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"FAIR, SIMPLE, SPEEDY AND EFFICIENT"

NATURAL JUSTICE AND THE NEW ZEALAND HEALTH AND DISABILITY COMMISSIONER- THE FIRST FIVE YEARS

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ABSTRACT

This thesis is written by a midwife and lawyer who strongly supported the establishment of the Health and Disability Commissioner. With the enactment of the Health and Disability Commissioner Act 1994 ("HDCA") a new complaints jurisdiction was established. Midwives, like all other health providers became subject to the requirements of this Act. I was appointed to assist and defend employed and self employed midwives from all over New Zealand. These midwives worked in the community and in hospitals. My work also encompassed other jurisdictions, including the professional disciplinary bodies, the Coroners' Courts, the medical misadventure unit and Reviews, the High Court, and other Commissioners.

My role provided a unique opportunity to follow the initial development of the Office of the Commissioner. I was often closely involved in the HDCA complaints process and saw all documentation, correspondence, and opinions generated between the Commissioner, her Office and the midwife for whom I acted. I was able to observe the internal processes of complaint, investigation and prosecution and to see firsthand the impact of these on the profession of midwifery and on individual midwives, often over a period of several years. Inadvertently I began to gather material as a participant/observer as the early midwifery HDCA cases were processed. I soon observed with growing concern that many of the legal protections, usual to investigatory bodies, such as the Office of the Ombudsman or that of the Privacy Commissioner or the Nursing Council of New Zealand, had not been built into the HDCA processes.

A further concern was a growing fear of the Commissioner amongst midwives. This fear did not arise because the midwife was worried that someone might lodge a complaint against her, as midwives recognised the right of consumers to make complaints. Instead this fear seemed grounded in a midwifery view that the Commissioner would not follow a fair process. As an original supporter of the HDCA, I felt increasingly worried that health professionals were losing confidence in the Office so soon after its inception, and that they were questioning the integrity of the Commissioner.
In time I began to speak out and write about my concerns in the hope that this would lead to change. I also inadvertently began to gather information and note where shortcomings in the processes of the Commissioner occurred. I knew that some procedures were established in the Health and Disability Commissioner Act 1994 ("HDCA") but that others such as notice and disclosure were left largely to the discretion of the Commissioner. In other jurisdictions, fundamental protections, tested in the Courts, gave protections to health practitioners but in the Commissioner’s jurisdiction these protections were not in place. I could only base my observations on my own midwifery clients, but I considered that in many cases fair procedures were not being followed. This caused great distress to my clients and increasing frustration to me as a lawyer.

I began to research and read widely about natural justice, fair procedures and fair processes and identified the fundamental requirements of these concepts. I reviewed the history of the Commissioner and closely studied the legislation and case law to determine whether the Commissioner was bound to give effect to the principles of natural justice. I also closely analysed the HDCA and the midwifery cases to identify whether the procedures had been fair. I confined my research to the term of the first Commissioner.

This thesis describes what I discovered.

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ACKNOWLEDGEMENTS

Dedicated to the ones I love –
Lemuel, Ben, Phillippa and our extended whanau.
I could achieve nothing without you.

My special thanks also to my supervisors Professor Peter Skegg and Professor Don Evans, and to Vicki Lang of the Centre of Bioethics – Dunedin School of Medicine, for their long encouragement and support. Thank you for hanging in there with me. I would also like to acknowledge the many midwives who have enriched my life and taught me so much, kia kaha, kia manawanui.
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INTRODUCTION

The advent of a comprehensive accident insurance and compensation\(^2\) ("ACC") scheme in New Zealand in the early 1970's gave cover to anyone experiencing 'personal injury by accident'. This included patients who experienced harm through the negligence of registered health professionals. The original Act was eventually amended so that any person receiving cover under ACC, was statutorily barred from making a claim for compensatory damages against the registered health professionals involved in their care.

The decisions of the ACC were not well publicised and practitioners who caused medical error were not named, and there was seldom any sanction against them. Any regulatory or disciplinary issues were dealt with internally by the professions, in meetings and hearings closed to the public and media. This meant that medical error or adverse disciplinary findings were not talked about nor publicized, as sometimes happens in other jurisdictions when matters are settled rather than litigated, and so unfortunately other practitioners seldom heard about and therefore could not learn from, the medical errors of their colleagues. The result was that similar mistakes continued to be repeated.\(^3\)

It was not until the late 1980s that the practice of health professionals came under increasing scrutiny. Consideration of the socio-political context of that time demonstrates a growing disquiet about the adequacy of medical self-regulation and a recognition among New Zealanders of their right to personal autonomy and self-determination in the area of health. As people became more educated they expected to take an active part in the decision-making about their own and about their family's health care.

\(^2\) The first enactment granting rehabilitation and lump sum compensation for those suffering personal injury by accident was entitled the Accident Compensation Act 1972. The statutory bar to civil claims for damages was enacted in the Rehabilitation and Compensation Insurance Act 1992, section 14. This Act also introduced a specific definition of medical misadventure, section 5.

An additional factor was that while there had been a general satisfaction with the level of compensation under the ACC scheme were a lump sum monetary payment could be given as compensation for personal injury, the view of people changed once such payments were abolished in 1992. When this occurred those who had experienced adverse outcomes of medical treatment, no longer felt adequately compensated for the harm they had suffered. They also no longer believed that errant practitioners were being held sufficiently accountable for that harm, and they wanted the right to complain about what had happened to them, to someone other than the professional bodies. Two frequently expressed motivations for an independent avenue of complaint was that people wanted practitioner’s to learn from their mistake(s) and they wanted to stop similar harm from happening to anyone else.

This thesis will consider how public concerns about medical accountability came to a head following revelations during a Commission of Inquiry into the treatment of women at one of New Zealand’s foremost hospitals, (“the Cartwright Inquiry”). One of the key recommendations from this Inquiry was the call for an independent Health Commissioner. The development of that office will be considered along with the establishment of New Zealand’s first Health and Disability Commissioner (“HDC”). The first Commissioner was charged with drafting a Code of patient rights and setting up an office that would accept, mediate or investigate complaints on behalf of health consumers.

The Commissioner was a statutory officer and like any such officer acts on delegated authority. This thesis will argue that both the Commissioner and the procedures she or he sets in place are subject to the legal principles of natural justice. While not strictly bio-ethical in nature, the principles of natural justice arguably epitomize the essence of many other ethical constructs, including the overarching need for all citizens

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4 Part of this dissatisfaction may have also derived from the paltry financial penalties awarded to successful complainants by the professional disciplinary bodies. Fines were capped at $1000 until 1985.

who are subject to the laws of this country to be treated justly and fairly. The critical importance of these principles to both law and medical ethics is why they have been selected to provide a theoretical framework for this work.

In pursuing this matter I wanted to do three things. First, to review the principles of natural justice, including the relevant literature and case law, and to identify what these principles entailed in a jurisdiction such as that of the HDC. This would enable me to determine if the expectations that I had had for the processes under the *Health and Disability Commissioner Act 1994* ("HDCA") were unrealistic or unachievable. Secondly I wanted to consider the processes and procedures that come into play following receipt of a complaint under the HDCA and whether the Commissioner was bound to give effect to the principles of natural justice. Finally I wanted to analyze past midwifery cases where there had been a concern that these principles had not been followed. Where apparent shortcomings were identified, I planned to measure these concerns against the Commissioner's own governing statute and the expectations of a fair process, to determine whether these shortcomings were significant.

A further factor that prompted this thesis was the realization that, although improvements in process have eventually been made (particularly under the helm of the second Commissioner) the governing *modus operandi* of the Office would always be largely dependant on the beliefs and views held by the incumbent Commissioner. It therefore seemed even more important to review the early years of the Office to see what could be learnt from them. This work is limited to consideration of the first five years of the office of the Commissioner and of the experience of members of the midwifery profession. It is acknowledged that there have been many positive changes in the Office of the Commissioner since that time. The thesis will finish with a conclusion of the primary findings.
CHAPTER ONE - METHODOLOGY

When I was appointed as a defence lawyer to midwives in 1995, one of the jurisdictions with which I became familiar was the Health and Disability Commissioner. I was in a unique position to observe first hand the growth of the jurisdiction and the development of its processes and procedures. I was often closely involved in the HDCA complaints process and saw all documentation, correspondence, and opinions generated between the Commissioner, her Office and the midwife for whom I acted. I was able to observe the internal processes of complaint, investigation and prosecution and to see the impact of these on the profession of midwifery and on individual midwives, often over a period of several years. Inadvertently I began to gather material as a participant/observer about the early midwifery HDCA cases being processed. At that stage I was not intending a research project but I came to realize that the difficulties that midwives were experiencing were not isolated incidents or oversights, but the result of significant procedural shortcomings. I developed the tentative hypothesis that fair processes were not being established or adhered to. After some years, I decided to formally undertake some post-graduate research to explore this hypothesis further.

I wanted the research to have an applied focus as it arose in response to a specific problem and I hoped that it would have a practical application, by highlighting past issues and preventing similar problems occurring in the Office of the Commissioner in the future. I planned to begin by undertaking an extensive review of the relevant literature, a statutory and experiential identification of the procedural steps set out within the HDCA and then to carefully analyse the cases and experiences of several midwives who were subjected to an HDCA investigation. The key questions that I posed was whether these

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6 It is unusual to place the methodology section so early in a thesis but this is where it best informs the reader and it will not break the flow of the review and discussion.

midwives had been treated in accordance with the principles of natural justice and if not, whether they should they have been.

It was difficult to find a theoretical approach that sufficiently informs methodology to enable me to fulfil the wide-ranging aims of this thesis. I found the analysis that I wanted to complete did not easily fit bio-ethical theories, although it sat squarely within the area of traditional health law. Initially it seemed possible to adopt a 'case based' or casuistry approach. Casuists attempt to answer questions by appealing to maxims grounded in experiences and tradition as well as by reason in analogous cases. They recommend immersion in the particulars of a specific case or cases, in order to draw moral principles and reasoning. The casuist identifies the particular features of the 'paradigm' case and considers these against other cases and precedents. In this thesis I wanted to consider actual midwifery cases and consider these against the precedents and case law of similar jurisdictions, to determine if some rule of moral judgement or relevance emerged to link the concepts.

The study of individual cases, enables the casuist to move from specific to increasingly complex fact situations and to then, through case analysis develop a wider theory to systematize and to explain the elements which have emerged. It also enables us to examine practices and policies and determine whether these align with commonly held ethical standards and will inform us how to act according to those standards.

Casuistry is often closely linked, although not invariably, to narrative, although in narrative ethics several 'stories' may arise from the study of the same case. In casuistry each case is considered and the details are debated. The case becomes the narrative which provides a matrix for consideration of theoretical concepts such as the principles of

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8 Notes taken in a lecture for Issues in Law, Ethics and Medicine (BITE 403) 1999. Centre of Bioethics, School of Medicine, Otago University. Lecturer Neil Pickering.


natural justice. Blaxter writes that the case study is the method of choice when the phenomena under study is not readily distinguishable from its context.\(^{11}\) He describes the context as related to the background of existing research, knowledge and understanding that informs new and existing research projects.\(^{12}\) The difficulty with the context that I was dealing with was that the HDCA was a new jurisdiction about which very little had been written. I could agree that the midwifery cases were certainly intrinsically mixed with the changing context of widened consumer rights and greater professional accountability but I needed to understand how these interrelated with traditional legal notions of fair process and the expectation that persons subject to statutory law, will be accorded the fundamental protections of the principles of natural justice. I was aware that study of each of these aspects would help me to develop insights, reveal new ways of seeing,\(^{13}\) and hopefully by case illustration, contribute to changing practice.\(^{14}\)

The primary difficulty that I had with the Casuistry approach was that while it focuses on practical decision making in particular cases,\(^{15}\) it suggests that moral reasoning in decision making, is often hampered by the inflexibility of overriding principles used to inform or justify those decisions.\(^{16}\) I wanted to take the opposite view. Cases often do not inform moral judgement purely by their facts alone and some rule of moral relevance must connect the cases that are being considered. I considered that a purely casuist approach would not be appropriate because consideration of overriding principles such as those of natural justice, in the jurisdiction of the Commissioner, were critical to the development of my thesis. Procedural certainty and fair treatment could only occur if the principles of natural justice were consistently applied. Compliance with those principles would lead to

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\(^{11}\) Blaxter, L., Hughes, C. and Tight, M. *How to research (2\textsuperscript{nd} ed)*. (Buckingham: Open University Press. 2001): 71.


\(^{16}\) Ibid : 94.
better decisions and more just outcomes for all involved in the HDCA processes. This would increase confidence in the work of the Commissioner.

There is also a danger with casuistry of the researcher starting with a bias or proposition and imposing his or her own personal filter on the cases to ensure that the interpretation fits with the researcher's own hypothesis. Nussbaum\(^{17}\) argues that this can be avoided by the researcher being open to other explanations and being ready to be surprised by the conclusions discovered. Although partially rejecting the theory of casuistry to underpin this work, I was aware that analysis of cases could serve to illustrate principles more easily than a dry dissertation or a formal literature review – particularly when much of that literature was case law and statute. I agreed with Blaxter's argument that the insights gained from studying cases can contribute to changing practice because the data is close to people's experience and thus more persuasive and accessible.\(^{18}\) I also realized that case studies would be helpful to demonstrate the principles and concerns that underpin this work. I therefore could not reject this theory completely, so while part of this work is loosely casuist, I decided to concentrate on the theoretical framework provided by the principles of natural justice. These principles can be utilized to inform many aspects of bio-ethics such as where there is distribution of scarce resources, areas of rule utilitarianism, and where there are considerations regards the ethics of process in decision making.

The method that I used was inductive. Trochim describes inductive reasoning as that which moves from specific observations to broader generalizations and theories.

\[\text{The researcher takes these] specific observations and measurements begins detecting patterns and regularities, formulates some tentative hypotheses that you can explore, and finally ends up developing some general}\]


\(^{18}\) Blaxter et al., (2001): 73.
conclusions or theories.\textsuperscript{19}

Inductive research is generally a process of reference from the particular to the general. Edwards writes that it is frequently used where typical cases are given as illustrative of wider principles.\textsuperscript{20} I then began to look at ‘inductive’ models to inform my research methodology. The models of methodology that I primarily utilized were a combination of participant/observer observation, grounded theory, and close textual analysis.

The concept of grounded theory arose from the work of Glasser and Strauss.\textsuperscript{21} They consider that theories arise “from the ground up”. A key object is that a researcher goes “into the field to observe the phenomena in its natural state” or in situ and the theories that emerge are grounded in what is observed.\textsuperscript{22} This is sometimes referred to as the concept of emergence. Yee writes that with grounded theory, the researcher starts with no preconceptions, and that the research problem, the sample, the concepts, the relevant literature and finally a theory, emerges during the process of the study itself.\textsuperscript{23} Certainly the research problem for this thesis arose from my observations of practice and HDCA processes. The sample emerged from the group of midwives I was closely working with. My role as legal advisor enabled me to study what Yee describes as the lived experience of these participants as they became subjected to the HDCA complaints process. I saw their tears, shared their concerns, and heard their fears and frustrations. Edwards states that:


\textsuperscript{21} Glaser, B.G. and Strauss, A.L. \textit{The discovery of grounded theory: strategies for qualitative research.} (New York: Aldine de Gruyter, 1967). The two theorists parted company and went on to develop two very different aspects of the theory. Yee writes that Glaser became interested in studying core processes based on the concerns of the people in the study and this interpretation was helpful in completing this research. Yee, B. (2003, ch 2).


Grounded theory is developed inductively from the content analysis of records of phenomena that occur in a natural setting and that the theories or frameworks produced can provide new ways of seeing these phenomena.\textsuperscript{24}

While it might seem unusual to view the Office of the Commissioner as a ‘natural setting’, for the purposes of research, the midwives and I were involved day to day in the usual processes and procedures of that Office. The correspondence and findings were very typical of that jurisdiction, at that time and therefore arguably ‘natural’ in terms of the usual way the Office operated.

Having identified the research sample, the researcher gathers data and takes extensive field notes and begins to generate questions, analyze themes and identify core concepts.\textsuperscript{25} This is followed by a stage that Yee describes as conceptualisation, where a researcher has to step back from the data and write memos and notes to develop tentative hypotheses.\textsuperscript{26} In this research, the early data collection was partly inadvertent. I began to accumulate information and keep notes on themes that were arising. I am uncertain if I ever consciously stepped back to develop a hypothesis. I do recall recognising a pattern of concerns, and analysing the differences between other jurisdictions and the way that the Commissioner conducted her investigations. I developed the tentative hypothesis that the processes were not always fair, but it was not until I began to closely study the principles of natural justice and place these alongside the HDCA processes and the midwifery cases, that the extent of the problem began to emerge. The process that I followed was in accord with the final stage of grounded theory research, noted by Yee. He calls this the assessment phase, where the analyst assesses whether the data, fits the emergent theory.\textsuperscript{27} This stage confirmed my hypothesis that in some midwifery cases the fundamental protections of the principles of natural justice were not being accorded to midwives.

\textsuperscript{25} Yee (2001) ch 2:2.
\textsuperscript{26} Ibid
\textsuperscript{27} Ibid
Textual Analysis

In grounded theory the literature review or textual analysis is not a distinct portion of the research but is incorporated into the thesis itself. This was the method that I found best informed the subject matter of the thesis. I used a variety of methods to collect data including on-line searches, informal discussions, observations, case reviews, examination of documents, and close textual analysis of the case law and literature. My predominant and method was manual library searches of texts, case law, newspapers, journals and periodicals. This was time consuming but the inefficiencies with this method, were balanced by the breadth of information that I accessed. Fortunately from the inception of the Commissioner, I had had an avid interest in the Office and so by the time I commenced my formal research, I had accumulated a large amount of data, conference notes and journal and media clippings.

