assurance Act 2003, s 84.

23 For example, the Medical Council of New Zealand or the Dieticians Board.

24 The Professional Conduct Committees' professional membership depends on the profession of the health professional who is the subject of the charge. Therefore, if a nurse was charged with professional misconduct, the two professional members would be nurses.

25 Health Practitioners Competence Assurance Act 2003, s 71; and Medical Practitioners Act 1995, s 88.

26 Under the MPDT all the health professional members were doctors.

27 Health Practitioners Competence Assurance Act 2003, s 100(1)(a) and (b), which was based on the definition of professional misconduct in the Nurses Act 1977, s 2.

28 Disgraceful conduct in a professional respect; professional misconduct; or conduct unbecoming a medical practitioner, and that conduct reflects adversely on the practitioner's fitness to practise medicine: Medical Practitioners Act 1995, s 109.

before the HPDT than the MPDT. There was some discussion of the change from the hierarchy of three offences to one offence of professional misconduct. When the Health Practitioners Competence Assurance Act 2003 was at select committee, some submitters argued the three levels should be in the Health Practitioners Competence Assurance Act 2003 "to reflect the different degrees of misconduct that exist".[29] However, the majority of the committee concluded that was not necessary.

The Acting Minister of Health said:[30]

> … that in fact all matters that get to the stage of a disciplinary hearing are likely to be serious, and that differentiation between degrees of seriousness is likely to be reflected in the penalty imposed rather than the charge.

In the first doctor case appealed to the High Court to contest a finding of professional misconduct by the HPDT, it was argued that the threshold for a finding of professional misconduct under the Health Practitioners Competence Assurance Act 2003 was higher than under the Medical Practitioners Act 1995.[31] However, Courtney J found:[32]

> There is, however, no suggestion in the HPCAA that the range of conduct that might attract a disciplinary sanction is to be narrower than it was previously. Instead, the range of conduct previously accommodated in the three offences … is now accommodated within the new charges of professional misconduct in one of its two forms.

There was no apparent reason to anticipate a shift in charging practices between the HPDT and the MPDT as no new regimes were implemented for doctors under the Health Practitioners Competence Assurance Act 2003.

V HAS THE THRESHOLD TO LAY A CHARGE BEEN RAISED?

Despite there being no reason to anticipate a change in charging practices between the two Tribunals, anecdotal evidence suggested this may have occurred, specifically that prosecutors[33] (or the authorities, who refer the matters to the prosecutors)[34] have raised the threshold to lay a charge.

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29 Health Practitioners Competence Assurance Bill 2002 (230-2) (select committee report) at 6.

30 (31 July 2003) 610 NZPD 7536.

31 *Martin v Director of Proceedings* [2010] NZAR 333.

32 At [13].

33 The Professional Conduct Committees and the Director of Proceedings.

34 The Medical Council (in the case of doctors) and the Health and Disability Commissioner.

To investigate this issue, an examination of all 199 charges laid against doctors before the MPDT and HPDT, since the MPDT was established, was undertaken.[35] The tables and graphs below compare the charges in the MPDT with the doctor charges in the HPDT. Theoretically there should be no difference in findings between the two Tribunals.

Figure 2 below shows the differences in the number of charges laid in the different Tribunals over time. It should be noted that 2001 was an outlier year as one doctor faced nine charges[36] and another faced six charges.[37] Nevertheless, this graph indicates there has been a marked shift in the number of charges laid between the MPDT and the HPDT.[38] From 1997 to 2005 (inclusive) there were 126 charges laid in the MPDT, an average of 14 charges per year. From 2005 to 2014 (inclusive) there were 69 charges heard by HPDT against doctors, (plus four charges yet to be heard).[39] There has been a total 73 charges laid with the HPDT, an average of 6.6 charges per year; less than half of the previous annual rate.[40]

35 All HPDT decisions relating to doctors published at 1 June 2015, from Health Practitioners Disciplinary Tribunal <www.hpdt.org.nz> and all MPDT decisions from Medical Practitioners Disciplinary Tribunal <www.mpdt.org.nz>.

36 Dr Warren Wing Nin Chan: see "Precis: Decision No: 01/88C – Practitioner: Dr Warren Wing Nin Chan" Medical Practitioners Disciplinary Tribunal <www.mpdt.org.nz>.

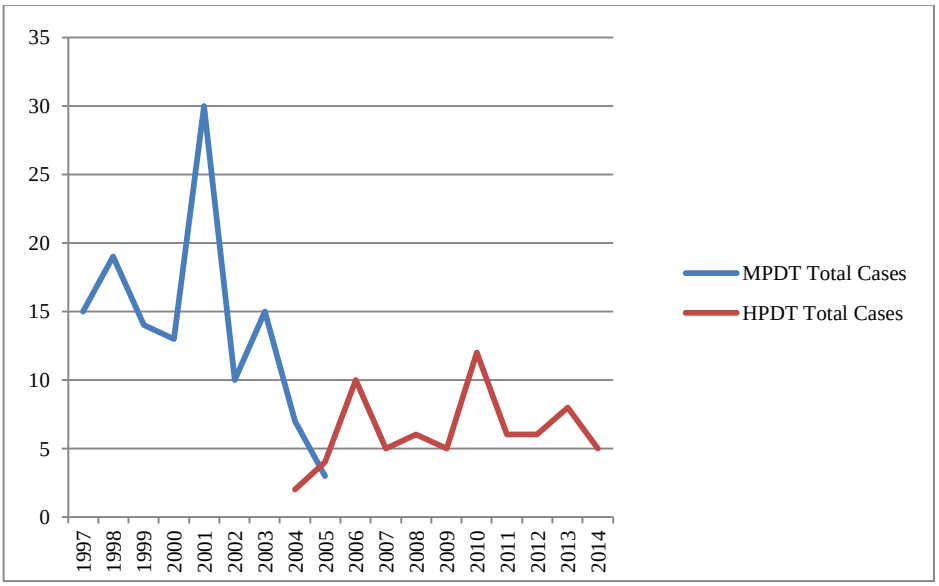
37 Dr Beris Ford: see "Precis: Decision No: 01/84C – Practitioner: Dr Beris Ford" Medical Practitioners Disciplinary Tribunal <www.mpdt.org.nz>.