The initial literature review was comprised of five parts: the first was a comparative analysis of the history and operation of the Health Commissioner of the United Kingdom. I undertook this study in order to develop the history of an Health Commissioner in at least one other similar jurisdiction although when it came to writing up the thesis I omitted this section as not relevant to the New Zealand context. The second part was a review of the literature related to bio-ethics in order to develop my methodology and a theoretical framework for the thesis. Unfortunately after initially considering various models such as the four principles approach, Rawls theory of justice, utilitarian theory and casuistry, I found that none of these approaches really enabled me to develop and analyze the hypothesis that I had proposed and I turned to the theory of natural justice.

The third area of textual analysis related to the development of the Office of the Health and Disability Commissioner in New Zealand. I tracked the legislative history from

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29 One difficulty I experienced was that although I had copies of newspaper clippings sent to me by people who knew of my interest in the jurisdiction, these were often not referenced. It has been difficult to track down exact references while compiling this thesis.

30 Looking back from the end of this work, I now recognise that it is possible that due to my legal training, I had already subconsciously embraced the ethical/legal construct of the principles of natural justice.
the parliamentary response to the recommendations arising from the “Cartwright Inquiry” through to the advent of the first Health and Disability Commissioner. This entailed a review of the Parliamentary debates, the various Health Commissioner Bills, commissioned reports such as the “Vennell” Paper\(^{31}\), Standing Order Papers and Select Committee data in order to follow the changing emphases within the legislation.

Once the HDCA was enacted, the Commissioner spent her first year travelling nationally and internationally, and consulting with key stakeholders in order to establish a Code of Health and Disability Services Consumers’ Rights (“the Code”). There was a considerable amount of literature generated over that time and many health professionals were involved in the consultation process, including the New Zealand College of Midwives. After the first year the Commissioner began to implement the Act and concentrated on the establishment of systems to cope with an unexpectedly high number of complaints. I reviewed much of this early literature, the consultation documents, the Commissioner’s educational literature, press and media releases, articles and conference papers from this period.

The fourth area of textual analysis was required to articulate the ‘principles of natural justice’. This phrase has become almost trite in law and while it is frequently bandied around by defence lawyers, there is not always a clear knowledge of what these principles entail in a complaints or investigatory setting. I needed to read extensively on how these were formulated and expressed in both the literature and in the common law. This reading included a comprehensive review of legal texts, journal articles, case law and legal jurisprudence to enable me to identify the principles of natural justice and then to develop these as a helpful way of both identifying fundamental legal and ethical expectations of the HDCA processes and of illustrating when departures from these standards occurred.

The final area of textual analysis arose from the complaints and midwives themselves.

Having completed a review of both legal and ethical sources, I began a close reading and review of the files of midwives who had been subject to HDCA investigations. I wanted to consider the 'pro forma' documentation from the Commissioner such as letters of notification, requests for information and disclosure, both from the midwife and the Commissioner, and to read the provisional and final opinions along with the evidence. (An edited version of many of the cases became available on the HDC website). This was a surprisingly difficult aspect of data collection. While analyzing the cases and deciding which to include, I frequently had to put them aside to regain my objectivity. I was aware of the words of Edwards who warned that:

*researchers who are too close to or part of a case being examined can be blinkered and fail to see an alternative interpretation of events. [They] need to achieve the balance between valuable inside knowledge and the fresh insights that might be offered by a theoretical framing of the events they’re studying.*

I frequently worried that my analysis of the Commissioner was too critical, particularly when I found myself recalling the circumstances of individual midwives in particular cases and I bore in mind Weinberg’s warning of the “*subtle equilibrium between detachment and participation*” One technique from grounded theory that helped me greatly was the concept of triangulation. Edwards describes triangulation as:

*...a three point perspective on an event or phenomenon that uses several methods to get purchase on a case.*

The object in this technique is to gather information from more than one source, or to cross reference facts or inferences, in order to ensure the validity or reliability of your conclusions. I found this particularly helpful in ensuring that the conclusions and generalizations that I was making were objective. I spent a great deal of time reading a
wide variety of documents and cross referencing these to verify the statements that I was formulating.

The Case Samples

The sample was self-selecting in many ways or in the words of Yee - emergent. I began by reviewing approximately forty files where complaints had been laid against midwives. I then concentrated on complaints that had occurred during the years 1996 to 1999. I deliberately confined my analysis to cases in the era of the first Health and Disability Commissioner because almost immediate and quite wide-ranging changes to processes and procedures occurred as soon as the second Commissioner took office. Initially I began to closely analyze every midwifery case but this proved to be an unwieldy task and I instead concentrated on developing themes that arose from these cases. This provided a pragmatic solution to an unexpected difficulty that emerged. I had expected to go back and discuss my perceptions with the midwives as I reviewed their files. When I began to do this, I found that some midwives had moved away or had left midwifery practice. Others became upset at the prospect of revisiting a period in their lives that had been painful and difficult. This raised a dilemma and I felt unable to develop some of the cases in depth while the midwives were still feeling this way. I decided to restrict most of the discussion to the Commissioner’s opinions or published information in these cases.

Fortunately I had often discussed the procedural difficulties with midwives while their cases were ongoing. Midwives would identify shortcomings in the processes and ask me why they were not allowed to know the name of the expert giving an opinion on their case; or why they did not see key evidence until after the final opinion; or why there was not disclosure in a timely way or at all. These were questions that I was also asking and we made frequent requests and letters to the Commissioner about these matters. I also kept notes of the issues that we were facing. When I discussed the possibility of researching the jurisdiction, it was these midwives who urged me to try to effect change, so that future investigations and prosecutions to be fair to all involved.
Data Analysis and Discussion

Data analysis proved the most difficult part of the thesis, and like many beginning researchers, I had collected a huge amount of interesting but tangential material. A key aspect of grounded theory research is the analytic strategy of coding, which Trochim describes as a process for 'categorizing qualitative data and describing the implication and details of these categories'\(^\text{35}\) and memoing which he defines as a process for recording thoughts and ideas as they evolve through the study.\(^\text{36}\) I endeavored to use both of these techniques, although I did far too much memoing and it took some time before the data was sufficiently grouped to allow the emergence of the key themes, concepts and categories of information.

Research Issues - Process

I found that the most logical way to proceed was to formulate the subject headings into chapters and write each quite discretely. This worked for the consideration of the UK Health Commissioner, the socio-historical and legislative review and the early development of the Office. When I came to analyze the principles of natural justice, I became bogged down and was not certain how to apply these to so many cases. I decided to use a form of coding and summarized key points from the documentation of each midwifery case, and identified any concerns that either I or the midwife had had during its consideration by the Commissioner. I placed these summaries on separate data sheets and noted at which stage of the Commissioner’s process that the concerns had arisen. I then identified each principle of natural justice as identified in common law and then analysed these alongside the Commissioner’s documentation and the relevant sections of the HDCA. As I did this I considered what minimal requirements of natural justice could or should be imported into the implementation of these sections.

An example is where the HDCA requires the health provider to be notified that a complaint has been received about the service that they have provided to the consumer.


\(^{36}\) Ibid.
The provider is then asked to formulate a response. The most obvious principle of natural justice related to this provision is *audi alteram parte* which may be translated as ‘hear the other side’. The reason for this ‘rule’ is that the provider has the right to know the nature of the allegations being made about his or her care. Additionally the provider has the right to know who is making the complaint and should be entitled to see the complaint letter if it exists. When coding I would state the principle and then discuss the requirements of the statute to which the Commissioner was required to give effect, and finally illustrate by use of cases whether this principle had been breached. Often there were several cases where a difficulty had arisen, and so I would just use a single case that was generally illustrative of the problem. I was aware that corroboration was important and so triangulation was applied wherever possible, using the Commissioner’s statements, interviews, or other documentary evidence. I would then move on to consider the next section of the Act, apply the relevant principles of natural justice, and again give illustrations of difficulties by reference back to actual cases.

Confidentiality

New Zealand is a very small country and I was constantly aware of the need to maintain anonymity and protect the identity and confidentiality of those involved. This was equally true for complainants as well as for midwives. In order to achieve this both midwives and complainants have been given an initial of the alphabet as an unique identifier. This initial bears no resemblance to their actual name. Even where the Commissioner has named one midwife, or where parent complainants have “spoken out” in the media, I have refrained from naming these persons in order not to subject them to further scrutiny. I have tried to avoid naming regions or locations to further protect people’s privacy.

As the thesis was drafted, it was necessary to cull out a great deal of information that while helpful to my arguments, may have breached the privacy of individuals or led to their identification. This was a frustrating aspect of the research as after months of close study of all the documentation in the cases, there was a great deal of additional material that supported my hypothesis, but it was not appropriate, or at times it was simply too prejudicial, to use. In the end I decided to rely heavily on the Commissioner’s actual
opinions and concentrated on cases that were in the public domain or where there was a lot of publicity and debate, or which were illustrative of serious concerns about process. I used non-identifying data at all times.

One other aspect of confidentiality concerned me when I decided to use a lap top computer to take with me to the various libraries. I could not borrow or use a work computer, and as much of the early information I was gathering was confidential, I was worried that subsequent users might access this. I therefore entered a hire arrangement with a specific contract term that the hard drive would be completely wiped of all data immediately at the end of the hiring period. I was also very protective of my “field notes”, floppy discs and case summaries. I gave the cases, identifying numbers and removed any place names or other identifying data, in case someone looked at them.
CHAPTER TWO:— THE CALL FOR A NEW ZEALAND HEALTH COMMISSIONER.

The “Unfortunate Experiment”— A key pre-cursor to the HDCA

It is impossible to consider the development of the Health and Disability Commissioner (“HDC”) in New Zealand without looking at the social, political and clinical seedbed from whence it came. A growing dissatisfaction with professional self governance, the inadequacy of sanctions for errant practitioners, a lack of redress for consumers, the international human rights movements and increased education of consumers have all been cited as factors leading to a call for greater professional accountability. Although these were all an important part of the context, arguably the primary pre-cursor for the development of the Office was the “Cartwright Report”. That report recommended that an Office of an Health Commissioner be set up in New Zealand.

The “unfortunate experiment” is well documented and it is not proposed to consider the events leading up to the Enquiry in any detail. To summarize briefly, two health activists Sandra Coney and Phillida Bunkle had become aware, through health and women’s networks, that there was a concern about the way staff at National Women’s Hospital (“NWH”) in Auckland were treating women who had carcinoma in situ of the uterine cervix. The treatment appeared completely contrary to both international treatment regimes and the body of research on the optimal way to treat this potentially fatal condition. Coney and Bunkle began to compile evidence and stories from women undergoing “treatment” and initially tried to get answers to their concerns and inquiries from the hospital and its medical staff.

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37 Although this phrase was incorporated into the title of the Metro article, Rosier states that it seems that the first person to term the research “the unfortunate experiment” was Professor David Skegg in a medical journal. Rosier, Pat. “It wasn’t my fault.” Broadsheet, 154 (1987): 5-7.

They recalled their frustration at that time:

[We] were met with closed ranks from doctors and initial disinterest from the media. Doctors said to leave it alone, it was in the past and no good would be served by revelations in the lay media. It was seen as a matter for the medical profession, not the public.  

The treatment was based on an isolated and unproven hypothesis of the [then] Medical Superintendent Herbert Green, that CIS was not a precursor to invasive cervical cancer. He commenced an experiment to prove this and between the years 1956 and 1982 entered women into his “study” by flipping a coin and then telling them what ‘treatment’ they would get for CIS. While other New Zealand centres were treating this condition with cone biopsy, radiation or hysterectomy, Green’s ‘treatment’ appeared to consist mainly of endless examinations and cervical smears, and passive monitoring to watch the progress of the condition. Some of these women went on to develop full-blown carcinoma and eight women died. Despite the overwhelming international evidence that non-interference did not work, the experiment appears to have continued for over 20 years, with the apparent collusion of many staff and hospital management.

It should be stated that not all health professionals were comfortable about what was happening. A small group, Doctors McIndoe, McLean, Warren and Jones tried in a variety of ways to challenge Dr Green and his team. These collegial challenges ranged from private discussions with Green about their concerns, through their seeking advice from a world authority in gynaecological oncology treatment in order to discuss their concerns about Dr Green’s treatment methods. When they continued to be ignored, they raised safety issues with the Hospital Medical Committee. This also failed to affect change and so the doctors published their concerns in medical journals in 1984 and again in 1986. Despite these concerted efforts to stop the research, the Medical Research Committee and the Area Health

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Board took no steps to investigate the concerns of the dissenting clinicians and nor did they ensure that patients were not being put at risk.\textsuperscript{41}

Coney and Bunkle, alerted in part by these medical articles, continued their investigations. In June 1987 they published an article in Metro magazine.\textsuperscript{42} The authors told of the long running experimental program and that (except for one woman) those being treated did not know that they were in a research program nor that alternative forms of treatment were used elsewhere.\textsuperscript{43}

The "Cartwright Enquiry"

The governmental response to the "Metro Article" was almost instantaneous. On 10 June 1987 a Committee of Enquiry was appointed to inquire into the treatment of CIS at National Women's Hospital and Judge Sylvia Cartwright (as she was then) was appointed Commissioner. The Commissioner wrote to 1000 women who had been treated at NWH to offer them the opportunity of viewing their records and giving evidence.\textsuperscript{44} As the Terms of the Inquiry were established, concerns about other practices at NWH surfaced and the Inquiry was broadened to cover additional allegations that included the routine cervical swabbing of all newborn baby girls without parental consent, the study of the histology of the cervixes of aborted female foetuses and stillborn infants, and the vaginal examination of women under anaesthetic by various students without consent.\textsuperscript{45}

During this Inquiry the general public got a glimpse, perhaps for the first time, of what happened to women in hospital and they demanded answers: not just from the doctors

\begin{footnotesize}
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\item Coney, Sandra and Bunkle Phillida, "The Unfortunate Experiment at National Women's Hospital" \textit{Metro}, (June 1987):46-65.
\item Cartwright, (1988):153. The survivors were to later give disturbing evidence of the impact of this "management" on their lives, their relationships and their self-esteem. See the section in the Report from pg 153, that reproduces actual quotes from the women about the effect of the experiment on women and their families.
\item One of the specialists at the Enquiry gave evidence that informing a women (note not gaining consent) would take ten minutes and "we couldn't afford it".
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but from managers, nurses, midwives, and social workers as well. Although many doctors did not question the research, and closed ranks and claimed that no one had the right to interfere with the clinical freedom of their medical colleagues, other health professionals had also been silent about the research programme. The fundamental question to all of these staff was "Why did you not protect them?"

When "The Cartwright Report" was released in July 1998. It contained a number of comprehensive recommendations including the need for informed consent procedures, peer review, the establishment of ethics committees and the employment of an independent full-time patient advocate at National Women's Hospital. For the purposes of this thesis it is proposed to simply summarize the recommendations which led to the establishment of the Office of the Health and Disability Commissioner. Judge Cartwright wrote:

In the absence of a Bill of Rights, and in a jurisdiction where the financial accountability of the medical profession has been distorted by no-fault Accident Compensation legislation, there needs to be a procedure which patients or their relations can follow if they want more information about their health problems; or if they want some form of sanction to be considered.46

In view of the inadequate response of the hospital, its staff, the Area Health Board and professional disciplinary bodies, Judge Cartwright saw the need to appoint a completely independent and impartial health arbitrator. She referred to the United Kingdom Health Services Ombudsman ("HSO") and recognized similar issues between the complaints that the HSO had investigated and those which had arisen during the Inquiry. She recommended that the New Zealand Government appoint an Health Commissioner who would be tasked with accepting complaints about incompetent or negligent practitioners, and who would negotiate or mediate solutions to disputes between them and patients. The relevant recommendations stated:

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

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

The Commissioner should have the power to accept complaints from, or refer complaints to, the patient advocate or the Board and was additionally to have access to the disciplinary procedures pursuant to the Medical Practitioners Act 1968. Adequate resources to service the increased work of the Human Rights Commission were to be provided. Judge Cartwright wrote that what the professions, patients and public have in common, is a need for:

1) The [health] professions to be properly regulated and controlled; and
2) An adequate and rational system of compensation for patient suffering and injury; and
3) Effective means of investigating medical accidents; and
4) Provision for [practitioners] to be given comprehensive guidance in those areas of practice of moral and ethical sensitivity.

When the “Cartwright Report” was published, many New Zealanders were shocked to learn that “leading” medical specialists had been able to continue unethical clinical experimentation over so many years. The public looked to the Government for a response.

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48 Ibid.
CHAPTER THREE - THE LEGISLATIVE PATHWAY OF THE HDCA

A key recommendation of Judge Cartwright was that a position of Health Commissioner be established. The Health Commissioner was to have an important role in educating both patients and practitioners and would be able to develop procedures for negotiation and mediation should patients be dissatisfied with their care. Where these low level solutions failed, the Commissioner would have the ability to access the disciplinary bodies on behalf of complainants. It was hoped that the formation of an independent complaints body would encourage practitioners to listen more actively and sympathetically to patient grievances; and that they would develop a greater understanding of patients' rights and gain insight into the effect of behaviour and poor practice on both patients and their families. Optimally this would lead to improved accountability and an overall improvement in patient care.

The Legislative Timeframe

The Health Commissioner Bill – First Reading - 4 September 1990

It might be expected, after the happenings at NWH and the publication of the Commission of Inquiry Report, that the Government and professions would take swift action to reassure the public and ensure that the recommendations of Judge Cartwright were promptly fulfilled. In reality the Parliamentary response was anything but swift. Although the Labour Government adopted the recommendation for a Health Commissioner, it was two years before the legislation to establish the office was brought before parliament. The Health Commissioner Bill was introduced by the Minister of Health, the Hon. Helen Clark [as she was then] on 4 September 1990, but the passage of that Bill proved to be very protracted. At introduction it was one of 15 Bills set down for consideration in a single day of sitting prior to the Government going into pre-election recess. The Bill made provision for the appointment of a Health Commissioner who would develop a Code of patient rights. The Commissioner was to be easily accessible to the public; have jurisdiction over all health services in New Zealand; adopt a mediatory
approach to complaints; have the power to require remedial action to be taken by health professionals should the complaint be upheld; provide a voice for all patients; have the primary role of promoting and supporting patient interests; adopt a bicultural approach; and educate the public and health professionals about the Health Commissioner role.49

Judge Cartwright had also called for advocates who could provide information for people in emotional cultural and social need so there was to be both a Commissioner and an advocacy service. The proposal was that the health consumers' advocacy service would take up complaints close to source and advocates would work with patients and practitioners to resolve complaints, wherever possible by agreement.50

The final Act was to be in five Parts:

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The Health Commissioner Bill was referred to the Social Services Select Committee but there it stalled. The elections of 1990 ousted Labour and returned a National Government to power. Under National the Bill was also given a low priority while the Government embarked on a series of major health system reforms. Although the Bill was not given priority, many argued that the health restructuring which accompanied the reforms, the lack of local accountability, the continual shortages of staff and resources, increased the vulnerability of patients and made the need for a Commissioner who could mediate between them and practitioners even greater.

As the Bill languished in the parliamentary processes, consumer groups became increasingly frustrated with the lengthy delays. In August 1992 Sandra Coney presented a

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paper entitled "Why are we waiting? - *The Fate of the Health Commissioner". She considered that patient’s rights and consumer interests were being seen as expendable and she called for urgent implementation of the Bill.

In 1992 Margaret Vennell, an Associate Professor of Law at Auckland University, was asked to review both the *Health Commissioner Bill* and the *Medical Practitioners Bill* and report to the Social Services Select Committee. The "Vennell Report", as it became known, made a series of recommendations. The following points are a summary of the introductory pages of the Report.

- That every effort be made to redress the imbalance of power between health professionals and clients and thus prevent situations of conflict arising.
- If there was conflict, early conciliation and resolution should be attempted.
- Complaints should be resolved at the lowest possible level.
- There should be a clearer distinction between advocacy which can prevent disputes and disagreements, and mediation and conciliation, which is a means of resolving a dispute once it has arisen.\(^53\)
- Three possible complaints avenues for the same complaint - ACC, medical discipline and Health Commissioner - would be cumbersome, costly and unwieldy.
- There should be a national, independent, and independently funded, advocacy service, available at the point of entry into health service.
- This service should address the imbalance in power and information between the participants.
- Where there is a dispute, the advocacy service should endeavor to obtain resolution in a non-confrontational way.

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\(^{53}\) Ibid.
There should be an independent Health Commissioner, separate to other Commissioners, who would develop a Code of Patient Rights and be able to investigate complaints about all health services.

The Code should be enforceable, possibly through regulation, be an integral part of standard setting for health professionals and should take into account the needs of the 'tangata whenua'.

The Health Commissioner should be the single entry point for all complaints and would receive, investigate, seek expert advice, conciliate and refer to the appropriate professional authorities.

The Commissioner must be seen by the provider and health client to be an impartial conciliator.

The Commissioner may refer the complaint to the Accident Rehabilitation and Compensation Insurance Corporation (ACC) or prosecute the complaint before the disciplinary bodies where appropriate.

There should be a National Health Care Ethics Committee.

There should be a single professional Tribunal funded by a health provider levy, which would deal with all complaints.

The Tribunal should have the powers to make suspension orders, require payment of fines, reparation and damages awards, and orders for costs.

The Tribunal should act in accordance with the principles of administrative law and with natural justice.

There should be a right of appeal to the High Court.  

Professor Vennell recognized that it would not be sufficient for a Commissioner to focus solely on issues of negligence, as many of the adverse events that occur during health care are systems problems, or arise from communication difficulties. She considered that the Commissioner should attempt to eliminate adverse events of all kinds, including identifying and improving practice by drawing attention to the factors through which they occur.

54 Ibid: i - vii.
Supplementary Order Paper 247 - 3 August 1993

On 3 August 1993 when the Minister of Health the Right Honorable W.F. Birch [as he was then] moved that a Supplementary Order Paper ("SOP") 247 relating to the Health Commissioner Bill be referred to the Social Services Committee for consideration. The SOP recommended that the powers of the Commissioner be widened to include voluntary and disability services. Although the SOP purported to extend and improve the proposed complaints processes and enhance the accountability of providers, the Government argued that the Bill needed to fit the new environment of the health reforms and to this end the SOP ensured that the Health Commissioner Bill was consistent with the Health and Disability Services Act 1993.55

The SOP was based largely on the Vennell recommendations56 including the view that the original Bill had been flawed in that it required the Commissioner be both mediator and investigator. Birch warned that "it was inappropriate for a Commissioner who was expected to act as an independent mediator in a dispute, to employ advisors on one side of the dispute."57 The SOP reflected acceptance of the view that in order for the Commissioner to be accepted by health professionals and consumers, she or he needed to be both neutral and impartial. The separation of the investigatory and advocacy roles was seen as critical in achieving this impartiality. The SOP proposed that four major sections be established under the Bill each with separate functions. These were:

- the Office of the Health and Disability Commissioner
- the Code of Consumer's Rights
- the Consumer Advocacy Service
- the Proceedings Commissioner.

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The rationales for the changes proposed by the SOP changes were not widely discussed in the parliamentary session, although the debates reveal concern about the mechanics of the Office and note possible solutions. The Bill and SOP were then referred back to the Social Services Select Committee and there was a call for public submissions.

The submissions process was extensive as there was considerable opposition to the SOP both inside and outside parliament. Key sticking points were the suggestions that the requirement for informed consent be removed; that advocacy services would be located within the Ministry of Health; and that upon receiving a complaint, the Commissioner would confer with professional bodies in order to negotiate an agreement. Consumer groups strongly opposed these recommendations and a large number of submissions were made calling for changes. After going through several permutations the Bill ended up, pretty much back where it started.

Select Committee Report -16 June 1994

The Select Committee reported back almost four years after the Bill had been first introduced. The Bill had jettisoned any reference to the principles of the Treaty of Waitangi despite the recommendations and stated concerns of Judge Cartwright that these were important. It also narrowly missed discarding the principle of informed consent. The role of the Commissioner was to be expanded to include jurisdiction over disability services and the Commissioner was to be the principal investigator and assessor of all health and disability support service complaints. There was to be a written Code of patient

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60 Ibid. 114 submissions were received, and during the years 1991-2, 50 witnesses representing 31 individuals and organizations were heard.

61 Pettis, J. *New Zealand Parliamentary Debates*, 543 (27 September 1994): 3755. Pettis was one Minister who criticized the decision to remove from the Bill any acknowledgement of the rights of Maori, and the special place of Maori as tangata whenua. The specific requirement that the Bill be consistent with the principles of the Treaty of Waitangi was removed.
rights. The roles of mediation and advocacy were to be split because it was accepted that the Commissioner needed to be seen as acting impartially. The Commissioner would have differing methods of intervention available to deal with complaints – first attempting resolution, advocacy and mediation, and if these attempts failed or the matter was serious, an investigation and possible disciplinary action could follow. A Proceedings Commissioner was to be appointed to prosecute cases, and a consultation process would be established between the Office of the Commissioner and the professional bodies to consider whether following a finding of a breach of the Code, professional disciplinary action was warranted.

The task of forming a Code of Rights and creating an office which would fairly and expeditiously serve both patients and health professionals would be a considerable challenge. The importance of getting the right person for this new role of Commissioner was highlighted by the Honorable Bill English, who by his own admission had initially approached the Bill with a great deal of scepticism:

*I think it is necessary to remember that the operation of a Health Commissioner and the success of that operation will depend a lot on its credibility, not so much on the legal powers of the Commissioner although it does have a number of significant legal powers but on its credibility with the different parties to the dispute. The Commissioner has to be credible with the least articulate health consumer as it is often those people who most need the services of an advocate and the Commissioner, as well as the most powerful medical specialists and the most active health consumer groups.*

This view was echoed by other politicians who considered it important that any complaints service be seen as independent, credible and neutral.  

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63 Gallagher, Martin. *New Zealand Parliamentary Debates*, 540 (16 June 1994): 1813. McCardle, Peter. *New Zealand Parliamentary Debates*, 540 (16 June 1994): 1812. As noted above Associate Professor Vennell had also stated that for the Commissioner to be successful as an independent agent investigating and mediating complaints, she or he could not be seen to be supporting one side of a disputed claim.
The Second Reading - 27 September 1994

The Bill returned to the House for its Second Reading on 27 September 1994. The purpose of the Bill was encapsulated in Clause 5A which stated:

_The purpose of this Act is to promote and protect the rights of health consumers and disability services consumers, and, to that end to facilitate the fair, simple, speedy, and efficient resolution of those complaints relating to infringements of those rights._

Much of the debate accompanying the Second Reading focused on the role of the Commissioner and the importance of an independent advocacy service within the Office of the Commissioner. An entire thesis could be written on the tasks which faced the Commissioner and in particular the enormous amount of work and consultation required to formulate the Code of Rights. That discussion is outside this brief. It is however helpful to summarize the expectations Parliament had of the Commissioner. These were to:

- develop the Code of Rights
- promote the Code through education
- protect Consumers
- publish reports
- prompt, low level resolution
- receive and investigate complaints
- prepare guidelines for advocacy service
- advise the minister on consumer rights

Where there was an allegation of breach of the Code, there were to be five possible levels to try to resolve the issues. Briefly these were:

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**Level One:** Consumers were to act for themselves to get resolution by talking with the health professional and/or by requesting an apology and a change to the offending practice.

**Level Two:** Consumers would access independent advocacy, concerns would be documented and there would be a formal written complaint. The expectation was that the majority of complaints would be resolved between the parties.

**Level Three:** If there was no resolution, the matter would be referred to the Commissioner who would institute an independent investigation and determine if there had been a breach of the proposed Code.

**Level Four:** The Commissioner could recommend dispute resolution or a mediation conference to enable parties to meet in a supported environment and try to mediate the issues and a solution.

**Level Five:** If this was not possible or the issues were serious then the Commissioner could refer the matter to the Proceedings Commissioner who could determine if charges should be laid before the disciplinary bodies or the Complaints Review Tribunal ("CRT"). CRT remedies ranged from the issue of a simple apology to an award of financial compensation.  

Much of the debate during this reading recounted reasons for the long delays in the passage of the Bill, but Parliament also focussed on the need to redress the power imbalance between patients and health practitioners. Overall bipartisan differences were minor and there was a general recognition that although it had taken far too long to enact the Bill, it represented a major step forward for patient’s rights. Many of the speakers recalled the reason why the legislation was so critically needed. The comment by the Leanne Dalziel is typical:

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65 The description of these levels comes from a distillation of various sources but the five levels were specifically discussed by M.P. Roger Sowry, *New Zealand Parliamentary Debates*, 543 (27 September 1994): 3738.
This Bill is an indictment on those people who thought they had an absolute right to conduct an experiment on women without telling them about it, without asking their permission and without their knowledge in any sense of the word. Indeed it is an indictment on any people who think they can use knowledge and power and ignore the human rights of those who must rely on their knowledge and power.  

One Minister Diane Yates, was concerned about the general vulnerability of people in the medical system and that people could no longer talk to their elected representatives on Area Health Boards. Ms Yates echoing the earlier concern of Helen Clark, stated that the fundamental requirement of the legislation was that aggrieved consumers needed someone to appeal to and who would help practitioners to be accountable.  

During this reading the name of the Bill was changed to the Health and Disability Commissioner Bill to reflect the widened jurisdiction of the Commissioner to include investigating and receiving complaints from persons with disabilities. The Bill was then read a second time.  

Third Reading- 13 October 1994  

The Bill received its third reading on 13 October 1994, along with a raft of other professional Bills including the Medical Practitioner's Bill. The much-debated informed consent provisions had been retained, due largely to the lobbying of consumers representatives such as Sandra Coney, Phillida Bunkle and Judi Strid, of Womens' Health Action. There was support across party lines for the Bill, although there was no contribution to the debate from the Alliance party. Remaining concerns included the lack of a national advocacy service and the omission of any reference to the principles of the Treaty of Waitangi and ethics committees, in the legislation.

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During this final debate, tributes were paid to the numerous women 'treated' at National Women's Hospital, the consumer groups and activists involved throughout, the various staff and members of parliament who progressed the Bill and the seminal work of Judge Cartwright in calling for the establishment of an independent advocate for health consumers.

Parliament also had concern for the person who would take on the role of New Zealand's first Health and Disability Commissioner. Bill English stated:

We had to keep in mind that whatever we wish the Health and Disability Commissioner to be...it is such a complex area that the processes of the legislation must be robust. Because the matters the Commissioner will be dealing with on occasions, will be very serious. The checks and balances in there and the different roles that have been defined for the various statutory officers are very important because there will come a time when they will come under great pressure. The Officers who have these jobs will need the protection that Parliament would certainly want them to have when carrying out what will, at times, be a very difficult job.68

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CHAPTER FOUR - THE FIRST HEALTH & DISABILITY COMMISSIONER OF NEW ZEALAND

The first New Zealand Health and Disability Commissioner ("HDC") Mrs Robyn Stent, was appointed in 1994. Her first major task, was to prepare a *Code of Health and Disability Services Consumers' Rights*, ("the Code"). Although some New Zealand hospitals such as National Women's Hospital had adopted voluntary, written statements of patients rights, these rights were not substantive and did not have the weight of law. In practice such statements were often ignored by clinicians as there was no compliance monitoring of their use and no sanction should they be breached. The Commissioner embarked on extensive national and international consultation and research in order to first prepare a draft Code. Once this was written, submissions were called for and further consultation occurred before the Code was formally adopted into law. The Code is a highlight of the first Commissioner's term and continues to be a useful and effective statement of Rights.

The Commissioner then began to establish a team and develop procedures for the processing of complaints. This required the employment and training of further staff, contracting and maintaining an advocacy network, establishing mediation services, formulating documentation and data systems, and setting up investigation teams. Additionally during this period the Commissioner was in considerable demand as a speaker, particularly for health professional groups who were trying to grasp their new responsibilities under the HDCA.

**The Health and Disability Commencement Order - 1996**

*The Health and Disability Commencement Order* was made on 29 April 1996 and the schedule that contains the Code came into force on 1 July 1996. The legislation is unique because it codified patients', (now referred to as consumers) rights, and it covered

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69 The Code was contained in the Schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (made in exercise of a power conferred by s74(1) of the HDC Act 1994.)
all health professionals and additionally anyone providing a health care or disability service.

The Code lists the rights of consumers and concomitant duties of providers. The headings for each of the ten Rights are as follows:

- Right to be treated with respect
- Right to freedom, coercion, harassment, and exploitation
- Right to dignity and independence
- Right to services of an appropriate standard
- Right to effective communication
- Right to be fully informed
- Right to make an informed choice and give informed choice
- Right to support
- Right in respect of teaching or research
- Right to complain

The Years 1996-1998

For first 18 months as Health and Disability Commissioner Mrs Stent and her staff were almost fully occupied in the formulation of the Code and the establishment of the Office. In the February 1998 issue of the journal “New Zealand GP” Mrs Stent reflected on her first year as Commissioner. Even at that stage, the Commissioner was aware of the political and media pressure exerted in health issues and wrote that she was concerned about the “use of health as political ammunition”. Mrs Stent felt that these tactics were not good for consumers and she called for an objective multi-political party Health and Disability Accord to “reduce the endless source of emotionally charged and often frightening medical stories”. In this article the Commissioner responded to politicians who had criticized the


Office for not delivering expected outcomes and for its failure to prosecute health professionals more vigorously. She had also come under pressure from the media who assumed that she would discuss individual complaints and she firmly stated that her office was impartial and did not function as a regular source of stories for the media. Ms Stent stated:

This [impartial manner akin to the model of the Ombudsman] is partly out of a need to effect fair, simple, speedy and efficient resolution of complaints, which is best achieved out of the media limelight. Additionally section 67 of the Act prevents the Commissioner from making any statement that is adverse to any person unless that person has had a chance to provide a written response to the criticism.

This statement was very reassuring to the health professionals involved in complaints and is akin to the protection provided in the Coroners Act 1988.

During its first year, the Office received 1000 complaints involving 1451 providers. The Commissioner closed a little over half of these complaints, 581 to be precise. Of those, 25 resulted in a finding of breach of the Code. Two of the breaches (one by a dentist and one by a podiatrist) were referred to the Director of Proceedings for further action. The Director was an independent statutory officer, who would assess any findings of breach of the Code and determine whether the matter should be taken further. The options open to the Director, who would take on the role of prosecutor on behalf of the aggrieved consumer, were to lay a charge before the professional disciplinary body of errant practitioner and/or to seek damages from the Complaints Review Tribunal[as it was then].

Mrs Stent reported that in the ensuing months there had been seven further breach findings, three involving general medical practitioners, and that of the 1000 complaints, 42 had been resolved by the parties, 53 had been withdrawn, a further 27, approximately 5%
were resolved with the assistance of advocates. Five mediations took place resulting in binding confidential agreements. 153 complaints were carried forward from the 1996/7 year.⁷⁴

1997 – 1998

In the years 1997-1998 a priority for the Commissioner’s office continued to be consumer and health professional education. Additionally the Commissioner had the task of refining processes so that complaints could be dealt with in a manner that fulfilled the statutory mandate of a “fair, simple, speedy and efficient resolution of complaints for both parties”. In this second year the Commissioner reported closing 743 complaints but the number of unresolved complaints was escalating and by 30 June 1998, 778 complaints remained open. Of the complaints that had been closed, 92 had not been considered as they were outside the Commissioner’s jurisdiction, 181 had been resolved, 96 had been referred (it is uncertain from the Report to where the referrals were made) and 39 were withdrawn. No action was taken in 131 cases and no breach found in 136. 68 of the 743 complaints resulted in a finding of breach of the Code and of those 68, proceedings were being considered by the Director of Proceedings in 14 cases.⁷⁵

The statistics reflect the growing use (an almost five fold increase) of advocacy as a means of resolving complaints. This was in line with the Vennell recommendations and the Parliamentary intent that prompt resolution or mediation be utilized at the lowest appropriate level, close to the source of the complaint. Despite this trend and the apparent effectiveness of advocacy the Commissioner was reconsidering the Office’s priorities. In the Annual Report for the period concluding on 30 June 1998, Mrs Stent stated that advocacy spending, which


had represented 43 per cent of the total budget, was to be cut so as to permit greater focus on other areas; one of which would be the appointment of a full time Director of Proceedings.\(^7^6\)

The growing numbers of both new and “historical” open files and the delays in achieving closure, were becoming a concern for consumers and providers. The Commissioner attributed the backlog to the growing complexity of complaints, the legal challenges of providers, and investigations by the Privacy Commissioner and Ombudsman into the HDC Office.\(^7^7\) What the Commissioner did not mention was the effect of a major diversion of the personnel and financial resources of the Office into an extensive investigation into Christchurch Public Hospital.\(^7^8\)

Canterbury Health Investigation

The Commissioner’s enquiry into issues at Christchurch Public Hospital, arose after senior doctors at Canterbury Health became concerned about a number of deaths which in their view were preventable. The Christchurch Hospital’s Medical Staff Association (CHMSA) released a Report in December 1996 called “Systems Failures Threatening Patient Safety at Christchurch Hospital”.\(^7^9\) Most of the deaths mentioned in that Report had been notified to the Coroner but despite growing concerns and a *prima facie* public interest, an Inquest had not at that time been held.\(^8^0\) When the ‘Patients are Dying’ report was issued on 24 December 1996 it alleged serious issues about the quality of patient care in Christchurch Hospital. Not surprisingly there was a flurry of media coverage and a great deal of public interest in the allegations.