38 2004 and 2005 was a transition period so the total number of charges heard was nine charges in 2004 and seven charges in 2005.

39 See "Tribunal Statistics – Medical Practitioners" Health Practitioners Disciplinary Tribunal <www.hpdt.org.nz>.

40 In 2004 and 2005 some charges were laid with the HPDT and some were laid with the MPDT due to the transitional provisions of the Health Practitioners Competence Assurance Act 2003.

Figure 2: Charges Heard Against Doctors by Disciplinary Tribunals



One possible explanation could be that fewer complaints are being made. If the number of complaints is decreasing it would be expected the number of charges would also go down. However, the opposite is true. The total number of complaints lodged with the Commissioner is rising. In 1998 there were 1,102 complaints, and by 2009 there were 1360; a 23% increase over a period of 11 years.[41] Since then, the numbers have increased more rapidly and by 2014 there were 1784 complaints lodged; a further 31% increase in just five years.[42] These numbers relate to complaints against all health practitioners, but the majority of complaints against individual health practitioners are made against doctors.[43]

It does not necessarily follow that with a higher number of complaints, the number of charges should increase. As the Commissioner points out:[44]

41 Health and Disability Commissioner *Report of the Health and Disability Commissioner: For the year ended 30 June 1998* (E17, October 1998) [*1998 HDC Annual Report*] at 21; and Health and Disability Commissioner *Annual Report for the year ended 30 June 2009* (E17, September 2009) at 3.

42 Health and Disability Commissioner *Annual Report for the year ended 30 June 2014* (E17, October 2014) [*2014 HDC Annual Report*] at 12.

43 At 13.

44 At 12.

> … with the number of incoming complaint … increasing year on year, it is easy to speculate that we should be concerned about the standard of care in the sector. However, there is no evidence that this is the case; rather, more people are choosing to complain to HDC.

This may well be true as there has been a lot of publicity about how to complain to the Commissioner over recent years. Explaining away the increase in complaints does not, however, explain why charge numbers should be going down.

As can be seen from Figures 3 and 4 below, there are a significantly higher percentage of guilty findings in the HPDT than the MPDT. In the MPDT, 66 per cent of the charges laid resulted in a guilty finding, whereas the HPDT found doctors guilty on 96 per cent of the charges.[45]

Figure 3: Medical Practitioners Disciplinary Tribunal[46]

Year	Total number of charges	Number guilty	Percentage guilty
1997	15	9	60
1998	19	10	53
1999	14	11	79
2000	13	7	54
2001	30	21	70
2002	10	8	80
2003	15	10	67
2004	7	4	57
2005	3	3	100
Total	126	83	66

45 It is interesting to note that in the New Zealand criminal courts in 2014 there was a 76 per cent conviction rate for adults: Ministry of Justice *Trends in Conviction and Sentencing: Court statistics for adults (aged 17 and over) in 2014*.

46 The year that the charge is categorised under is the year in which the charge was laid with the MPDT. Information used for the calculations is from the Medical Practitioners Disciplinary Tribunal website <www.mpdt.org.nz>. Withdrawn and stayed cases were not included in the calculations, and where a MPDT decision was overturned on appeal the finding of the appeal was used.

Figure 4: Health Practitioners Disciplinary Tribunal – Charges against Doctors[47]

Year	Total number of charges	Number guilty	Percentage guilty
2004	2	2	100
2005	4	4	100
2006	10	10	100
2007	5	4	80
2008	6	6	100
2009	5	5	100
2010	12	12	100
2011	6	6	100
2012	6	6	100
2013	8	8	100
2014	5	3	60
Total	69	66	96

At face value, the statistics suggest there has been a significant change in the decision making process on whether or not to lay a charge with the HPDT.

The above statistics considered the overall charge rate. A further possible explanation could be that one of the two prosecuting authorities (or the referring authorities) significantly changed their charging practice. All HPDT and MPDT cases were examined to try to establish whether or not this reduction in the number of charges being laid was led by either the Professional Conduct Committees and the Medical Council, or the Director of Proceedings and the Commissioner.[48]

47 Information used for the calculations is from the Health Practitioners Disciplinary Tribunal website <www.hpdt.org.nz>. The same approach as described above at n 46, was used in the calculations.

48 Information is from the Medical Practitioners Disciplinary Tribunal website <www.mpdt.org.nz>, and the Health Practitioners Disciplinary Tribunal website <www.hpdt.org.nz>.

Figure 5: Total Charges Laid with Disciplinary Tribunals

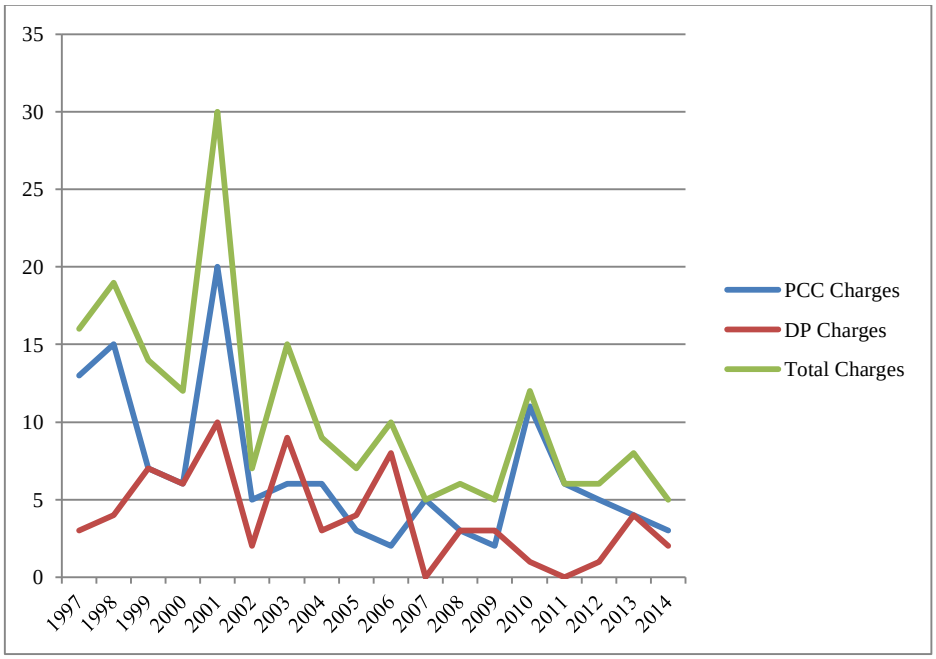


Figure 5 demonstrates that both prosecuting authorities have reduced the number of charges they have laid over time. However, it is interesting to note that in 2013 to 2014 the Director of Proceedings has increased the number of charges back to the 2007 and 2008 levels, compared with the period 2010 to 2012 when only two charges were laid over the three years. This may be due to the transition between Commissioners as a new Commissioner was appointed in 2010. It should also be noted the probable reason fewer charges were laid by the Director of Proceedings in 1997 and 1998 was because no Director of Proceedings was appointed until May 1997[49] and a fulltime Director of Proceedings was not appointed until June 1998.[50]