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\(^7^6\) A full-time Director had not been appointed prior to this, due to budgetary constraints and possibly an insufficient workload. A barrister was acting in that position for ten hours a week.


\(^7^8\) Stent (1998 Annual Report): 41, states that the costs of that investigation was $1.51m and this funding was pruned from other areas of the Office’s work. See also McLoughlin, David. “Face to Face—Robyn Stent”, *North & South*, (February 2000): 99 where Mrs Stent said she had three senior people, (at a time when staffing levels were not high and staff were still relatively inexperienced) in Christchurch for 6–7 months and she herself frequently went down to Christchurch.

\(^7^9\) The Report is sometimes referred to as the “Patients are Dying” Report

\(^8^0\) The Coroner later stated that relevant information in some cases was omitted and that had such information been available, this may have impacted upon his decision whether to hold an Inquest. See McElrea, Richard. “Hospital Deaths in New Zealand – A Coroner’s Perspective,” *Australian Coroner’s Society Conference*, (Brisbane, 2000): 8.
The Minister of Health, Bill English announced on 1 February 1997 that a Commission of Enquiry would be established to consider these deaths. The Health and Disability Commissioner had been on leave. After reputedly reading the media reports she announced on 3 February that she also would be setting up an Enquiry into events at Canterbury Health to determine whether the Code had been breached. The Commissioner's decision to undertake an inquiry independent of the Crown, was initially heavily criticized as it was seen by some as an unnecessary duplication and waste of resources. A judicial review of the Commissioner's decision was lodged by Professor Nicholls, a representative of the Christchurch Hospital's Medical Staff Association, and Mrs Brown, a widow of one of the deceased patients.

This was the first major legal challenge to the Commissioner's jurisdiction. The application for judicial review was brought, largely on the premise that the Commissioner's decision to proceed with her own Inquiry was unlawful, as many of the events in question had occurred before 1 July 1996, the date upon which the Code came into force. Further grounds of the Review were that the Commissioner's investigations would be very limited as she could only consider alleged breaches of the Code, and that the decision of the Coroner, and the management practices and decisions that may have contributed to the outcomes, would be outside her jurisdiction. The plaintiffs were also concerned that a second investigation would be costly and would unnecessarily disrupt the Commission of Enquiry established by the Minister of Health.

Mrs Stent had relied on section 35 of the Act to justify her decision to commence an


82 A reading of the Parliamentary debates accompanying the Third Reading of the HDCA shows that parliament did not intend the Commissioner to be fettered in investigating particular areas of concern. The Hon. Katherine O'Regan flagged the possibility of such inquiries when she stated "Perhaps in the future the Commissioner may wish to instigate a wider inquiry into why complaints are coming from one particular area [or service] and he or she may be able to investigate." The New Zealand Parliamentary Debates, 543 (13 October 1994): 4299.

investigation on her own initiative, into two of the deaths at the hospital and the ‘generic systems errors’ which had occurred. When her decision became the subject of a judicial review, the legal focus for the proceedings became the interpretation of this section. It reads:

35. Investigation of breaches of Code –

(1) It shall be a function of the Commissioner to investigate any action of any health care provider or any disability services provider where that action is, or appears to the Commissioner to be, in breach of the Code.

(2) The Commissioner may commence an investigation under subsection (1) of this section either on complaint made to the Commissioner or on the Commissioner’s own initiative.

The plaintiffs lodging the judicial review claimed that “own initiative” investigations of a Commissioner were limited by law to investigating any action of a health provider which breaches or appears to breach the specific rights of an individual consumer and could not be extended to generic systems errors. They alleged that the Commissioner acted for an improper or collateral purpose in her desire to hold an inquiry and that she intended to preempt the ministerial inquiry and thus stake a prior claim to the proposed area of investigation. They considered that her decision was simply an attempt by the Commissioner to “keep the minister off her turf”. Tipping J could not find on the evidence that this was the case and in his judgment stated that “the fact that [the Commissioner’s] decision had this effect does not establish that this was the Commissioner’s intention and motivation in making her own decision”. 84 He felt the Commissioner could not be criticized for deciding to exercise the powers of inquiry which Parliament had so recently given her. He wrote:

To the extent that circumstances or events have occurred before 1 July 1996 are relevant to whether there has been a breach of the Code they may be

considered, although not in themselves amounting to any such Breach. It is for the Commissioner to determine whether such earlier events or circumstances have the necessary relevance.\textsuperscript{85}

Tipping J ruled held that the Commissioner could also consider generic systems errors and incidents occurring before this date.\textsuperscript{86} He stated that provided the issues the Commissioner intends to investigate are fairly capable of being conceptually linked to an apparent breach of the Code, there could be no suggestion that the Commissioner was acting outside her powers.\textsuperscript{87} He concluded that not only was the Commissioner entitled to investigate any action which appeared to be in breach of the Code, but that the Commissioner may in fact be required by the Health and Disability Commissioners Act 1994 to undertake such an investigation.

The Nicholls decision was welcomed by the Commissioner and since that time it has opened the way for a number of significant HDCA Enquiries.\textsuperscript{88} A remaining difficulty for subsequent Commissioners is that these continue to be funded out of the wider budget. Given the expensive and resource-consuming nature of these Enquiries, this is unsatisfactory. It would be more logical and more cost effective, particularly when considering the growing expertise of the Office, for the Commissioner to conduct all health related Inquiries and for these to be separately funded by government.

After the Nicholls decision, it was inevitable that Mrs Stent, having achieved recognition of her entitlement to undertake the Canterbury Health Enquiry, would make this

\textsuperscript{85} Ibid : 37.

\textsuperscript{86} Judge Tipping recognized that the statutory framework left open the possibility of concurrent HDC and Ministerial inquiries but he put aside the issue as to whether it was reasonable for both to occur. \textit{Nicholls v. Health and Disability Commissioner} [1997] NZAR, 351: 364.

\textsuperscript{87} Ibid: 361.

\textsuperscript{88} There are a number of reports from such Inquiries but two of the most comprehensive are “Gisborne Hospital 1999-2000” \textit{A Report by the Health and Disability Commissioner},[Ron Paterson], Auckland, (March 2001) and “Southland District Health Board Mental Health Services Report” \textit{A Report by the Health and Disability Commissioner}, Auckland, (October 2002).
investigation a priority in the Office’s work. The problem was that the numbers of staff were few, the number of complaints were escalating and the investigations were already backlogged. The Canterbury Health investigation took fifteen\textsuperscript{89} months to complete. Although the core work of the Commissioner was not suspended, in the view of involved parties, it certainly slowed to a crawl.

The Commissioner’s comprehensive 300 page report on Canterbury Health Ltd\textsuperscript{90} was released a week after the report of the Ministerial Enquiry. While the Minister of Health, Mr English reported being reassured by improvements that had been made at the Christchurch Hospital Emergency Department, Mrs Stent’s report identified a “\textit{litany of failures}”. The Commissioner’s investigation uncovered four breaches of the Code and management was implicated at almost every level within the institution in these breaches. Her criticisms extended to the Minister of Health, the Crown Health Authority, the Regional Health Authority, the Crown Company Monitoring Advisory Unit and continued down to individual providers. The Commissioner made 112 recommendations to improve the care provided at Christchurch Hospital.

Although the growing back log of cases and the long delays were a concern to all involved in the HDC processes, another more serious concern was developing: apparent breaches of natural justice, at least in midwifery cases. The next section will consider the relationship between the Commissioner and the profession of midwifery and begin to analyse some of the midwifery cases. It will commence a discussion of the principles of natural justice and why they are important for any person undergoing investigation. These basic principles will be considered along with the processes of the Commissioner as set out in the statute or developed “in house”. It is then proposed to follow the progress of cases through the processes outlined in the Health and Disability Commissioner Act or adopted by the Office, and to consider whether, at each point, fair procedure was followed. The thesis will only consider the experience of one professional group, subject to the complaints process, namely the profession of midwifery.

\textsuperscript{89} The literature sometimes states 18 months.

CHAPTER FIVE– THE RESPONSE OF THE MIDWIFERY PROFESSION TO THE HEALTH AND DISABILITY COMMISSIONER

The early midwifery decisions are useful in identifying concerns about the way the protective mechanisms in the Health and Disability Commissioner Act were being implemented and interpreted. Before considering some of these in detail, it may be helpful to briefly background the reaction of the profession of midwifery to the establishment of the Office of the Health and Disability Commissioner.

The Midwifery Experience 1993 – 1999

The profession of midwifery had been supportive of the establishment of a patient advocacy service, even before the Health Commissioner was first mooted during the Cartwright Enquiry. As a profession New Zealand midwives had become subsumed within nursing to the point where they had lost their unique professional identity. They could identify with the powerlessness of women generally, in health institutions and clinics. Throughout the 1980’s there was a proliferation of consumer groups such as Parent’s Centre, Women’s Health Action, the Home Birth Association, and the La Leche League, all of which were lobbying for choice in childbirth. An offshoot of this concerted political action was that these groups supported domiciliary midwives because women wanted to regain and retain some control over how and where they birthed. Growing numbers of women saw strong and autonomous midwives who would care for them in hospital or at home, as essential to achieving those aims. The relationship was symbiotic, and consumers and midwives worked hard to reestablish midwives as different from nurses and as practitioners who were capable of managing all aspects of normal birthing. It was this partnership of consumers and midwives that enabled midwives to embrace the philosophy of informed choice and the empowerment of women’s rights in all areas of life. The establishment of a Health and Disability Commissioner (“HDC”) was therefore welcomed by the majority of midwives as a hard won legislative recognition and confirmation of the right of women to have choice and competence in health care.
The New Zealand College of Midwives ("NZCOM") was established in 1989, a year after the Cartwright report was released. It is a somewhat unique professional body as its members consist of midwives and consumers and both groups are an essential and integral part of the College at all levels. NZCOM produced a voluntary professional Code of Ethics and established the Midwifery Standards for Practice both of which were published in 1993. The first drafts of the Health Commissioner Bill had placed a heavy emphasis on low level resolution and mediation and flagged a requirement that the professions would need to establish resolution mechanisms. These mechanisms were to be a means whereby consumers and professionals could meet in a supportive environment to try to resolve problems, enable apologies to be made, and to identify where practices needed to be changed or improved. NZCOM could see the benefit of such early resolution and mediation in the area of birth care and so, instead of waiting until the Bill was passed, NZCOM responded to the intent of the Bill and embarked on the establishment of Regional Complaints Resolutions Committees. Each Committee was to consist of a nominated midwifery and consumer representative who could receive complaints from dissatisfied consumers and, if required, facilitate a meeting between the complainant and midwife. The process, which was only initiated if requested by the complainant, was voluntary. If the complainant remained unhappy or dissatisfied with the outcome of the various responses or meetings, she still had the option of taking her complaint to the Nursing Council.\(^{91}\)

The enactment of the HDCA and the formulation of the Code gave consumers a right to make complaints about providers. Consumers quickly realized that traditional barriers to complaining had been removed. There was no longer a requirement that complaints be written in a particular form or that they be substantiated by others. Complainants did not

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\(^{91}\) When the Resolutions Committees were first established, the HDCA had not been enacted and the Nursing Council of New Zealand was the only body receiving complaints about the practice of nurses and midwives. When the HDCA was eventually enacted, considerable changes had been made to the earlier Bills. There was no longer a requirement for professions to maintain low level resolution mechanisms such as the Resolutions Committees, although NZCOM continued offering these to women. Although initially supportive of the Resolutions Committees, the first Commissioner did not utilize the Committees, preferring instead for matters to remain within the HDC processes.
need to incur the costs of legal assistance and there was now a free, readily accessible person to whom they could complain. Anyone could simply pick up the phone, “toll free”, and lodge a complaint. Complainants did not even need to be present when the care complained of was given or when the alleged incident occurred. With such ease of access to the Commissioner, it was inevitable that numbers of complaints would escalate once the role and function of the HDC Office became more widely known. Another less acknowledged reason for the rapid increase in the number of complaints, was that health professionals were fulfilling their responsibilities under the Code by informing consumers that they had the right to complain if they were dissatisfied with their care.

This was a requirement that midwives took particularly seriously. When the HDCA was first enacted, extensive programmes, study days and seminars were offered throughout the country, to educate midwives about their responsibilities under the Code of Rights. NZCOM also helped educate women about their rights under the new Code, including the right to complain if they were unhappy with the care that they had received. This right became a professional expectation and a part of the annual audit of midwifery care in the following way. As a re-emerging profession, midwives were very aware of the allegations that had been levelled, mainly at the medical profession, that health professionals were incapable of transparent self-regulation. To counter any future similar criticism of the profession of midwifery, NZCOM instituted a system of voluntary peer-review. Such review was seen as a means of educating midwives about practice, and identifying the practitioners who needed to upskill or improve their service delivery, with an ultimate aim of improving the overall level of care provided by midwives. The profession recognized that for such reviews to be successful for midwives, and also beneficial to women, they needed to be educative and practical. In the words of McIntyre and Popper:

92 Access for complainants was improved when the Office set up a toll-free 0800 number to assist complainants. It was marketed as 0800COMPLAIN.

[Peer review] must be linked to the improvement of all [practitioners] and not just to the punishment of those who err, as only with such an ethos can we establish a new type of confidence: that mutual criticism is not personal and pejorative but that it springs from a mutual respect and desire to improve the lot of patients.\textsuperscript{94}

The review mechanism developed was the annual Midwifery Standards Review ("MSC"). In line with its partnership philosophy, each Review Committee incorporated both midwifery and consumer members.\textsuperscript{95} One of the key areas of Review was whether midwives provided women with information about the Code of Rights and if this was not provided, the midwife was reminded that giving such information was a legal as well as a professional obligation. These educative attempts were very successful and in both the 1997 and 1998 Annual Report of the Health and Disability Commissioner, midwives had the highest awareness of the Code among all health professionals.\textsuperscript{96}

In the first year to eighteen months of her term, the Commissioner had minimal involvement with the profession of midwifery. NZCOM was not given any feedback about the numbers of complaints involving midwife members and readily accessible data on


\textsuperscript{95} To undergo a MSR a midwife would pay a fee and voluntarily submit her statistics and outcomes for evaluation by a Review Committee. Each midwife was required to send her client an evaluation form at the end of the episode of care and the women were able to complete this form and send it back, anonymously if they wished, and those forms would form part of the annual MSR. The midwife gained feedback on the strengths and weaknesses of her practice, whether she was meeting the Standards of Practice, and areas were identified where she needed to improve or up-skill. Most importantly the women she cared for had an opportunity to give critical feedback on how they had found the midwife's care.

midwifery complaints only started becoming available when the Commissioner’s web-site was established. Ten of the midwifery case notes were placed on the web-site for 1997.\textsuperscript{97} It was while assisting many of these midwives that I became concerned about procedural problems with the processes being put in place. It seemed that the principles of natural justice were not well understood by those implementing the HDCA. Others shared my view and initially those acting for health professionals were prepared to view the procedural shortcomings as teething problems. Hence for a time there was tolerance, and a hope that once the Office was fully operational and better resourced (in terms of staff and experienced legal advisors), these issues would be identified and sorted out. Unfortunately this was not to occur. While some processes became more defined, there were some cases, where the investigation and decision making procedures were simply not fair.

\textsuperscript{97} Not all these midwifery cases refer to midwives that I represented. The lawyers employed by the New Zealand Nurse’s Organisation acted for some midwives and others were not represented.
CHAPTER SIX – PROCEDURAL FAIRNESS OR THE PRINCIPLE OF NATURAL JUSTICE

Jeremy Bentham (1748 – 1832) considered that fair procedures are essential to accurate outcomes. Professor D.J. Galligan, a Professor of Law at the University of Oxford, summarizes Bentham’s theory as saying that procedures are there to produce accurate outcomes or ‘rectitude’ and that such outcomes are valuable as they uphold social values and produce stability. Procedures and outcomes are thus inexorably linked.

The Health and Disability Commissioner Act 1994 (“HDCA”) outlines the statutory procedures that the Commissioner is obliged to follow and it also grants the Commissioner wide discretion. This discretion relates to the areas of evidence, investigation, disclosure, and publication. Any discretion in the hands of an official must be carefully exercised as its application can be utilized for inappropriate objects such as political point-scoring, publicity or personal expediency. It is therefore critical that where a discretionary power can be exercised, the decision maker is bound by some legal or normative standards against which they can justify their decision and thus validate their actions. Commitment to these standards should also be demonstrable in the way the procedures and processes established within the statutory framework, are applied.

The set of standards that this thesis will consider in analyzing the procedures of the Office of the Health and Disability Commissioner are loosely termed the ‘principles of natural justice.’ These principles have been well established in law. Although they may be

98 Megarry VC used the term ‘fairness’ stating that “justice” is far from being a natural concept as the closer one goes to a state of nature the less justice does one find. McInnes v Onslow-Fane [1978] 1 WLR 1520: 1530. In Forbes, JRS. Disciplinary Tribunals. (Sydney: The Law Book Company, 1990): 60

described in slightly different terms, the basic concepts are constantly adopted and reinforced in the courts. Before commencing an analysis of the HDCA procedures, it will be helpful to consider some formulations of the principles of natural justice and, after that consideration, determine whether these principles relate to the Office of the Health and Disability Commissioner.

Natural justice has been described in many and various ways but is frequently summarized as "fair play in action"\(^{100}\) or "but fairness writ large and judicially"\(^{101}\). The principles have ethical as well as judicial implications. Professor Galligan reminds readers:

> If justice is the first virtue of law and politics, then procedural justice is an essential element in its attainment. For no matter how good and how just the laws and the political principles supporting them may be, without suitable procedures they would fail in their purposes.\(^{102}\)

He continues that once we are concerned about how people are treated, we are concerned with questions of fairness, both substantive and procedural.\(^{103}\)

When the Health and Disability Commissioner was appointed, she was to provide a voice and avenue of redress for consumers who were unhappy about the health and disability services that they had received. The ultimate aim of the HDCA was to enable a fair, simple, speedy, and efficient resolution of complaints for providers and consumers so that neither

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\(^{101}\) Ridge v. Baldwin [1963] 1 Q.B. 539: 578 per Harman LJ.


\(^{103}\) Galligan D.J. (1996): 32.
party was subjected to an extended and emotionally distressing complaints process. The Commissioner was to adjudicate and settle disputes about the quality of care provided by ruling whether the Code of Rights had been breached. A subsidiary goal was that people would learn from the complaints. Health practitioners would learn what standard of practice was required of them in order to provide a reasonable service and thus avoid complaints. Consumers would learn what standard of care they were entitled to expect. As a result it was hoped that the overall quality of health care in New Zealand might be improved.

In most areas of adjudication, well-established procedures are already in place to enable rational and effective decision making. When a novel jurisdiction is established, particularly a jurisdiction that relies on delegated authority, there is a need to design new procedures to achieve the statutory ends. When the Office of the Commissioner was set up, it did not have the benefit of precedent. It had no established body of case law and no criteria upon which base its standards. The procedures of the Office were originally very unclear and appeared to develop only as parties with conflicting interests and values participated in the investigations and, through their experience, became able to identify shortcomings.

**Developing Fair Procedures**

The concern that people whose rights may be affected by a decision should be treated fairly is inherent in the principles of natural justice. It will be argued that this is a fundamental requirement for any person exercising a statutory power. However before this is argued, it is important to consider what these principles actually entail. In the English case *Byrne v. Kinematograph Renter’s Society*, Harman J stated:

> First I think that the person accused should know the nature of the accusation made; secondly, that he should be given an opportunity to state his case; and thirdly of course, that the tribunal should act in good faith [freedom from
bias, arbitrariness, irrationality and unreasonableness]. 104

The primary limb of the principle of natural justice, or (as it is sometimes known) the concept of procedural fairness, is this right to know and be heard about the case against one. 105 It can be summarized as follows:

Firstly there is a right to be heard and to be given an opportunity to show why adverse action should not be taken. This rule is sometimes referred to as audi alteram partem or hear the other side. 106

Another useful formulation of the rule can be found in the case of McCarthy v. Grant, where Gresson J. stated that:

The rule is that no one is to be condemned, punished or deprived of his property in any judicial proceedings unless he has had an opportunity of being heard—audi alteram partem—is an ancient principle of the common law and anything done contrary to that principle is contrary to natural justice. It is a rule of universal application based on the plainest principles of justice. 107

D. E. Paterson, a New Zealand legal scholar who specialized in Administrative Law, considered that the particular circumstances of each individual case will determine what

104 Byrne v. Kinematograph Renter's Society [1958] 2 All ER 579: 599 per Harman J.

105 Various texts state other limbs such as; that a man must not be judge in his own cause; no party must be condemned unheard; and that a party is entitled to know the reason for the decision. See Hewitt, D.J. Natural Justice. (Sydney: Butterworths, 1972): 9-10. This thesis will primarily consider the latter two limbs.


constitutes an adequate opportunity to be heard. Several basic principles can be extrapolated from his writings and the first of these is that the person affected cannot be heard unless given reasonable notice that action is to be taken. Paterson writes:

\[
\text{[T]he official should indicate with reasonable clarity not only the time and place at which he intends to consider taking action, but also what action it is that he is contemplating taking so that the person concerned can know to what extent and in what manner he should make representations with regard to the action.}
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Notice should always be given to the person who is likely to be affected by the actions of any decision maker, able to affect that person’s rights and freedoms, of the case or allegations against them. Such notice should be timely, in order to give that person an adequate opportunity to mount a reply or defense. The nature of the notice also requires the official to make reasonable disclosure of the material that she or he is taking into account in determining what action will be taken, so that the affected person can respond or make representations. Normally this disclosure of relevant material would precede the right to make representations, but if it does not then it should occur before the official takes any action.

Adequate disclosure as a critical component of natural justice was also considered in the English case of \textit{R v Architects’ Registration Tribunal, Ex parte Jaggar} \(^{11}\) This was an


\(^{109}\) Ibid: 129

\(^{110}\) Paterson D.E. (1967: 132, 139)

appeal against a decision of the ‘quasi-judicial’ Architects’ Registration Tribunal. Mr
Jaggar’s original application for registration was made to the Architects’ Admissions
Committee. When this Committee declined to recommend registration, Mr Jaggar appealed
to the Architects’ Registration Tribunal. The Tribunal was entitled to make its own
regulations and establish its own procedures. During the Appeal this Tribunal considered
letters about Mr Jaggar, but not only was he ignorant of their contents, he was completely
unaware that such letters even existed. The Tribunal dismissed his Appeal and Mr Jaggar
successfully sought an order of certiorari to quash the decision of the Tribunal. One of his
grounds related to issues of natural justice, namely the adequacy of disclosure and notice of
evidence. In finding for Mr Jaggar, Lewis J. stated:

_The Tribunal had before them, and used, documents which should have been
disclosed, or documents which the applicant was entitled to see if they were
going to be used by the Tribunal...[The Tribunal] did not do what the [legal] authorities say they should have done, which was to give a real and effective
opportunity to the litigant to deal with or meet, any relevant allegations made
in these documents._112

Lewis J. continued:

_When [disclosure] is not done, as it was not in this case, and the Tribunal
have before it correspondence of this nature which is not disclosed, and the
Tribunal look at that correspondence, and base what they call relevant
questions upon that correspondence, it seems to me, ...that that it is not doing
what this Tribunal in its position should have done, namely that, if they looked
at the letters at all, to inform the litigant what they contained and the source
from which they came._113

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112 Ibid: 139
113 Ibid.
This decision illustrates the requirement that decision-making bodies must disclose any relevant evidence that it is intending to rely upon when coming to a decision. An Australian case considering the adequacy of disclosure of key documents was *Macksville & District Hospital v. Mayze*.\(^{114}\) This was an appeal by a visiting obstetrician against termination of his appointment by the hospital board. The hospital had been concerned at the doctor's 40.6 per cent incidence of third degree perineal tears (for which he charged a higher fee to repair) in women undergoing childbirth. Experts put the usual incidence of such tears as 2-5 per cent. The doctor alleged breaches of natural justice in the way the investigation and termination of his access to the hospital was carried out. He lodged an appeal that came before the Equity Division of the New South Wales Court of Appeal. Of note for our purposes was the finding that a series of 'serious procedural defects' in the Board's procedures were found. These included:

- the doctor did not hear evidence of key witnesses including his partners.
- he was not provided with a copy of an adverse expert report until very late in the proceedings.
- he was not given an opportunity to cross examine the expert on the views expressed, nor to answer his views.
- he was not permitted to be present during the testimony of key witnesses.

As will be shown, many similar shortcomings in disclosure of evidence and witness reports, were apparent in the early years of the office of the Commissioner.

While not finding that a medical practitioner was entitled to any higher standards of fairness than other persons in the community, the Court in *Macksville*, acknowledged that the interests of doctor at stake were substantial. Both through the "by-laws and the Common Law" there was a *prima facie* obligation that he be afforded natural justice and a "due hearing" neither of which he was found to have received.\(^{115}\) Kirby J. wrote

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\(^{114}\) *Macksville v District Hospital v Mayze*, (1987) 10 NSWLR 708.

\(^{115}\) Ibid: 713
I record these defective procedures to ensure compliance with the requirements which natural justice dictated, ultimately by the obligation to conduct such proceedings fairly and in such a way that the manifest fairness of what occurs is demonstrable not only to the person accused but to reasonable observers among the public.\textsuperscript{116}

One of the first cases to consider the application of natural justice to non-judicial or quasi-judicial bodies who exercise monopolistic powers and whose "decisions may ruin a man by their recommendations" was Byrne v. Kinematograph Renter's Society.\textsuperscript{117} Harman J. held that if such bodies set up an investigation committee about those over whom they claim to exercise jurisdiction, then that committee must give an assurance that the proceedings will be fair.\textsuperscript{118}

The extension of the principles of natural justice to quasi-official bodies and officials was also accepted in New Zealand law. In Re: Erebus Royal Commission (No 2)\textsuperscript{119} the New Zealand Court of Appeal, while recognizing there is no right of appeal against reports of Commissions of Enquiry, stated regarding such reports:\textsuperscript{120}

Nevertheles they may greatly influence public and government opinion and have a devastating effect on personal reputations and in our judgment these are the major reasons why in appropriate proceedings the courts must be

\begin{itemize}
\item \textsuperscript{116} Ibid.
\item \textsuperscript{117} Byrne v. Kinematograph Renter's Society Ltd [1958]2 All ER 579.
\item \textsuperscript{118} Ibid: 598.
\item \textsuperscript{119} Re: Erebus Royal Commission (No 2) [1981] 1 NZLR 618: 653.
\item \textsuperscript{120} See Pearlberg v. Varty [1972] 1 WLR 534: 547 where Lord Pearson held that while a presumption of compliance with the principles of natural justice is not always required from those making administrative decisions, the Courts will, perhaps always, imply an obligation to act with fairness.
\end{itemize}
ready if necessary, in relation to Commissions of Inquiry just as to other public bodies and officials [my emphasis] to ensure that they keep within their lawful powers and comply with any applicable rules of natural justice.

The New Zealand case of Phipps v. Royal Australasian College of Surgeons demonstrated the willingness of the courts to require a professional college exercising a 'statutory power' act according to the principles of natural justice. The Royal Australasian College of Surgeons ("RAC") were asked to investigate the clinical practice of Dr Phipps and make a determination on his competency to practice surgery. The resultant report contained adverse findings. Dr Phipps objected to the report and sought to have it set aside on the basis of procedural unfairness and unreasonableness. The appeal was heard in the High Court. Chisholm J. found that Dr Phipps had inadequate access to the files of patients whose care was part of the review, and that he was not informed who was being interviewed. An additional shortcoming was that allegations about the complaints were not put to him during the investigation or interviews. Chisholm J. held that it has been accepted in principle that the requirements of fairness will, in appropriate circumstances, be imposed on private bodies exercising administrative discretion (as opposed to judicial or quasi-judicial discretion), if the interests of justice make it apparent that fairness is to required in the exercise of the particular administrative functions. He set aside the report. The RAC appealed.

In considering the Appeal, the Court of Appeal recognized that a negative competency report would have major significance for the subject doctor's reputation, employment and professional future. It also held that the competency report was "exactly the type of situation in which high standards of procedural fairness are expected." The RAC was required to follow a fair procedure, and in particular to make Dr Phipps aware of all

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121 Phipps v. Royal Australasian College of Surgeons [1997] 2 NZLR 598

122 Ibid: 608

significant issues that might have given rise to an adverse finding against him.\textsuperscript{124} It set out four factors required for reviewers to follow in order to ensure a fair procedure. These were that the party under review:

- be given an adequate opportunity to know the allegations made against him;
- know the evidence in support of those allegations;
- be able to bring evidence;
- be allowed to make submissions to counter the allegations and evidence.\textsuperscript{125}

Although the Court of Appeal confirmed that there had been significant procedural errors, it held that they did not taint the whole of the report. It made a declaration that parts of the report be set aside, but the remainder and the recommendations were allowed to stand. Dr Phipps appealed this decision to the Judicial Committee of the Privy Council which also confirmed that procedural errors had occurred, and set aside the recommendations, but the Appeal was otherwise dismissed.\textsuperscript{126}

The principles of natural justice impose a requirement that parties will be treated fairly and that adjudicators will act justly. The basis for this requirement is that such decisions can cause serious harm to the reputation and future prospects of parties and can severely affect their rights, and interests. In an earlier Privy Council decision \textit{Durayappah v. Fernando}\textsuperscript{127} the Judicial Committee considered the circumstances in which natural justice would be required of a decision maker. It held that this would depend on three things. These were the nature of the right affected by the decision, the width of the decision-maker's power, and the seriousness of the effects of the decision.\textsuperscript{128}

\textsuperscript{124} \textit{Royal Australasian College of Surgeons} v. Phipps \([1999] 3\) NZLR 1.
\textsuperscript{125} Ibid: 14
\textsuperscript{126} \textit{Phipps v Royal Australasian College of Surgeons} \([2000] 2\) NZLR 513
\textsuperscript{127} \textit{Durayappah v Fernando} \([1967] 2\) AC 337
This decision had led to a ‘threshold test’ that was developed further in the Australian case of *Kioa v. West*. This case involved the potential deportation of two Tongan citizens from Australia as prohibited immigrants. Mason J wrote:

*The law has now developed to a point where it may be accepted that there is a common law duty to act fairly, in the sense of according procedural fairness, in the making of administrative decisions which affect rights, interests and legitimate expectations, subject only to the clear manifestation of a contrary statutory intention.*

The Commonwealth cases outlined above show that protections accorded to parties are not confined only to those involved in criminal and civil proceedings, but are also implicit in administrative inquiries. The term ‘natural justice’ has become a principle confined by no frontier, one that expresses the critical and fundamental protections extended to any person who is subject to criminal, civil or disciplinary investigations. Decisions such as *Macksville* and *Phipps* have extended the requirement of natural justice to investigatory bodies which may or may not be involved in the ultimate decision. A denial of natural justice is now held to be an error of law.

**Natural Justice and the HDCA**

The *Health and Disability Commissioner Act* 1994, unlike sections 77-78 of the *New

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131 *R v. Ealing Magistrates Court Ex parte Fannerman.* [1996] 8 Admin. L.R. 351: 356 where Staughton LJ warned against the destruction of a dog without hearing the owner. He stated “Down that slippery slope lies the way to dictatorship.”

Zealand Public Health and Disability Act 2000, does not contain express natural justice provisions, although the preamble of the HDCA cites the aim of a 'fair' resolution of complaints. The Commissioner is however an adjudicator whose decision, statutory or discretionary, might have a 'devastating' effect on the professional reputation, employment and future of any person. Given that power, it is therefore possible to extrapolate from the above cases, that in the absence of a clear parliamentary exclusion, the Commissioner must adhere to the principles of natural justice and ensure that a practitioner is subject to a fair and just process. Aronson and Dyer suggest that a silence of the legislature on such a matter is likely to indicate a parliamentary intention that common law principles determine which procedures are appropriate. It is the argument of this thesis that the HDC is implicitly bound to observe the principles of natural justice in both the investigative and decision making stage of the complaints processes.

Apart from the common law, these principles can also be imported into the HDCA through the New Zealand Bill of Rights Act 1990 ("NZBORA"). Section 3 of that Act requires any person or body in the performance of any public function, power or duty conferred on, or imposed on that person by or pursuant to law, to give effect to certain rights and freedoms of citizens. The Health and Disability Commissioner is just such a person. Section 27 of the NZBORA reads:

27 Right to Justice – (1) Every person has the right to the observance of the principles of natural justice by any tribunal or other public authority which has the power to make a determination in respect of that person's rights,

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Aronson, M. & Dyer, Bruce. (2000): 310-314. See also Pearlberg v. Varty [1972] 1 WLR 534: 547 per Lord Pearson, who stated "A tribunal to whom judicial or quasi-judicial functions are entrusted is held to be required to apply those principles [i.e. the rules of natural justice] in performing those functions unless there is a provision to the contrary."
obligations, or interests protected or recognized by law.\textsuperscript{134}

Although these refer primarily to criminal rights and court proceedings cannot be equated to a disciplinary hearing, it has been held that these rights are a guide which should not be discounted when setting out minimal fair procedure in other jurisdictions. This was confirmed by the High Court of New Zealand in \textit{Staite}.\textsuperscript{135} This was a professional disciplinary case where Ellis J. considered the subject of disclosure. He wrote:

\textit{In addition to deriving assistance from the common law requirements for disclosure by the prosecution for criminal cases, it could be said that those same requirements are imported into the procedure of the [Psychologist’s] Council by virtue of the obligations to observe the rules of natural justice.}\textsuperscript{136}

While the HDCA process is a more informal process than either a criminal or professional disciplinary hearing, the eventual Final Opinion of the Commissioner can become the basis for professional misconduct charges and proceedings before the Human Rights Review Tribunal. The Final Opinion therefore has potentially far-reaching implications for a practitioner’s reputation and livelihood and so it is crucial that all processes adopted by the Commissioner are procedurally fair and robust.

\textsuperscript{134} There are also minimal criminal rights which can be briefly summarized from section 25 of NZBORA. These include the:
a) Right to a fair, public and impartial hearing
b) Right to be tried without undue delay
c) Right to be presumed innocent until proved guilty according to law
d) Right not to be compelled to be a witness or to confess guilt
e) Right to be present at a trial and to present a defense
f) Right to examine the witnesses for the prosecution and to obtain attendance and examination of witnesses for the defense under the same conditions as the prosecution
g) Right if convicted of an offense in respect of which the penalty has been varied between the commission of the offence and sentencing, to the benefit of the lesser penalty.

\textsuperscript{135} In \textit{Staite v. Psychologists Board} 11 PRNZ 4 Ellis J cited \textit{Duncan v. Medical Practitioners Disciplinary Committee} [1986] 1 NZLR 513 (CA) regarding the need for disciplinary bodies to disclose reports and for practitioner’s to be given an opportunity to comment on these.