It can be inferred from the decrease in the number of charges and the higher guilty rate that prosecutors have raised the threshold before a charge is laid with the HPDT. This does not necessarily mean that the threshold for a finding of professional misconduct has been raised, but it does suggest fewer borderline charges are coming before the HPDT.

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49 Health and Disability Commissioner *Report of the Health and Disability Commissioner: For the year ended 30 June 1997* (E17, October 1997) at 35.

50 *1998 HDC Annual Report*, above n 41, at 31.

VI HAS THE TYPE OF CHARGE CHANGED?

The types of charges that get laid in the HPDT and the MPDT can be divided into two different categories: clinical misconduct and non-clinical misconduct.

All charges that relate to doctors were examined to consider whether the charge was a clinical charge or a non-clinical charge.

Clinical misconduct is where a matter relates directly to the practice of the health professional in the discharge of their professional duties. For example:

- a nurse administering the wrong quantity of medication;[51]
- a doctor ignoring an obvious symptom of a patient and failing to recommend tests; [52] or
- a dentist failing to adequately perform a root canal procedure.[53]

Clinical misconduct can be distinguished from misconduct relating to the health practitioner's ethical behaviour. For example:

- a dental technician practising without a practising certificate;[54]
- a psychologist having a sexual relationship with a patient;[55] or
- a midwife making fraudulent claims to the Ministry of Health.[56]

The analysis below compares the balance of clinical and non-clinical charges against doctors brought before the two Tribunals. Most charges were clearly clinical or non-clinical, however some charges combined both aspects. In classifying a charge as clinical or non-clinical, the charge as a whole was considered. *Director of Proceedings v Maharajh* is an example of a case that combined both clinical (inappropriate prescribing and inappropriate discharge of a patient) and non-clinical (inappropriate relationship with a patient, inappropriate sexual relationship and improper influence) aspects.[57] As the overall flavour of the charge related to an inappropriate sexual relationship, that charge was categorised a non-clinical charge.

Figures 6 and 7 below demonstrate that a much lower proportion of charges relate to clinical misconduct in the HPDT than in the MPDT. Only 36 per cent of charges laid in the HPDT relate to

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51 *Director of Proceedings v A* HPDT 33/Nur05/18D, 10 April 2006.

52 *Complaints Assessment Committee v Gorringe* MPDT 03/113C, 10 May 2004.

53 *Director of Proceedings v Aladdin* HPDT 13/Den04/02D, 10 August 2005.

54 *Professional Conduct Committee v Vitali* HPDT 583/Dtech13/255, 2 December 2013.

55 *Director of Proceedings v Paterson* HPDT 172/Psy08/84D, 25 August 2008.

56 *Professional Conduct Committee v Wang* HPDT 654/ Mid14/283P, 16 September 2014.

57 *Director of Proceedings v Maharajh* HPDT Med13/243D, 20 September 2013.

clinical misconduct compared with 76 per cent of the charges in the MPDT. The nature of the charges laid has changed between the MPDT and the HPDT.

Figure 6: Medical Practitioners Disciplinary Tribunal

Year	Clinical	Percentage of clinical guilty	Non-clinical	Percentage of non-clinical guilty	Percentage of cases that are clinical
1997	11	55	4	75	73
1998	15	40	4	100	79
1999	11	73	3	100	79
2000	9	56	4	50	69
2001	28	68	2	100	93
2002	8	75	2	100	80
2003	11	64	4	75	73
2004	3	67	4	50	43
2005	0	N/A	3	100	0
Total	96	61	30	80	76

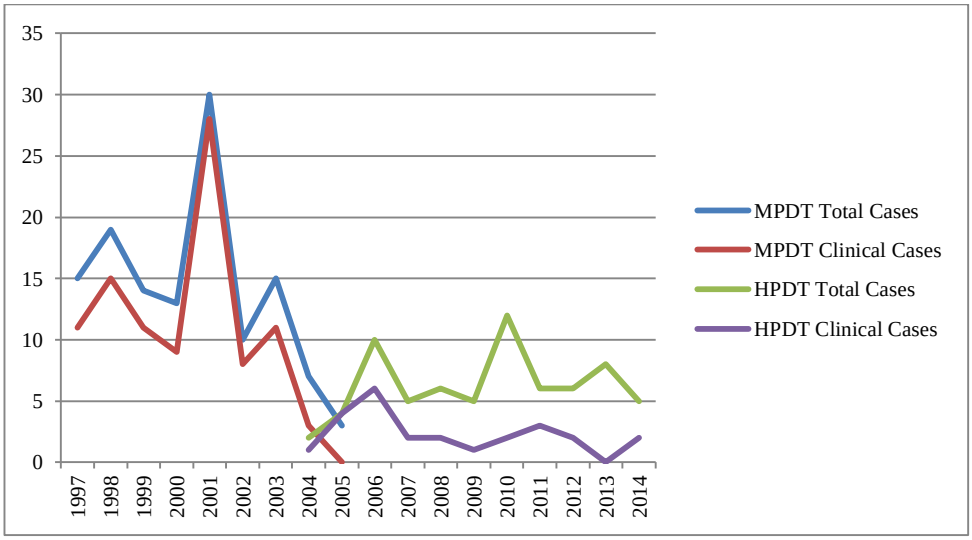
Figure 7: Health Practitioners Disciplinary Tribunal

Year	Clinical	Percentage of Clinical Guilty	Non-Clinical	Percentage of Non-Clinical Guilty	Percentage of cases that are clinical
2004	1	100	1	100	50
2005	4	100	0	N/A	100
2006	6	100	4	100	60
2007	2	50	3	100	40
2008	2	100	4	100	33
2009	1	100	4	100	20
2010	2	100	10	100	17
2011	3	100	3	100	50
2012	2	100	4	100	33
2013	0	N/A	8	100	0
2014	2	0	3	100	40
Total	25	88	44	100	36

These findings suggest it is easier for a prosecutor to succeed when bringing a non-clinical charge. In the HPDT, 88 per cent of the clinical charges resulted in a guilty finding whereas a resounding 100 per cent of the non-clinical charges were proven guilty. In the MPDT, the same pattern emerged with 61 per cent of clinical charges proven guilty compared with 80% of non-clinical charges.