\textsuperscript{136} \textit{Duncan} [1986]:548 per Cooke P. Also in \textit{Gurusinghe v. Medical Council of New Zealand} [1989] 1 NZLR 139: 155 the High Court held that disciplinary proceedings are sufficiently analogous to criminal proceedings to derive assistance from the criminal rules of procedure.
Under the HDCA the Commissioner is free to regulate his or her own procedure. This is common to many Tribunals, Councils and quasi-judicial bodies.\textsuperscript{137} While an Act may stipulate some general requirements such as forms of application, appeals and payment of officers. The development of the detailed rules and operational procedures are left largely to the discretion of the Commissioner.\textsuperscript{138} Although these should be sufficiently flexible to enable the tasks and objectives of the Office to be carried out, the most important consideration, is whether such processes and procedures are fair and are perceived as fair.\textsuperscript{139}

Having considered some of the fundamental aspects of the principles of natural justice, and accepting that both statute and common law require the Commissioner to adopt fair procedures, I will now consider whether such fairness was always evident in the management of some ‘midwifery’ cases. The following chapters track the usual process of a complaint from receipt by the Commissioner, through possible investigation, multi-stage decision making, to the Commissioner’s final opinion as to whether the Code has been breached, and any recommendations or further action that follows this decision. Each stage of the usual HDCA process will be reviewed to consider if the minimum standards of procedural fairness were extended to the midwife in these cases.


\textsuperscript{138} Orr, G.S. (1964: 70) Jackson, P. \textit{Natural Justice, (2\textsuperscript{nd} ed.)} London: Sweet and Maxwell, 1979: 84 discusses the well formulated requirement that justice must not only be done but be seen to be done. See also Galligan D.J. (1996): 73.
CHAPTER SEVEN: THE PROCESS OF AN HEALTH AND DISABILITY COMPLAINT

This chapter works through the procedures outlined in the Health and Disability Commissioner Act 1994 and discusses their application in midwifery cases. The comprehensive nature of the subsections of the Act, means that this chapter is necessarily quite extensive.

Section 59 of the HDCA enables the Commissioner to regulate his or her own procedures, to hear or obtain any information, and make such inquiries as the Commissioner sees fit. The Commissioner may request and receive any evidence from any person, apart from those subject to privilege. Such a wide discretion must be exercised with caution. Anyone who obstructs, hinders or resists the requests of the Commissioner commits an offence and is liable on summary conviction to a fine not exceeding $3000.

Reception of Complaints

Section 31 of the HDCA states that any person may make a complaint to an advocate or to the Commissioner alleging that an action of any health care provider or disability services provider is, or appears to be, in breach of the Code. The receiving of a complaint from ‘any person’ be they friends, family members or other health practitioners is an extremely broad catchment and it is not uncommon for complaints to be received from people who were not present at the time of the incident.

The Act allows a complaint to be oral or written, although advocates are available to help consumers clarify their complaint and reduce it to writing. The acceptance of oral complaints in the HDCA was novel, as traditionally most disciplinary bodies and other
Commissioners have required official complaints to be written down. The traditional purpose for requiring a written complaint was to succinctly set out the allegations and the grounds which a respondent must answer. This enables a clear identification and particularization of the issues for all concerned. From a legal perspective there are evidential risks associated with receiving oral complaints. One such risk is that any later rendition of the complaint to writing by another person, becomes a translation of what the hearer believes has been said. A further difficulty is that a complaint may come from a phone call to an office staff member and that person is hearing only one side of events and inevitably filters and summarizes the points they consider important. Even when such summaries are later reflected back to the original complainant, there is still a risk that key information will not be requested or will be missed or omitted. Another difficulty with oral complaints is that they enable a complaint to be made without the complainant taking a responsibility for actually setting down the primary areas of grievance. With oral complaints, those areas frequently shift over time. This can make it difficult for respondents to answer complaints.

The acceptance of oral complaints is, however, in keeping with both the recommendations of the “Cartwright Report” and consumer calls that barriers to making a complaint, such as language difficulties or illiteracy, should be removed. In a multi-cultural society such as New Zealand, where a growing number of our citizens have English as a second language or have literacy problems, the acceptance of oral complaints is one way of providing better access to investigation and possible redress for the less fortunate and most vulnerable in our society.

S 36 Action on receipt of complaint

Upon receipt of a complaint the Commissioner has several available options. She or he can investigate; screen the complaint out as trivial; refer it to an advocate for resolution (if not already attempted); or decide to take no action. The Commissioner is to inform the

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140 This thesis deals only with the processes set out in the HDCA 1994 and does not include any subsequent amendments.
complainant and health care provider "as soon as is practicable" about the complaint and which procedure the Commissioner proposes to adopt. There is a fundamental requirement in the HDCA that the Commissioner attempt mediation and resolution as a primary step. In part this was to achieve the statutory imperative of fair, simple, speedy and efficient resolution of complaints, envisaged by Parliament. Such resolution and reconciliation can provide early satisfaction to complainants, and almost immediate change of practice from providers. It also acts as a means of settling disputes, and of enabling closure for both complainants and respondents. Despite this resolution imperative very few midwifery complaints were referred for mediation or resolved during the term of the first Commissioner. This was not the case for other providers as the Commissioner recorded that 74 cases in 1997; 181 for 1998; and 195 in 1999 had been referred for resolution and mediation. 141

Section 35 Investigation of breaches of Code

If a complaint is first made to an advocate and the advocate cannot achieve resolution, the complaint is to be referred to the Commissioner to decide whether further action is required. The Commissioner may commence an investigation where the action is, or appears to be, in breach of the Code. The Commissioner can also undertake investigations on his or her own initiative. 142

No Action.

Section 37 of the Act enables the Commissioner to take no action or no further action in certain situations. These include where there was a considerable length of time since the

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141 Report of the Health and Disability Commissioner Te Toihau Hauora Hauatanga for the Year ended 30 June 1999, presented to the House of Representatives pursuant to section 16 of the Health and Disability Commissioner Act. On several occasions where midwives requested mediation, there was no response to their request.

142 This right was upheld in Nicholls v. Health and Disability Commissioner [1997] NZAR, 351:364.
incident, where the subject matter was trivial or the complaint frivolous, vexatious, or not made in good faith. Other factors to be taken into account were whether the complainant desired the action to be taken or continued, and whether alternative remedies were available. I am unaware of any midwifery cases under the first Commissioner that were screened out as trivial.

Investigation

Once the Commissioner rejects the option of mediation or resolution, the next step is to commence an investigation. Often there is a gap in time between the receipt of the complaint, the decision to investigate, and the notification to the provider. In some ways this is inevitable as there needs to be an opportunity for the Commissioner to determine whether there are grounds for further action. The only requirements are that the decision to investigate must be bona fide, made on reasonable grounds, and not be arbitrary or for some ulterior purpose.

On about five occasions of which I am aware, the Commissioner commenced an investigation regardless of whether or not the consumer who received the care, was supportive of the complaint. A concern for some midwives, was the pressure put on some complainants to lay a complaint, particularly in home birth situations. This pressure frequently came from other practitioners who opposed home birth. Midwives described women being told that they had to support the complaint or “other women could suffer” or “babies might die”. One midwife told me of a young woman who apologised to her and said that she felt she had no option but to join the complaint or she would be seen as a bad mother. Young women were particularly vulnerable to this type of pressure and yet frequently these reluctant complainants would become pregnant again while the investigation was continuing and ask the same midwife to provide care.
Proceedings of the Commissioner

Section 41 requires that before proceeding to investigate, the Commissioner inform both the complainant and provider to whom or to which the investigation relates, and any person alleged to be aggrieved (if not the complainant), of the Commissioner's intention to make the investigation. The Commissioner must also inform the provider of:

i) the details of the complaint (if any) or, as the case may be, the subject matter of the investigation; and

ii) the right of that person to submit to the Commissioner within a reasonable time, a written response in relation to the complaint or, as the case may be, the subject matter of the investigation.143

Once the decision is made to commence an investigation, the Commissioner must apply the principles of natural justice. At one time it was thought that preliminary decisions which could not affect rights, without some further action or decision being taken, would not attract a duty to observe natural justice. That approach has since been rejected.144 Galligan argues that while at first sight investigations and inquiries are just preliminary to some later decision, the view that there is slight need for procedural protection has little merit.145 He writes:

It is not hard to see that the very process of the inquiry affects interests and values, of which privacy and confidentiality are the most notable, while the ensuing report and recommendations might themselves have a detrimental effect upon the person under investigation, not least to reputation but also in other ways.146

143 Section 41 of the HDCA
146 Ibid.
Notice

As has been shown both the principles of natural justice and procedural fairness require that a person knows who is bringing a complaint, the nature of the complaint, the reasons for why it is being brought and sufficient detail of the questions to be decided, in order to make a defense. Flick writes that while notice need not in all cases quote chapter and verse, particularly in the early stages of an investigation, it must be formulated with sufficient precision to inform the ordinary reasonable man as to what is being complained of and what he is required to do. It will be deficient if a party is left guessing as to what the charge actually is or if he only knows one out of many charges.147 As Lord Morris stated in the English case Malloch v. Aberdeen Corporation "What would be the point of giving someone a right to be heard, while denying him any knowledge as to what he is to be heard about?"148

Reasons for notice can be extrapolated from many sources but in summary notice is also needed to:

- provide a party beforehand with a sufficient indication of the factual issues involved;
- provide detail of the subject matter of the inquiry, the legal and factual issues to be canvassed;
- give notice of the rule allegedly breached;
- identify the consequences of an adverse adjudication so as enable case preparation.149

Well particularized allegations enable the respondent to make a full and robust defense but also assist the decision-maker to see clearly what is being alleged, so that he or

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she is in a better position to consider the evidence, and apply accurate tests of relevance. This is arguably more conducive to a fair hearing, free from side issues and prejudicial 'surprise' and will result in accurate judgements and outcomes. 150

Let us consider the type of particulars given to midwives by the Commissioner. The notice given to midwives when the Office was still in its infancy was frequently vague and allegations of a breach of the Code were not well specified. In some cases the allegations were so non-specific that the midwife would not know what she was required to answer and so would request the original complaint letter to see if this could enlighten her. Forbes writes that where the substance of a document cannot be conveyed without producing it for inspection, then inspection should be allowed. 151 Unfortunately this was not the practice of the Commissioner. Even if a complaint letter existed, in the first year to eighteen months after the Code was enacted, it would routinely be withheld. 152

The Commissioner began to summarize aspects of the complaint and these would be included, usually in quote or bullet point form, as part of the Notification Letter to the practitioner. These summaries were frequently a mixture of statements of fact and allegation. Often there was no date, time nor location given with respect to the incident complained of, and a midwife could be left completely unaware of what she was supposed to have done, and thus be unable to formulate an answer. An example of this type of allegation is where the Commissioner wrote to one midwife:

152 This withholding of key information and the lack of fundamental discovery of relevant documents, was to be a constant source of frustration and a major concern for those involved. It was also a policy that was very out of step with the practice of the Privacy Commissioner and the professional disciplinary bodies. They had moved to greater and more open disclosure. Galligan states that disclosure is closely related to notice and that parties should be given information and materials upon which the authority intends to make its decision and which may be adverse to the parties. Galligan, (1996): 357.
On x date your husband had to point out to hospital staff that your drip had nearly finished.153

Clearly the Commissioner or one of her staff was reflecting back a conversation with the complainant, but this phrase was contained in the midst of other allegations against the midwife. The above example is useful as it illustrates a common problem with the early complaints letters - namely a lack of specificity or particularization. The above example gives rise to the following questions given that there are three shifts of staff in most hospitals. What time did this incident occur? Was anyone else present? Who was the staff member that the husband talked to? Was that person the one responsible for care? At what time did this conversation occur? Was the infusion attached to a pump (because if it was then shut-down as the fluid level decreased might have been automatic)? What is meant by ‘nearly finished’? Did the staff member do anything as a result?

All of these questions could have been asked by the Commissioner when formulating the particulars of the complaint. Ultimately it turned out that the above incident had nothing to do with the midwife who received this particular as part of the complaint. Her client was in hospital under secondary care and the midwife was not present nor responsible for the care provided during that time.154

There were many other procedural shortcomings in the communication of complaints to midwives. A midwife would often not know who had lodged the complaint against her, particularly when it was another health professional nor would she know whether the

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153 Case HDC16912/VC

154 The next bullet point in the same Notification Letter was equally puzzling and referred to a visit that the complainant had with a doctor where she was concerned about shortcomings in his communication. This was also ‘put’ to the midwife who had not been present during the doctor’s visit - a matter that could have been clarified simply by asking the complainant who had been there.
complaint had been oral or written. Complaints were often largely based on hearsay and second hand information such as the complaint, against the wishes of the consumer and her partner, by a paediatrician who had no part in the actual birth or resuscitation. Another was the complaint of the friend of a woman who birthed precipitously before her midwife could arrive.

Eventually, after numerous requests for better particularization of complaints by health practitioners and their lawyers, the Commissioner began to attach a copy of the complaint letter where it was available. This would identify the grievances of the complainant. However it was only on rare occasions, such as where an effective advocate had helped formulate the letter of complaint, that the midwife would receive some indication on which part of the Code she was alleged to have breached.

The Commissioner’s letter of notification set out other information that was useful to the practitioner. This included the aim of the legislation, that certain cases would be dealt with by advocacy, agreement, resolution, or the calling of a mediation conference. She would advise that a complaint had been received and whether she intended to investigate so as to enable an opinion to be formed as to whether the Code had been breached. The provider would be reminded that the Code imposed duties upon providers and that an opinion would not be formed until the midwife had been given an opportunity to comment. Where a breach was found, the Commissioner stated that she could make a report with or without recommendations, and in appropriate cases refer the matter to the Director of Proceedings who would decide whether action before the Human Rights Review Tribunal or a disciplinary body was warranted.

The wording of the early Notification Letters presented the two forums as alternatives which mislead some people into believing they would face either HRRT (then Complaints Review Tribunal) or a disciplinary hearing but not both. The legislation clearly sets out the possibility of prosecution before both forums, although this only occurred in one midwifery case.
In the Notification Letter the Commissioner would request certain information from the midwife and ask her to forward to the Commissioner a written reply, giving her employment status (as employers can be liable under the Code) and all clinical notes and supporting documentation. The Commissioner would then provide the provider with the name and contact details of the investigator assigned to the file.¹⁵⁹

Section 41 (1)(b)(ii) of the HDCA gives the provider a right to submit a written response in relation to the complaint (or as the case may be the subject matter of the investigation) to the Commissioner within a reasonable time. In practice two different rights of reply were afforded. The first was the right to reply to the brief bullet points in the notification letter, or to the complaint letter and the second was to the Commissioner's Provisional Opinion. Often the midwife did not know what the complaint was actually about until she received the Provisional Opinion. When the Commissioner failed to provide adequate particulars and the midwife remained uncertain about the specifics of the complaint, she would usually just provide a broad statement of her involvement with the complainant, over the pregnancy, birth and postnatal period.

When the second Commissioner was appointed he was immediately concerned to find that providers often did not know why they were being investigated. He was interviewed by the media and the following account was reported:

_Some providers have complained that they do not know exactly why they are being investigated and Mr Paterson says this confusion is evident from the files he has read. At the moment, providers get a factual litany of the alleged incident but, Mr Paterson says, there is no information about whether the_

¹⁵⁹ The letters of the second Commissioner have a similar format but give more detail on the impartial and inquisitorial nature of the investigation process, asks for a wider range of material and stipulates that it should be sent 'in confidence'. The Commissioner now notes with regret that investigation processes can be lengthy and recommends that the provider seek collegial support. Information is included on the role of the Commissioner.
complaint relates to lack of communication skills, lack of information given to the patient, or standards of care. "I don’t think the Commissioner is required to spell out which part of the Code a provider may have breached, but I think it would be fair to give providers some idea about the areas of practice which are under review".160

The majority of midwives would forward their reply with copies of the midwifery notes to the Commissioner within a month of receiving the complaint, although many responded sooner. These responses would not usually be acknowledged and the midwife would hear nothing more for some years. Part way through 1998, when concerns about process delays were growing, the Commissioner initiated progress letters and these were sent out, usually after about a year, simply confirming that the matter was still under investigation.

The Investigation Process – After the Initial Response

The Commissioner makes a decision whether to investigate the complaint subject only to the expectation that the decision would be made in good faith, and be based on relevant concerns and valid considerations. After the Commissioner receives the midwife’s response to the original letter of notification, the process of investigation continues. Reports are received, hospital notes accessed, people are interviewed - both eyewitneses and others, experts are consulted, guidelines, manuals, standards and policy documents are gathered and considered, and throughout this process, the midwife often has no idea what evidence the Commissioner is considering, who has given evidence, the nature of that evidence and which experts have become involved. Despite numerous common law precedents that approve disclosure in disciplinary cases, including those discussed above, the majority of the reports

and documents collected during the investigation were not disclosed or forwarded to the midwife for comment. This was very different to the practice of the Nursing Council of New Zealand when exercising its disciplinary jurisdiction or the Accident Compensation Commission medical misadventure process where as soon as witnesses statements and expert reports were received, they were circulated among all interested parties.

The High Court of Australia held in 1992 that natural justice included the right to test the case [against one] including the evidence called and the right to put a case to the contrary. The High Court of New Zealand found that it was a breach of natural justice for an Authority to obtain further information without giving this to respondents for comment. In Redcliff Estates Ltd v. Enberg & Anor the High Court set side an arbitration award because the arbitrator had been requested to take account of evidence and “incriminating submissions” that were never disclosed to the plaintiff. Panckhurst J held that the failure to give the plaintiff an opportunity to respond to those submissions was a breach of natural justice.