Figure 8 below demonstrates the significant decline in the number of clinical charges that are being laid. In the MPDT the proportion of clinical charges laid was a more significant proportion of total charges than the HPDT. This trend is not observed with the non-clinical charges where the annual numbers bounce around in no obvious pattern.

Figure 8: Charges Heard Against Doctors by Disciplinary Tribunals



A possible reason a lower proportion of charges of alleged clinical misconduct are coming before the HPDT is because clinical complaints make up a lower proportion of the total number of complaints laid than non-clinical complaints. In the annual reports of the Commissioner there are up to 13 different categories into which the complaints are divided. The categories are: treatment; communication; professional conduct; consent/information; medication; access and funding; medical records/reports; management of facilities; privacy/confidentiality; fees and costs, discharge and transfer arrangements; and grievance/complaints process.[58]

58 Health and Disability Commissioner *Annual Report for the year ended 30 June 2013* (E13, October 2013) [*2013 HDC Annual Report*] at 13; and *2014 HDC Annual Report*, above n 42, at 13.

By far the most common complaint to the Commissioner was about treatment, which alone accounted for about 49 per cent of complaints.[59] Communication was the second most common reason and, when combined with consent and information issues, accounted for approximately 20 per cent of complaints.[60] Treatment, communication, consent and information issues would have all been categorised as clinical issues in Figures 6 and 7 above. Clinical issues may well fall into other categories such as "medication" as well, but clinical issues make up at least 69 per cent of all complaints.

This can be contrasted with about six per cent of complaints being about "professional conduct".[61] The annual reports do not explain what conduct is categorised as a professional conduct complaint. It could be argued that any complaint could fall into the professional conduct category as a broad definition of professional conduct is simply the accepted way in which a professional will act.[62] However, given there are 13 different complaint categories many of which would relate to the accepted way a professional will act, a narrower definition of professional conduct is meant. Of the 13 categories, most of the conduct which has been categorised as non-clinical in Figures 6 and 7 above, such as practising without a practising certificate, would fall into the category of a professional conduct complaint.

A further issue that could result in a reduction in charges being laid with the HPDT is, in 2009, a performance measure was reintroduced that the Director of Proceedings establish a finding of professional misconduct in at least 75 per cent of the charges brought before the HPDT. There had been a target prosecution success rate of 75 per cent in 1998 and 80 per cent in 1999 and 2000. These targets were not achieved in 1999 and 2000 and targets were abandoned from 2001 to 2008 (inclusive).[63]

Targets may be put in place either to create an incentive for performance or as a way of calibrating a risk level for prosecution. Either way, they could have the effect of encouraging a more conservative charging threshold which may result in fewer charges being laid and fewer (harder to prove) clinical charges being laid.

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59 Health and Disability Commissioner *Annual Report for the year ended 30 June 2011* (E13, October 2011) at 9; Health and Disability Commissioner *Annual Report for the year ended 30 June 2012* (E13, October 2012) at 15; *2013 HDC Annual Report*, above n 58, at 13; and *2014 HDC Annual Report*, above n 42, at 13. The average was used and the range was 48 per cent–50.5 per cent.

60 Annual Reports cited above at n 59. The average was used and the range was 19.3 per cent–21 per cent.

61 Annual Reports cited above at n 59. The average was used and the range was 5.5 per cent–6.9 per cent.

62 As used by Ian St George (ed) *Cole's Medical Practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013) at 6.

63 See the 1997–2014 Annual Reports of the Health and Disability Commissioner: "Annual Reports" Health and Disability Commissioner <www.hdc.org.nz>.

Despite the fact that complaints about clinical matters make up by far the majority of complaints there is a lower proportion of clinical charges coming before the HPDT.

VII HOW ARE COMPLAINTS ALLEGING CLINICAL MISCONDUCT RESOLVED?

To better understand what was happening to clinical complaints a detailed analysis of 369 Commissioner investigations into doctors was undertaken.

It is not possible to examine the decisions of the Medical Council if a complaint is referred back to it by the Commissioner as these decisions are not made public. Similarly, it is not possible to consider the cases that the Medical Council may refer to a Professional Conduct Committee as these are not published either. Commissioner decisions into an investigation are published, however, so all 369 decisions relating to doctors from 2003 to 2015 were examined.[64]

The decisions were examined to see whether or not the decision related to a clinical or a non-clinical issue, and whether or not a breach of the Code finding was made. If a breach finding was made, the decision was examined and the recommendations of the Commissioner were noted.[65] In the decisions examined the Commissioner made the following recommendations:[66]

- the medical practitioner provide a written apology;
- the medical practitioner undertake some further education;
- an internal or external audit or review of medical practitioner's practice;
- the Medical Council undertake a competence review of the medical practitioner;
- the case be referred to the Director of Proceedings to consider whether or not to lay a charge.[67]

For the purposes of categorising the recommendations, education, review and audit were all included in the "education" category.

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64 Information used for the calculations was obtained from "Commissioner's Decisions" Health & Disability Commissioner <www.hdc.org.nz>. The years do not correlate with the years in the above graphs and tables as Commissioner Decisions are categorised by the date of the decision, whereas the Tribunal decisions are categorised by the year in which a charge is laid.

65 Health and Disability Commissioner Act 1994, s 45.

66 In two decisions, the Commissioner recommended that a refund be paid for substandard care. As there were only two, these recommendations have not been included in the analysis.

67 For the purposes of this article, it has been assumed any referral is a referral for the Director of Proceedings to consider whether or not to lay a charge with the HPDT. The Director of Proceedings or an "aggrieved person" can bring a charge to the Human Rights Review Tribunal (HRRT). However, only one case has been brought against a medical practitioner in the HRRT since 2012. This case was not brought by the Director of Proceedings but by an aggrieved person. The HRRT found it had no jurisdiction to hear the case and the statement of claim was struck out. See *Gravatt v Bulmer* [2014] NZHRRT 40.

If a doctor undertook an action before the decision was produced and the Commissioner commented that this action had been undertaken, it was recorded that the Commissioner recommended the action. An example of this was when, before the Commissioner's decision was produced, a doctor had reviewed educative material, had undergone further professional training and had provided a written apology in response to the Commissioner's provisional opinion.[68] Both apology and education were considered to be recommendations of the Commissioner for the purposes of this article.

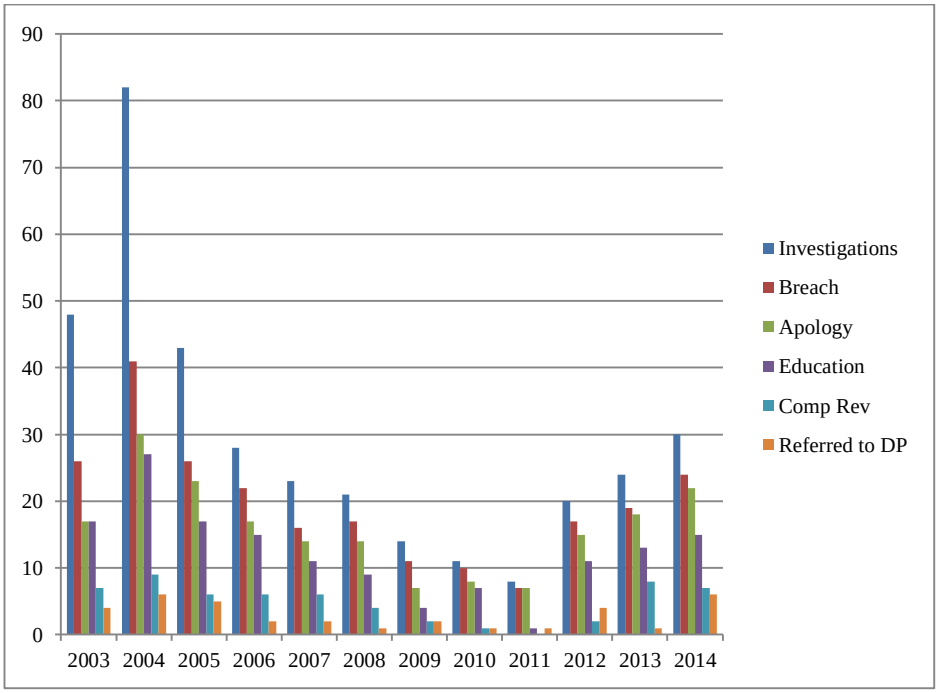
It was noted whether or not the matter was referred to the Director of Proceedings, whether or not a charge was laid in the HPDT and whether or not the charge against the doctor was upheld.

Sometimes the Commissioner found no breach of the Code but still made an adverse comment about a doctor and recommended an action such as an apology to the patient. This data was not collected. However, as would be expected, no adverse comment finding on its own resulted in a referral to the Director of Proceedings.

Almost all investigations related to the clinical conduct of the doctor: 359 clinical and 10 non-clinical. This was expected as clinical concerns made up the majority of complaints. No further analysis was undertaken of the 10 non-clinical investigations.

68 *General Practitioner, Dr C: A Medical Centre (A Report by the Health and Disability Commissioner* (Decision 13HDC00015).

Figure 9: Health and Disability Commissioner – Clinical Investigations and Recommendations



It is evident from Figure 9 above, the more significant a recommendation the less frequently it is made. This accords with the stated aim of the Office of the Commissioner that "[c]omplaints alleging a breach of the Code are resolved at the lowest appropriate level … The emphasis is on 'resolution, not retribution' and 'learning, not lynching'."[69] The majority of breach findings are resolved at a low level without the need for involvement of the Director of Proceedings.

Not surprisingly the more investigations made, the more breaches found. However, as can be seen for the years 2003 to 2005 (inclusive) there is a limit to this correlation in that a high number of investigations occurred and, although the number of breach findings was higher than other years, it is a lower proportion of the total number of investigations. There is some correlation between breach numbers with the number of charges referred to Director of Proceedings. It is interesting to

69 Ron Paterson "Protecting patients' rights in New Zealand" (2005) 24 Med Law 51 at 51.

note that in 2010 to 2012 (inclusive) only two charges were laid with the Tribunal by the Director of Proceedings which probably correlates with the 2009 to 2011 (inclusive) period on Figure 9.[70]

VIII PURPOSE OF THE HPDT

The principal purpose of the Health Practitioners Competence Assurance Act 2003 is to protect the health and safety of members of the public.[71] One of the ways the Health Practitioners Competence Assurance Act 2003 seeks to do this is by providing "for a consistent accountability regime for all health professions".[72] The HPDT is part of this accountability regime.

Another primary role of the HPDT is the setting and maintenance of professional standards. In the often cited case[73] *Dentice v Valuers Registration Board*, Eichelbaum CJ found disciplinary hearings "exist … to enable the profession or calling, as a body, to ensure that the conduct of members conforms to the standards generally expected of them".[74] The HPDT also has cited with approval that "in some cases the communities' expectations required the Tribunal to be critical of the usual standards of the profession".[75] The HPDT "may depart from even unanimous expert opinion, if it forms the view that the expert opinion or evidence as to the usual practice of other similar practitioners does not reflect the appropriate professional standards".[76]

The other purposes of disciplinary proceedings, where there is a finding of professional misconduct, is to issue a penalty that:[77]

- allows for the rehabilitation of the health practitioner;
- promotes consistency with penalties in similar cases;
- reflects the seriousness of the misconduct;
- is the least restrictive penalty appropriate in the circumstances; and
- looked at overall, is the penalty which is "fair, reasonable and proportionate in the circumstances".

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70 There would be a lag between a charge being referred to the Director of Proceedings and a charge laid with the HPDT, as the Director of Proceedings needs time to decide whether or not to lay a charge.