When concerns were raised at the lack of disclosure, one justification of the Commissioner was that she was protecting the privacy of parties who were providing

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161 Forbes (1990): 171. In Freedman v. Petty and Greyhound Racing Control Board [1981] VR 1001: 1021 The Court found it can be an error to put questions to a defendant and not tell them that the questions are based on a document in the [authority’s] possession. See also Brinkley v. Brinkley [1965] 75: 78 where Scarman J. held that for a court to take into consideration evidence which a party to the proceedings has had no opportunity during trial to see or hear ...[strikes] at the very root of the judicial process. Also R v. Architects Registration Board ex parte Jaggar [1945] 2 All E.R. 131 and Phipps as above.


163 Martin v. CEO of the Department of Labour, HC, Auckland, M 113-98 – 4/11/98, per Cartwright J. This was a successful Appeal against a decision of the Residence Appeal Authority.

164 Redcliff Estates Ltd v. Enberg & Anor. HC, Christchurch, M 150-99, 22/7/99. Panckhurst J. quoted Wilmer J. in R v. Deputy Industrial Inquiries Commissioner ex parte Moore [1965] 1 QB 456: 476 where the Court of Appeal held that it would not be in accord with natural justice to act on information obtained behind the backs of parties without affording them the opportunity of commenting on it.
to her information. Even if this reason were valid, it did not justify an outright refusal to disclose. It is quite possible to disclose the relevant information without providing a person’s name or personal details. This type of argument was considered in an unsuccessful appeal against a decision of the English Architects Registration Tribunal and it was held that the tribunal could receive evidence in confidence if it disclosed to an applicant both the contents of the evidence and its source.\textsuperscript{165} This has continued to be the view of the New Zealand court. In an unsuccessful appeal against a decision of the Building Industry Authority, Gallen J nevertheless found that the BIA was wrong to receive and consider reports of third parties without disclosing them to parties and allowing time for submissions or for further evidence to be presented.\textsuperscript{166}

When material collected during the investigation is relied upon to make a decision that is adverse to any person, then that information should be disclosed. Professor Galligan states that:

\begin{quote}
\textit{The underlying point, is that no matter how well founded the adverse material might be, the party should have the chance to cast doubt on it and, in that way, give a fuller and possibly more balanced account of the facts.}\textsuperscript{167}
\end{quote}

A key protection in the collection of any evidence is that it disclosed \textit{at some point} before the ultimate decision, so a party has a right of comment. Disclosure becomes more critical if evidence and decision may lead to an adverse finding capable of \textit{“damaging a person’s reputation and economic prospects”}. It is important before making such a finding that a person be given the opportunity to see and make submissions on any evidence that could lead to that finding. This is usual practice in the Coroner’s jurisdiction. A well

\begin{footnotes}
\item[165] R v. Architect’s Registration Tribunal ex parte Jagger [1945] 2 ALL ER 131
\item[166] Auckland City Council v. New Zealand Fire Service & Anor. [1996] 1 NZLR 330 per Gallen J
\end{footnotes}
known formulation of the principle comes from the case *Mahon v. Air New Zealand*.\(^{168}\) It was there said of a Coroner’s Court adverse finding, that:

> In practice the principles of natural justice mean that Coroner’s cannot make findings adverse to the interests of people to whom a right of representation is granted without giving the opportunity to be heard in opposition to that finding.\(^{169}\)

The Final Opinion and recommendations of the Commissioner can be akin to an adverse finding and yet the failure to disclose key evidence to respondent practitioners was a frequent problem at all stages of the investigations.

Take as an example, where a midwife was interviewed by HDC investigators. These encounters often lacked procedural fairness. A difficulty in those early interviews was that the investigators had varying degrees of skill and experience. While some were perceived as very professional, the practice of other investigators was worrying to midwives. One example related to the practice of interviewers interviewing the midwife in her home. When this occurred the midwife was forced into a hostess-type situation and the formal, and to some intimidating, interview process then impinged on her personal space and family.\(^{170}\)

In early interviews, investigators would frequently talk first to the complainant, their friends and family and medical critics and thereby gain a preliminary view of their version of events. Midwives reported feeling disadvantaged where they were interviewed after these

\(^{168}\) *Mahon v. Air New Zealand* [1984] AC 808.


\(^{170}\) Midwife’s reported feeling the house had to be very tidy, they worried about what to do with young children, or that a friend would drop in during the interview and “find out” about the complaint and so on. One interviewer went to a midwife’s very well-appointed home and according to the midwife commented continually on how much money the midwife must earn.
witnesses. Their fear was that by the time they were interviewed, the investigators may have developed a sympathy for the complainant, particularly where a baby had died or had suffered a pregnancy or birth injury. The midwives worried that this would make the investigators less accepting of a midwife's explanations. It is difficult to know if interviewers were affected in this way, and it is probable that an appropriate professional distance to all witnesses was maintained. This concern is mentioned because in the early years of the Office, several of the midwives who were interviewed, feared that the practice of interviewing the majority of witnesses from "one side" first, might lead to a bias against their evidence.

A further difficulty was that the interviewers often had a health background. While this had some benefits, it could also lead to problems. One interviewer asked the midwife why she had not performed a rectal examination on the woman in labour. This particular examination was a procedure that had been discredited over twenty years before and the midwife tried to explain that it was no longer considered good practice. The question remained an issue through to the provisional opinion but was removed once the midwife made submissions to the Commissioner on current practice. The example is unusual but it demonstrates the danger of investigators mistakenly applying their own clinical experience or outdated knowledge to the clinical decision making of the midwife.

In another case the midwife's support person during the interview was skilled in shorthand. Her detailed notes were at complete variance to the notes the investigator later presented to the midwife as the summary of what she had said. The midwife refused to sign the investigator's transcript.171

A common problem was that the midwife was often uncertain about which aspects of her practice or care of the complainant, was giving rise to the complaint. In the interview

171 HDC 14894/VC
some matters would sometimes be "put" to the midwife and she would be asked to comment. At such times the midwife might gain a glimpse of the concerns of the Commissioner or investigators, and so be able to make explanations or submissions related to these issues. At other times the midwife would have no idea why she was being asked certain questions.

Arguably the procedures of investigators should also take account of the principles of natural justice. Investigators need to be skilled at what they do, and fair and unbiased in their approach. This is very important, as it is the interviewer who influences key decisions in the HDCA process. These include which other witnesses to interview, what information to seek, and whose evidence they believe. It is the interviewer who will draw preliminary conclusions on the strength of the case against the provider, including a view as to whether there has been a breach. When the interviewers report their views, impressions and conclusions, this information may greatly affect or inform the ultimate decision of the Commissioner. The Commissioner is heavily reliant on the interviewers to furnish full, impartial and appropriate evidence in coming to assist him or her in coming to a conclusion about whether the Code has been breached.

The issue of evidence and evidence-taking in cases where health professionals are involved, requires patience, skill and an open mind, as there are many factors that may challenge the investigator. One of these is the unique context of the clinical relationship. In most midwifery cases, the woman, her friends, partner, or other family members are frequently present during clinical interactions, while the midwife is often there alone. A result of this reality is that when a complaint is initiated, there may be several people giving evidence "against" the midwife and it is inevitable that differing recollections and conflict of evidence will occur. Matters are complicated when lay witnesses try to recall or interpret retrospectively clinical events and clinical decision-making, without ever having talked through the reasons for those decisions with their immediate caregivers. The risk of collusion or contamination of evidence is increased if the family and close friends recite to each other what they recollect as happening. This is an especial risk when witnesses live together or see each other on a frequent basis. The difficulty in these circumstances is that witnesses may
consciously, or unconsciously, bolster, or slant their evidence to fit the common version of events. This danger is greater where the situation has been an emergency and communication has been reduced to a minimum, or where the outcome has been traumatic and the subsequent grief has been extreme. In these situations the witnesses often care deeply about the complainant and his or her concerns, and often share the complainant’s passion to achieve professional accountability or desire to exact some type of recompense.

A further concern is the type of situation where there is more than one witness saying similar things, is that the accumulating evidence can appear to give extra credence to a claim. While corroboration may be quite valid and helpful in establishing the facts, Forbes warned that natural justice may require adjudicators to limit the inclusion of evidence where there is frequent repetition of essentially similar evidence.\(^{172}\) This is not to suggest that such repetition cannot also occur in hospitals where staff may fall into inadvertent collusion, in an effort to protect a practitioner who is well liked or respected. This danger needs to be remembered by anyone interviewing a number of witnesses, particularly when their evidence does not add anything more to what is already known.

From a legal defence perspective, a more worrying shortcoming of the investigation process was the failure to interview key witnesses. This was a critical concern as a decision-maker must consider all relevant evidence and the Commissioner is dependent upon his or her investigators to amass that evidence. In *Prasad v. Minister for Immigration and Ethnic Affairs*\(^{173}\) Wilcox J held that, while it is not the duty of the decision-maker to make the appellant’s case for him:

> in a case where it is obvious that material is readily available which is centrally relevant to the decision being made, it seems to me that to proceed to a decision without making any attempt to obtain that information may

\(^{172}\) Forbes (1990): 106.

\(^{173}\) *Prasad v. Minister for Immigration and Ethnic Affairs* (1985) 6 FCR, 155 per Wilcox J
properly be described as an exercise of the decision-making power in a manner so unreasonable that no reasonable person would have so exercised it.\textsuperscript{174}

In several of the midwifery cases, there was a failure to interview key witnesses and obtain information from them. In another case the second midwife at the birth and attempted resuscitation, was not interviewed yet she was there at all relevant times.\textsuperscript{175} In another case the second midwife, student midwife, the mother and the grandmother who were all present at the birth, were not interviewed.\textsuperscript{176} It was notable that family members were less likely to be interviewed when they did not support the complaint, and yet sometimes witnesses of questionable relevance, such as complainant doctor in the same case (who was not present at any stage of the birth and resuscitation and so had no direct evidence to give),\textsuperscript{177} or the parent of the consumer\textsuperscript{178} (who was not present during the key times), were interviewed.

In some cases, the midwives themselves were not interviewed and so had no opportunity to gain greater detail of the case against them nor to orally answer concerns.\textsuperscript{179} The omissions to interview relevant witnesses became of greater concern when an adverse finding was made, particularly when that finding was based on contested facts.

\textsuperscript{174} Ibid: 170
\textsuperscript{175} 9RHDC12370/MR. In this case two midwives were involved and the complaint was laid after the stillbirth of the baby. The Coroner had dismissed the case part-way through an Inquest finding the babe was effectively stillborn and died of an abnormally short cord. A key allegation against the second midwife was a failure to do a blood test at an exact gestational date of the pregnancy where the woman's dates had been uncertain and where the blood tests had actually been done earlier by the hospital and were normal. (A set of tests later in the pregnancy were also normal). The Commissioner investigated and there was a four year delay between the stillbirth of the baby and the Commissioner's decision that the timing of the blood tests did not breach the Code. This midwife provided a written statement but was not interviewed.
\textsuperscript{176} HDC5342/VG
\textsuperscript{177} HDC5342/VG
\textsuperscript{178} HDC1353/VC
\textsuperscript{179} HDC12370/MR
Unfortunately the midwife would often not know who had or had not been interviewed until the Commissioner released the Provisional Opinion.¹⁸⁰ Even then she would not usually be given any details of what that person had said.

Omitting to interview eye-witnesses can mean that critical evidence, which could provide corroboration for the family or the midwife, is unavailable to the Commissioner to assist in the deliberations and decision-making. The failure to interview key witnesses had the additional adverse effect of making some midwives feel as if the process was not neutral, and that finding out what actually happened was secondary to finding evidence to support the complaint.

The Commissioner has a discretion to decide whether to interview any witnesses, and there are budgetary considerations when deciding to commit resources to a number of interviews. A key consideration should be relevance. The Commissioner must be prepared not only to hear both sides, but to be perceived as hearing both sides. Any adjudicator who ignores, disregards, or who does not require, the collection of all relevant evidence, arguably closes his or her mind to the full facts.

**Considering the Evidence**

The processes of the Office of the Commissioner are not the same as a Tribunal and are even less bound by the strict rules of evidence. Once the interviews are completed it is the role of the Commissioner to sift all the witness statements and weigh the evidence. Where recollections about events differ or conflicts in evidence occur, the Commissioner must make a finding of credibility as to which witnesses to believe. The Commissioner is at a disadvantage from most adjudicators, as the finding is generally made without the

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¹⁸⁰ By way of contrast the investigator for the Preliminary Proceedings Committee ("PPC") of the Nursing Council of New Zealand has the task of interviewing all those directly involved in a complaint, and not just those who support the complaint. This is done to enable the PPC to determine whether the midwife has a case to answer before the Nursing Council. This investigator considered that her statutory role in those investigations was to attain a record of events, that was as complete as possible so as to assist the Committee in its deliberations.
Conflict in evidence is almost inevitable, such as occurred in the following case.\textsuperscript{181} The issue of credibility arose in respect to a discussion between the mother, grandmother and the midwife about taking a heel prick sample to test the blood of a baby with jaundice. This test is called an SBR (“Serum Bilirubin test”). The midwife initially visited the mother and baby regularly after the birth and noted the baby had a faint jaundice. The baby appeared well, the mother’s milk supply was good and the baby was alert and feeding. On post natal day six, while the grandmother was present, the midwife did the routine Guthrie blood test (for genetic diseases) and decided to do an SBR to determine the level of jaundice. She explained to the family that if the SBR level was high, the baby would need to go the hospital for treatment. The midwife went out to the car to get her testing kit and came back and began to assemble the equipment. All witnesses agreed to events up until this point. No witness denied that the midwife visited and assessed the baby and that at some point during the visit, she stated that she wanted to test the baby’s level of jaundice. Similarly all appeared to accept that she warned the mother that if the test result (“SBR”) were high the baby would need to go to hospital.

At that point the evidence diverged. The evidence of the midwife was that the grandmother questioned whether given the baby was alert and feeding well, there was any need for the test. She said that the mother said to leave the test. The midwife says that after these comments, she checked the baby’s colour more closely by stripping it down and she bare-weighed the baby to ensure it was feeding and getting ample fluids. There was a weight gain which the midwife said tends to indicate the fluid intake is satisfactory. The midwife documented in the clinical records the increase in weight, and that the grandmother

\textsuperscript{181} 97HDC7147/MC
questioned a test on an alert baby who appeared well, and that the baby's mother agreed with the grandmother that the test should not be done.

The mother disagreed with the midwife's evidence. She says that they asked the midwife to do the test and she said not to worry. The midwife, denied this and questioned why she would stop part-way through assembling her equipment to do the test, unless the family had said or done something to stop her going ahead.

The baby's jaundice worsened and an SBR level done the following day was high and the baby was admitted for phototherapy. The family made a complaint against the midwife and the Commissioner investigated. In her Final Opinion, the Commissioner found the midwife in breach of the Code. She preferred the family evidence about the above interaction, over the evidence of the midwife but gave no reasons for this. Of concern to the midwife was that the Commissioner, in making this credibility finding, appeared to give no weight to the contemporaneous clinical record which supported the midwife's version of what had occurred.

While the requirement to give reasons for preferring the evidence of one witness over another, has not been elevated to a legal duty it is a growing component of the need for fair procedures. Reasons should be given when there is an adverse finding.

**Expert Reports**

We have seen that there was a failure to disclose key evidence or concerns during investigations. Another area where there was poor disclosure of relevant evidence related to expert evidence.

Many of the rights contained within the Code, are linked to a reasonable standard of practice in the circumstances. A breach would usually only be found where the provider failed to meet that standard. In order to form a view on what constituted "reasonable
"Practice" the Commissioner is empowered to contract expert witnesses from the different health professional groups. The Second Schedule of the HDCA states:

1. Employment of experts – (1) The Commissioner may, as and when the need arises appoint any person who, in the Commissioner's opinion, possesses expert knowledge or is otherwise able to assist in connection with the exercise by the Commissioner of the Commissioner's functions to make such inquiries and conduct such research or to make such reports or to render such other services as may be necessary for the efficient performance by the Commissioner of the Commissioner's functions.

The first Commissioner recognized the need to obtain independent expert opinion. The opinion of an expert can be an immense help to an adjudicator, as they provide specialist knowledge. But, as Professor Galligan warned, while such opinions are in one sense a matter of judgement about complex assessments in complex situations, in another sense they are largely discretionary.\textsuperscript{182} He writes:

\begin{quote}
They are reached partly by the straightforward application of knowledge, but also partly by a more subjective judgement about the best way of applying that knowledge under conditions of uncertainty, where rival judgements might be equally justified.\textsuperscript{183}
\end{quote}

In most forums where an expert is used, there is a right for parties to be given a copy of the report, and to cross-examine the expert in order to test whether that person is qualified to give expert opinion and the nature of that opinion. A midwife had input into the decision about which expert the Commissioner should approach, and had no ability to question or test that person's credentials or expertise. In the absence of these protections, it was important

\textsuperscript{182} Galligan (1996): 259.

\textsuperscript{183} Ibid.
that the experts used by the Commissioner were appropriately qualified.\textsuperscript{184}

Unfortunately unlike the practice of the Medical Misadventure Committees in the Accident Compensation Corporation, the professional disciplinary Bodies, Coroners and the Civil Courts, all of which utilized expert midwifery opinion when considering a midwifery case, there were times when the Commissioner received expert opinion from members of other professional groups. Those practitioners were not qualified in midwifery and were not the appropriate person to an expert opinion on what constituted reasonable midwifery practice.\textsuperscript{185}

In the early cases, experts were anonymous and midwives often did not even know if: an expert or experts had been used; who the expert or experts were; how and by whom they had been nominated; whether they were qualified to be an expert; the type of briefing they had been given by the Commissioner; the particular realm of their expertise in midwifery; what documentation or evidence they had seen and relied on before giving their opinion; whether they had given a written opinion, or an oral opinion over the phone; whether they had the opportunity to consider the midwife’s response to the provisional opinion and possibly modify their opinion in light of this; and what the totality of their evidence had been. The Commissioner’s practice was not to disclose the name of experts, and to quote, in her opinions, the portions of the expert’s evidence that supported the findings. One case where there was a lack of disclosure of expert evidence has already been considered, and

\textsuperscript{184} The NZCOM had established a rigorous method of nominating experts in midwifery. Each region would nominate potential candidates on the basis of their experience, qualifications, service, commitment to midwifery, and their standing in the professional community. The nominations would be forwarded to the National Committee, where there would be a further consideration of the appropriateness of candidates and those affirmed would be placed on a list of experts available to ACC, Nursing Council, any lawyers prosecuting or defending midwifery cases, and the Commissioner. The list contained a broad range of midwives practising in all different areas of maternity to ensure that appropriate and wide-ranging advice was available.