71 Health Practitioners Competence Assurance Act 2003, s 3(1).

72 Health Practitioners Competence Assurance Act 2003, s 3(2)(a).

73 For example in: *Singh v Director of Proceedings* [2014] NZHC 2848 at [63]; *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 3354 at [45]; and *Vohora v Professional Conduct Committee* [2012] NZHC 507, [2012] 2 NZLR 668 at [98].

74 *Dentice v Valuers Registration Board* [1992] 1 NZLR 720 (HC) at 724.

75 *Professional Conduct Committee v Nuttall* HPDT 8/Med04/03P, 18 April 2005 at [69] and [71].

76 *Professional Conduct Committee v MacDonald* HPDT 220/Med08/102P, 27 April 2009 at [33.2].

77 *Katamat v Professional Conduct Committee* [2012] NZHC 1633, [2012] NZAR 320 at [49].

There is some debate whether or not a further purpose of disciplinary proceedings is to punish the health practitioner for professional misconduct. Williams J, after considering the previous cases,[78] was satisfied "the need to punish the practitioner can be considered, but is of secondary importance".[79] Ellis J had "some reservations about the correctness of [that] statement".[80] When reflecting on *Roberts v Professional Conduct Committee* she considered that "punishment was not a necessary focus of the disciplinary penalty exercise. Rather … that punishment may be an incident of such an exercise."[81]

IX IS CHANGING THE CHARGING PRACTICE UNDERMINING THE PURPOSES OF THE HPDT?

This Part focuses on the purposes of holding a doctor to account, and the setting and maintenance of professional standards.

There are fewer charges being laid against doctors and so logically fewer doctors are being held to account for their misconduct. HPDT hearings by their very nature hold doctors to account for their conduct. The doctor is required to explain and answer the conduct in question in a public forum. Members of the public, press, and most importantly, the complainant attend. The decisions with reasons are published on the HPDT website and the name of the doctor is published unless the HPDT orders name suppression. A précis of almost all decisions setting out any important standard-setting comments of the HPDT is published in the New Zealand Medical Journal.

The HPDT is not the only way in which a doctor can be held to account for their conduct, others include: the competence and fitness to practise regime,[82] in-house hospital and clinic processes;[83] and the Commissioner complaints and investigations processes.[84] However, of these processes only the finding of a formal investigation by the Commissioner is published and rarely is the doctor's name published. From the perspective of the public, there is a "veil of secrecy" over the other accountability regimes.

This article suggests that prosecutors have raised the threshold before a charge is laid. If true this begs the question whether the "setting and maintenance of standards" purpose of disciplinary

78 In particular, *Roberts v Professional Conduct Committee*, above n 73.

79 *Katamat v Professional Conduct Committee*, above n 77, at [49].

80 *Singh v Director of Proceedings*, above n 73, at [56].

81 At [57].

82 See Part II.

83 For example, the complaints process at Capital & Coast District Health Board: "Feedback: Complaints, compliments and suggestions" Capital & Coast District Health Board <www.ccdhb.org.nz>. See also the complaints process at City GPs: "Feedback" City GPs <www.citygps.co.nz>.

84 Health and Disability Commissioner Act 1994, pt 4.

proceedings is being frustrated. If the charges are clear-cut (as they more often are in non-clinical cases), it is just a matter of proof; once the facts are proved there is much less consideration required as to whether or not the misconduct is professional misconduct. If fewer borderline charges are being laid this will compromise the ability of the Tribunal to be constructively "critical of the usual standards of the profession".[85]

The significant reduction in the proportion of clinical charges laid with the HPDT may also frustrate the Tribunal's ability to set standards of acceptable practice. It may be fewer clinical charges are being laid because they are less often successful. There is no doubt clinical charges can be harder to prove. Not only will it often be necessary to prove that the misconduct occurred, but that it was misconduct deserving of discipline. By comparison, in a non-clinical case once the misconduct is proved then it is more often a straightforward judgement that the health practitioner is deserving of discipline.

However, even in a case where the HPDT does not consider that the practitioner should be disciplined, standard setting can still occur through the HPDT setting out the reasoning supporting its decision. For example, a doctor was charged with "conduct unbecoming which reflects adversely on the practitioner's fitness to practise medicine"[86] as his communication and follow-up care of a patient were alleged to be inadequate.[87] The MPDT found his communication was inadequate but the follow-up care was adequate. The Tribunal considered that the unbecoming nature of the doctor's conduct could lead to a guilty finding but due to mitigating circumstances declined to make such a finding. In this borderline case the Tribunal was able to make a comment on acceptable clinical standards even though the doctor was found not guilty.

X WHAT DO PATIENTS WANT?

New Zealanders do not complain about health practitioners readily. Bismark and others found only about 0.4 per cent of adverse events and four per cent of serious preventable adverse events suffered by patients result in a complaint to the Commissioner.[88] In this study, adverse events were defined as "unintended injuries caused by health care management rather than the underlying

85 See *Professional Conduct Committee v Nuttall*, above n 75, at [69].

86 Medical Practitioners Act 1995, s 109.

87 *Complaints Assessment Committee v C* MPDT 16/97/12C, 27 November 1997.

88 Marie Bismark and others "Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events" (2006) 15 Qual Saf Health Care 17 at 21.

disease process, that resulted in disability".[89] Serious adverse events were "those which caused death or disability".[90]

Given this low complaint rate and that New Zealand aims for a patient-centred system, it is important that what patients want from a complaint system is considered. Bismark and others surveyed what complainants were seeking following an adverse event from medical care in New Zealand by examining complaints to the Commissioner.[91] They found complainants looked for accountability in the one or more of the following ways:[92]

- communication (explanation, apology or expression of responsibility) – 40 per cent;
- correction (competence review or system change to protect future patients) – 50 per cent;
- restoration (compensation or intervention) – 34 per cent; and
- sanction (punishment or discipline) – 12 per cent.[93]

It was observed that in general complainants were altruistic in their motivation for laying a complaint. Typical comments included: "I hope this complaint makes a difference for the treatment of others."[94] Ron Paterson, who was the Commissioner from 2000 to 2010, confirmed that these findings concurred with his observations and that:[95]

> … the majority of complainants are motivated by the altruistic motive of seeking to prevent the same thing happening to someone else … and a desire for communication about what happened. The oft-cited "vexatious" complainant is in practice rarely encountered.

It is interesting to note that only one to two per cent of complaints ever result in discipline[96] when 8.4 per cent of complaints sought discipline. Other than professional discipline, it is very difficult to formally sanction a doctor in New Zealand in any other way due to the no-fault accident compensation scheme. Arguably a breach finding by the Commissioner is a sanction in its own

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89 At 17.

90 At 18.

91 Marie Bismark and others "Accountability sought by patients following adverse events from medical care: the New Zealand experience" (2006) 175 CMAJ 889. See also Marie Bismark and Edward Dauer "Motivations for Medico-Legal Action" (2006) 27 J Leg Med 55.

92 Bismark and others "Accountability sought by patients following adverse events from medical care: the New Zealand experience", above n 91, at 891.

93 The figures do not add up to 100 per cent as complainants could seek more than one outcome.

94 Bismark and other, above n 92, at 891.

95 Ron Paterson *The Good Doctor* (Auckland University Press, Auckland, 2012) at 55.

96 Health and Disability Commissioner *Annual Report for the year ended 30 June 2002* (E17, October 2002) at 5; and Ron Paterson "The Bogeyman of defensive medicine" (6 September 2006) Health & Disability Commissioner <www.hdc.org.nz>.

right. It is unlikely, though, that if the complainants were seeking a breach finding by the Commissioner it would have been categorised as sanction for the purpose of the Bismark's research. The Commissioner can only make recommendations and cannot impose a penalty. However, just because a complaint seeks sanction does not mean it is warranted.

XI DOES IT MATTER THAT THE CHARGING PRACTICE HAS CHANGED?

Does it matter if the nature of charges has changed and fewer are being laid with the HPDT? If the complaints process is achieving what patients need then perhaps keeping charges to a low number and to non-clinical conduct may be for the best.

The Tribunal process can be stressful for both complaints and doctors. Tribunal hearings are usually held in a conference room in the town or city nearest to where the alleged event occurred, but otherwise the hearing is run like a court. There is a panel of five Tribunal members, witnesses are sworn and the process is adversarial. Complainants and doctors are required to give formal evidence which is often a new and not necessarily welcome experience for either of them. However, it can be argued this is a necessity. A finding of misconduct by the HPDT is a very serious outcome for a doctor and can have major consequences, the most serious being removal from the register and the resultant loss of income and status in the community.

Tribunal hearings are expensive. The average cost of a hearing is about $12,500 a day for the Tribunal costs alone.[97] This does not cover the cost of lawyers representing the parties at the hearing. In the case of a Professional Conduct Committee charge the cost is fully covered by the Medical Council which is totally funded by doctors. A prosecution charge led by the Director of Proceedings is funded from the Office of the Commissioner which is State funded. In the case of a guilty finding by the Tribunal some of the costs of the hearing (usually around 30 per cent) are recovered from the practitioner, but in the case of a not guilty finding the costs are left where they fall. While this seems unfair on the not guilty doctor, it can be argued it is just a cost of being a professional that one may be required to defend one's conduct. Most doctors insure for this event and, it should be noted, due to the ACC scheme the premiums paid in New Zealand are very low when compared with other similar jurisdictions. It is possible that reluctance to lay a charge may be due to the cost of proceedings. However, both the Commissioner and the Medical Council have a duty to protect the public and if the conduct is deserving of sanction by HPDT then the matter should be prosecuted.

The best reason not to lay a charge with the HPDT is that the matter could be adequately (and perhaps better) dealt with at a lower level. There is a shortage of doctors in New Zealand so a far

97 Author's personal experience from attending HPDT hearings.

more satisfactory outcome would be achieved if it were possible to remediate and rehabilitate a doctor without the need for an HPDT hearing.

Where the Commissioner has made a breach finding and review, audit, education and apology are the only recommendations made, it is most unlikely that this would be a matter that should be considered by the HPDT. These are presumably less serious cases and the Commissioner must be satisfied that while the doctor may need some remediation, the overall competence of the doctor is not in question. The borderline matters are more likely to be where the Commissioner recommends the Medical Council consider a competence review.[98]

XII COMPETENCE REVIEWS – SOME CONCERNS

Competence reviews are a broader way of assessing and improving a doctor's competence than discipline. The review can be targeted to the particulars of the complaint but need not be. If a reviewer discovers an area of incompetence entirely unrelated to the complaint, that can be investigated and remediated. This is a significant benefit of competence reviews which is not possible under the discipline system. Only the particulars of the charge can be considered by the HPDT.

Competence reviews are confidential.[99] This is necessary as the process was designed to encourage doctors to admit failures and reflect on their practice. The Medical Council has a philosophy of attempting to deal with concerns about competence in a collaborative, non-adversarial way.[100] The downside of this necessary privacy is that the complainant may not know the outcome of the complaint. They may not know whether a competence review has even occurred unless conditions are placed on the doctor's scope of practice. In addition, if the doctor enters into a "voluntary agreement" to have conditions placed on their practice these are not published. The complainant can feel they have "no voice" in the competence review process even though it may have been their complaint that led to the incompetent practice being revealed. Complainants and members of the public may consider they are back in the days of the Medical Practitioners Act 1968, with the whole matter sorted "in house" and the public left in the dark.

A further issue with competence reviews is that some doctors react defensively to a complaint.[101] Despite the confidential and remedial approach of competence reviews, they are

98 Or where a complaint was referred to the Director of Proceedings and the Director of Proceedings took no action.

99 Health Practitioners Competence Assurance Act 2003, s 44.

100 *Newsletter of the Medical Council of New Zealand* (December 2010) at 2.

101 Wayne Cunningham and Susan Dovey "Defensive changes in medical practice and the complainants process: a qualitative study of New Zealand doctors" (2006) 119 NZMJ 1.

"often bitterly contested".[102] In one research study, 31.5 per cent of doctors did not agree that "most complainants are normal people".[103] If this is the view of a doctor undergoing a competence review as a result of a complaint, it is hard to envisage that they will be open to reflective insight on their practice and to admit failure.

So, although it is probable that disciplinary proceedings encourage doctors to have a defensive response rather than reflect on their practice and admit to mistakes,[104] this is also occurring at least some of the time when a doctor undergoes a competence review. A disciplinary hearing has the benefit of being a public forum and the complainant is usually an active participant and able to tell their story. As Wendy Brandon, a chair of the MPDT, said:[105]

> It is not uncommon for complainants to tell the Tribunal … that for the first time since the incident giving rise to the complaint, they felt listened to, and how much comfort they derived from finally being given an explanation and understanding what had happened.

The reality is that relatively few doctors receive the majority of complaints, so perhaps these are practitioners upon whom discipline should be focused. Research in Australia[106] has shown that approximately three per cent of all doctors prompt half of all complaints.[107] It further showed that the complaint history of a doctor is predictive of subsequent complaints.[108] Doctors with two complaints had nearly double the risk of a further complaint than a doctor with only one complaint. Paterson commented:[109]

> Doctors complained about multiple times to commissions are likely to have been subject to local complaints and unsuccessful attempts to modify their behaviour…. [I]n my experience complaint-prone doctors are often in denial, and will skilfully use delay and legal tactics to avoid conditions being imposed on their practice.

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102 Paterson, above n 95, at 81.

103 Wayne Cunningham "The immediate and long term implications for New Zealand doctors who receive patient complaints" (2004) 117 NZMJ 1 at 5.

104 Collins and Brown, above n 7, at 600.

105 Wendy Brandon "Complaints against medical practitioners" [2001] NZLJ 249 at 252.

106 Australia has similar regulatory mechanisms for doctors to New Zealand.

107 Marie Bismark and others "Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia" (2013) 22 BMJ Qual Saf 532 at 536.

108 At 535.

109 Ron Paterson "Not so random: patient complaints and 'frequent flier" doctors" (2013) 22 BMJ Qual Saf 525 at 527.

It is unlikely doctors exhibiting these characteristics would be appropriate for a competence review and the more severe sanction of a disciplinary hearing may be required. Serious consideration should be given to laying a charge against a doctor who has received multiple complaints. Paterson suggests a number of these doctors avoid disciplinary action:[110]

> The community may be alarmed to learn that a small group of doctors, known to regulators but not to the public, attract half of all official complaints yet are able to continue in practice, often subject only to mild recommendations such as attending a 'communications skills course'.

This community alarm might turn to outrage if they or someone they loved suffered harm at the doctor's hand.

However, even if a doctor is disciplined there is no guarantee there will not be repeat misconduct. Research has shown in the United States that physicians requiring sanction by their State Medical Board were significantly more likely to require sanction again.[111] The researchers suggested that perhaps it was necessary to rely less on sanctions to rehabilitate:[112]

> One must compare the potential costs of removing competent or remediable professionals from practice with those of allowing incompetent physicians to remain in practice… remediable physicians should be rehabilitated, and the remainder should be removed from practice.

While this is logical, it is hard to know whether or not the doctor is remediable; a task of course of the HPDT. This task is made much harder if doctors are being diverted to competency reviews rather than discipline, as, unless a doctor consents, the confidentiality of the competence reviews means the HPDT has no access to the information. If an incompetent doctor was subject to discipline this would be on the public record and the information would be available to the HPDT when considering a penalty for a subsequent charge.

XIII PATIENTS IN THE DARK

"Ensuring doctors are fit to practise medicine is a fundamental purpose of the Medical Council."[113] The Council is responsible for registering doctors. The public need to be able to rely on the fact that if a doctor holds a practising certificate it means they are competent. Information available to the public about a practitioner's competence is severely limited. A determined patient may search the website of the New Zealand Medical Council[114] to check to see if a doctor has any

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110 At 527.

111 Darren Grant and Kelly Alfred "Sanctions and Recidivism: An evaluation of Physician Discipline by State Medical Boards" (2007) 32 J Health Pol Pol'y and L 867.

112 At 882.

113 "Fitness to practise" Medical Council of New Zealand <www.mcnz.org.nz>.

114 Medical Council of New Zealand <www.mcnz.org.nz>.

conditions on their practising certificate, or the Health Practitioners Disciplinary Website[115] to see if the doctor has been disciplined before (assuming the doctor has not been granted name suppression). However, the majority assume the doctor is competent and will provide good care.

This is particularly true when it comes to technical competence. Although "[p]atients generally rate technical competence as the most important attribute in a doctor",[116] there is very little a patient can do to assess technical competence even while they are being treated. It is only if something goes wrong that the patient becomes alerted to the fact that the doctor may be incompetent.

This leads to a much broader set of issues. From a patient's perspective it would be advantageous to have access to information about previous complaints – think about online reviews on sites like Trade Me.[117] Yet this information typically becomes available through disciplinary hearings. Perhaps there are better ways of informing patients, for example through a more proactive and careful disclosure regime overseen by the profession itself.

XIV CONCLUSION

The current system for dealing with patient complaints was designed to shift the focus of medical complaints from the doctor to the patient, to introduce a greater level of independence from the profession and create a better environment to improve the competence of doctors.

In the 22 years since the MPDT was established (and subsequently replaced by the HPDT) there has been a change in charging practice. Fewer clinical charges are being laid against doctors, with a higher rate of guilty findings. The evidence suggests the threshold for discipline has lifted with fewer borderline charges being laid. It is hard to escape the conclusion that the HPDT's ability to set and maintain standards, through holding doctors to account for their conduct, may have been undermined.

This research has further shown that relatively fewer clinical charges are being brought before the HPDT, notwithstanding that clinical concerns account for the vast majority of complaints made by patients. Issues of clinical conduct are being dealt with through non-disciplinary means. This outcome may well be preferable from the perspective of the doctor being investigated, but again limits the ability of the HPDT to improve standards of acceptable clinical practice.

The Commissioner recommends that many more doctors should undertake competence reviews than be referred to discipline. There are good reasons for this, such as avoiding excessively defensive practice and unnecessary expense. However, the question needs to be asked whether the

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115 New Zealand Health Practitioners Disciplinary Tribunal <www.hpdt.org.nz>.

116 Paterson, above n 95, at 4.

117 Trade Me <www.trademe.co.nz>.

appropriate balance has been found. Reports of "frequent flyer" doctors – those who are often complained against but continue to see patients – suggest not.

In the author's opinion, the Commissioner, the Director of Proceedings, the Medical Council and Professional Conduct Committees need to give serious consideration to whether the complaint system is becoming less patient focused through the laying of fewer clinical charges.

"Disciplinary proceedings are still an important means of dealing with questionable doctors."[118]

118 Collins and Brown, above n 7, at 606.