\textsuperscript{185} This confusion over appropriate professional expertise was not just a problem for midwives. GP’s had a similar problem and the Commissioner’s case notes disclose that at times, medical specialists inappropriately gave expert advice on GP practice. “Peers must judge us, say rural medics”. \textit{New Zealand Doctor}, (11 April 2001).
unfortunately this was the norm in early HDC cases.\textsuperscript{186}

The failure to disclose expert opinions, particularly when they are adverse or relied on by the decision-maker, has long been held as procedurally unfair. In \textit{R v. Westminster Assessment Committee Ex parte Grosvenor House (Park Lane) Ltd}, Du Parcq LJ warned that the expert must not be substituted for the ultimate decision-maker and held with respect to expert reports: (p.143)

\textit{Those whose claim is being considered have a right to question and to test every statement [the expert] makes, and any opinion he expresses. If that opportunity is denied them, justice is not done. On the ground, therefore, that the committee improperly ...considered and gave weight to evidence and, it may be, argument, which was never communicated to the parties most interested, we are of opinion that the respondents are entitled to have the determination of the Committee quashed.}\textsuperscript{187}

The view that parties should be given the right to see and comment on adverse reports continues to be the case in New Zealand. was expressed in \textit{Auckland Boxing Association Inc v New Zealand Boxing Association Inc}.\textsuperscript{188} This was a case where the ABA successfully applied for Judicial Review of a decision that the NZBA would cease to issue permits for amateur matches. The High Court held that the NZBA had breached the principles of natural justice because it had not told the ABA of the existence of reports recommending this action, nor was it given an opportunity to comment, and furthermore the NZBA had not warned the ABA of the possible action to be taken as a result of those reports.

\textsuperscript{186} One of the first changes of the second Commissioner was to disclose the full expert opinion and to name experts.

\textsuperscript{187} \textit{R v. Westminster Assessment Committee ex parte Grosvenor House (Park Lane) Ltd.} [1940] 4 All ER 132: 143.

\textsuperscript{188} \textit{Auckland Boxing Association Inc v. NZ Boxing Association Inc & Anor} (HC, 8/5/01). Auckland, M 1993-SWOO, Priestley J.
The need for such disclosures was also affirmed in the context of professional disciplinary cases in *Staite*,\(^{189}\) and *Duncan*,\(^{190}\) and *Phipps*\(^{191}\) which reaffirmed the need for disciplinary committees to disclose documents of significance, and for parties to be given an opportunity to comment on their conclusions.\(^{192}\)

Although the principle *audi alteram partem* requires sufficient notice of the case against a person to prepare a defense and submit evidence in support of her own case, it also includes the right to contradict evidence which forms the basis of the opponent's case. This is a key reason why a decision maker should not act on "secret evidence".\(^{193}\) Hewitt writes that evidence should not be given behind the back of a party without proper disclosure and cites *Ayers v. Pharmaceutical Society of New Zealand* where Edwards J. held that the Pharmacy Board, in arriving at a disciplinary decision, was bound to act according to the ordinary principles upon which justice is administered and should have disclosed the evidence it received.\(^{194}\)

Undisclosed key evidence was a common factor in early cases. It was not just the failure to disclose expert reports, but a failure to disclose standards, guidelines and policies relied on in making the decision, witness statements and complaint letters. Specific

\(^{189}\) *Staite v. Psychologists Board* 11 PRNZ 1: 4.

\(^{190}\) *Duncan v. Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513: 535 (HC)

\(^{191}\) *Phipps v. Royal Australasian College of Surgeons* [1997] 2 NZLR 518.

\(^{192}\) Halsbury's Laws of England discusses the need for wide disclosure of expert reports and states that the document served must include sufficient details of all the facts, tests, experiments and assumptions which underlie any part of the information, to enable the party on whom it is served to make, or to obtain, a proper interpretation of the information and an assessment of its significance. Usually the failure to disclose the expert's report means it may not be used in a trial. Halsbury's Laws of England (4th edition re-issue) 17 (1) (London: Butterworths LexisNexis, 2002), paras 768 - 772.


examples include a letter from the hospital confirming a midwife's view that a baby was well on discharge, and an obstetrician's letter whose evidence refuted one key allegation against the midwife. There were other cases where there was either no disclosure or no adequate disclosure. Repeated requests for disclosure by counsel, and arguments that the rules of natural justice required the Commissioner to provide reasonable discovery, were largely ignored. It eventually took a series of legal challenges to bring about change.

The first challenge arose from *Medical Practitioner's Disciplinary Tribunal v. E.* This was a case where the Commissioner found that the doctor, "E" had breached the Code and referred the matter to the Director of Proceedings. The Director laid a charge against E before the Medical Practitioners Disciplinary Tribunal. The doctor's repeated requests for access to key documentation had been continually declined. The case note reveals that the grounds of refusal had shifted frequently during correspondence between the Commissioner and counsel for E. These included the assertion that the Commissioner's files were privileged; that disclosure was against "policy"; that providing copies of expert evidence would discourage peer reviewers from providing free and frank information; and that the role of the Commissioner and Director are separate.

Counsel for the doctor sought orders from the Tribunal for the Commissioner and Director of Proceedings to give discovery of documents relating to either the investigation of the complaint, and/or the prosecution of the case, including a complete copy of the advice of "an independent expert"; or alternatively, that an affidavit listing all such documents be

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195. 97HDC7147/MC

196. 97HDC7147/MC. The allegation was that the specialist had asked the midwife to do a blood test and she had not done this. There was undisclosed evidence from the doctor that the allegation was not true.


filed within 14 days. The Commissioner and Director claimed privilege and argued that the Commissioner had no obligation to provide copies of the investigation file.

The Tribunal was not convinced and quoted from *Gurusinghe v. Medical Council*. The High Court advised regarding disclosure in disciplinary cases, that:

> Any prosecutor, however, would be wise to allow the defence to see information which is of concern to the defence unless there is a good reason for not doing so, in order to let counsel for the defendant decide whether the information might assist in showing that the defendant may not be guilty of the charges against him.\(^{199}\)

The Tribunal found that it was reasonable for Dr E to receive the documents and that receipt was required to comply with natural justice. It ordered the Commissioner and the Director to disclose the documents and for the Commissioner to pay costs of, and incidental to, the application. The Commissioner appealed and sought that the Tribunal’s Orders be quashed.

Shortly after the Tribunal’s ruling, in another medical disciplinary case, the MPDT ordered the Director of Proceedings to supply the Tribunal with a copy of a report by a peer general practitioner, so that the Tribunal could disclose the report to the respondent doctor, in order to fully discharge its own statutory obligation to observe the rules of natural justice. The Commissioner by letter dated 12 June 1998, declined to comply with the Tribunal’s request.\(^{200}\) The Tribunal hearing went ahead without disclosure having been made. In its decision to dismiss the charge against the doctor, the MPDT stated that had the charge been made out, it would have deferred announcement of its decision pending either

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until compliance with or appeal of the order by the Commissioner.\textsuperscript{201}

The appeal on both these cases was heard in the High Court in Wellington. Ellis J. held that disclosure should have been given. The Commissioner claimed litigation privilege. This argument failed because Ellis J. found that the dominant purpose of the Commissioner’s file was not prosecution. It was compiled to enable the Commissioner to report and refer matters on to the Director of Proceedings Ellis J. ordered that the Commissioner’s and Director’s files should “be discovered” unless there was a good reason for refusal.\textsuperscript{202} He said that, even independent of the discovery required as part of a prosecution, disclosure of personal information about the doctor could have been ordered under the Privacy Act 1993.

**The Provisional Opinion - A Right of Reply and Opportunity to Controvert Adverse Evidence**

Section 43 of the HDCA states that once the decision to commence an investigation is made, the Commissioner should conduct the investigation with due expedition, and shall inform the parties concerned as soon as reasonably practical after the conclusion of the investigation and in such manner as the Commissioner thinks proper, of the result of the investigation and of what further action (if any) the Commissioner proposes to take in respect of that complaint.\textsuperscript{203} The usual form of this notice is the Provisional Opinion, although in cases where there was no breach finding, the Commissioner often simply sends a letter to the midwife informing her of the finding and that if she does not want to comment further, the case will be closed.

If there was a provisional finding of a breach of the Code, this represented the first real opportunity for providers to know the breadth of the case against them; the particular


\textsuperscript{202} Health and Disability Commissioner v. Medical Practitioner’s Disciplinary Tribunal, [1999] 2 NZLR 616, HC Wellington.

\textsuperscript{203} Section 43, HDCA
rights they were alleged to have breached; the witnesses involved; and the possible recommendations or actions that the Commissioner intended to take.

The processes surrounding the Provisional Opinion must also be procedurally fair as there is no rule that natural justice is excluded from a preliminary stage. In Lewis v. Heffer, Lane LJ stated:

*In most types of investigation there is in the early stages a point at which action of some sort must be taken and must be taken firmly in order to set the wheels of investigation in motion ... but the further the proceedings go and the nearer they get to the imposition of a penal sanction or to damaging someone's reputation or to inflicting financial loss on someone, the more necessary it becomes to act judicially, and the greater the importance of observing the maxim audi alteram partem.*

In Home Secretary, Ex parte Doody, (PC) Lord Mustill identified several points that represented fairness; including the right of a person to make representations on a proposed decision or sentence. His fifth and sixth points were as follows:

(5) Fairness will very often require that a person who may be adversely affected by the decision will have an opportunity to make representations on his own behalf either before the decision is taken with a view to producing a favorable result; or after it is taken, with a view to procuring its modification; or both.

(6) Since the person affected usually cannot make worthwhile representations without knowing what factors weigh against his interests, fairness will very often require that he is informed of the gist of the case which he has to answer.

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205 Lewis v. Heffer [1978] 1 WLR 1061: 1078-79 per Lane LJ.

206 Home Secretary, ex parte Doody [1994] 1 AC 531: 560 (HL) per Lord Mustill
It was appropriate and fair for providers to be given an opportunity to respond to the Provisional Opinion before the Commissioner’s Opinion was made final. The only procedural shortcoming in this process was that disclosure of evidence did not accompany the Provisional Opinion, even when the evidence obtained during the investigation process was referred to in the body of the opinion itself. This meant that the provider was frequently still responding in a vacuum, without access to key evidence, or knowing what had been relied on by the Commissioner in forming the Opinion.

While the opportunity to review and comment on the Provisional Opinion is important for the provider, such comment is a critical additional safeguard for the Commissioner, as it allows errors to be corrected and for additional evidence to be called to refute wrong conclusions. This enables the Commissioner to produce more robust and well-reasoned decisions. Flick wrote of the importance of this type of correction and his justifications can be summarized as follows.\(^\text{207}\) Such comment will:

- provide considerable assurance that the decision will be better as a result of its being properly thought out
- encourage public confidence in the process
- provide guidance to those who advise parties as to their future conduct
- disclose correctable [practice] deficiencies for the education of others
- prevent arbitrary and abusive exercise of broad disciplinary powers.

The format of the early Provisional Opinions ranged from a short letter stating no breach had been found, through to a lengthy and detailed opinion about multiple providers. Commonly the opinion would list the original complaint by way of bullet points, even where they had been disproved or bore no relationship to the eventual finding. There would be disclosure of the date that the complaint was received by the Commissioner and generally at

\(^{207}\) Principles extrapolated from Flick ((1978): 86-88.
this point the complainant was disclosed if this had not already been done. The Commissioner would then list persons who had provided information during the investigation and summarize the information that had been gathered. As has already been pointed out this was often the first time that the midwife would become aware that key witnesses had not given evidence or that extraneous witnesses had been interviewed. Where witnesses were quoted it would not be clear whether the quotes came from a written or oral statement, or from an interview transcript. It was entirely at the discretion of the Commissioner what evidence was included in the body of the Provisional Opinion.

In the Provisional Opinion the Commissioner sometimes referred to independent expert advice that she had received. After summarizing selected aspects of that advice, the Provisional Opinion would list the Rights that were relevant to the complaint and any other standards such as the NZCOM Standards for Midwifery Practice which the Commissioner had taken into account when forming her conclusions. The Commissioner would then consider each Right individually and give her opinion as to whether or not there had been a breach of the Code.

The Provisional Opinion concluded with the Commissioner listing her proposed recommendations and explaining that the midwife had a right to make submissions on those recommendations. The Commissioner would also identify the organizations or individuals to whom she intended to circulate the Final Opinion. In serious cases the Commissioner advised the midwife of her intention to forward the opinion to the Director of Proceedings for a determination whether the complaint should be taken further (Section 45(1)(f)).

Under the HDCA, the midwife’s right to be heard before the Opinion is finalized does not include a right to an oral hearing. With so many cases and with often large numbers of parties, a routine right to be heard in person by the Commissioner would be an intolerable burden. The refusal of an oral hearing, is not necessarily a denial of natural justice, provided a party is given a fair and adequate opportunity to present his or her case. The Commissioner gives effect to that right by enabling the provider to provide written submissions in response
to the Provisional Opinion.

**A Final Right of Response**

After receiving the Provisional Opinion the provider usually needed to rapidly respond to a considerable amount of new evidence, and possibly new allegations, with no further disclosure. This was a considerable burden; particularly where there was a previously unseen adverse expert opinion. Sometimes such expert advice would come as quite a shock for the midwife. The burden was compounded where the expert appeared to be unaware of key or relevant evidence in the case, or where the midwife considered that the expert had given advice that did not reflect accurate research or reasonable practice. In these cases the midwife had a very short time-frame to find and instruct her own expert to try to controvert the evidence of the Commissioner's expert. This had to be done in a short time frame before the Preliminary Opinion was finalized. With the first Commissioner a midwifery provider was given an average of three weeks to reply to the Provisional Opinion, even where the investigation had been delayed for two to three years. On some occasions, short extensions would be granted for the midwife to compile and adduce further evidence.

The principles of natural justice establish the right for respondents to persuade the decision-maker as to their 'guilt or innocence' but additionally they give a right for an affected person to address the question of an appropriate penalty. Part of the provider's response to the Provisional Opinion needs to address the recommendations of the Commissioner and whether they are reasonable, or even possible, in the circumstances. An additional point for practitioners is that, where the finding of Breach is accepted, it is helpful for the provider to inform the Commissioner what they have learned as a result of the complaint and investigation. This may include any education or up-skilling they have

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208 *Malone v Marr* [1981] 2 NSWLR 894, was a case where the plaintiff sought a declaration that his suspension from the Rugby League Club was null and void, and to overturn an injunction in order to continue to enjoy the benefits of membership. The Club's failure to allow the plaintiff to make submissions on penalty was a breach of natural justice. *R v. Thames Magistrate's Court, ex parte Polemis* [1974] 1 WLR 1371: 1375, the Court held that the right to notice extends to giving a person a reasonable amount of time to prepare a response.

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undertaken, any changes they have made to their practice, or processes they have put in place, to try to avoid a recurrence of the breach. This information can be reassuring to the Commissioner and also to the complainants, who may find some solace in knowing a lesson has been learned or practice changed as a result of their complaint.

A good example of a midwife proactively trying to ‘put things right’ was 97HDC7147. The background was that a GP and the midwife (Midwife F) provided shared-care. This was another “jaundiced baby” case. The labour was induced and closely monitored and an instrumental hospital birth occurred. The baby had a large haematoma on its head from the difficult forceps delivery. The baby developed jaundice but was discharged home after a medical assessment. The jaundice persisted and the midwife wanted to do a blood test, but she was aware that the laboratory did not do these over the weekend. She rang and discussed the jaundice with the paediatrician and told him that, apart from the jaundice, the baby appeared well. He recommended a test on the Monday morning and said that if the result was elevated the baby could be admitted. The midwife discussed this advice with the parents. That afternoon the baby did not wake for feeds but the midwife was not contacted. On the Monday the baby was tested and the jaundice level was high. The baby was admitted for phototherapy. The jaundice rapidly improved but the midwife received a message from the parents that they no longer wanted her to provide care.

In this case the parents contacted an Health Advocate about the midwife. A meeting was held which the parents did not attend. After the meeting, having been told of the parents’ complaints, Midwife F wrote to the parents acknowledging their dissatisfaction and explaining the actions she had taken to try to address their concerns. They remained unhappy and formulated a new set of complaints which were forwarded to the Commissioner. An investigation was commenced eight months after the birth.

There were a number of mixed fact/allegations about the labour including that the consumer’s membranes were ruptured for 30 hours, which was a fact and she was in labour for 36 hours which was a fact. Another fact was that the baby developed foetal distress and had a CTG baseline of 80 for several minutes. When the drop in the baby’s heart beat occurred, medical assistance was promptly called. The midwife was not found in breach in relationship to any of the pregnancy or labour care.
The grounds of the complaint shifted but the Commissioner investigated and eventually found that while the midwife had acted appropriately and promptly during the labour and difficult birth, she had breached Right 4(2) because she failed to take a blood test on the Sunday and failed to ensure breast-feeding was established. (The midwife stated at all times that the clinical condition of the baby indicated that feeding was established.) The midwife was also found to have breached Right 6 (1) (b), because although she noted the baby’s jaundice and discussed this with the parents, the Commissioner found that she did not discuss testing options. The Commissioner said she found no evidence of the midwife’s advice to give the baby adequate fluids (although this was documented), but she eventually accepted that the midwife had asked the mother to keep a feeding diary for the baby, and she had documented this.

The midwife took the complaint very seriously and immediately began extensive attempts to change both her own practice and that of the local laboratory and hospital, to ensure this did not happen again. By the time of the Provisional Opinion she had attempted to negotiate weekend testing with local laboratories; had found an alternative after-hours laboratory service for blood tests and informed local midwives about this; she was producing a diary of community contacts for midwives; was lobbying the hospital for weekend access to the hospital laboratory so that babies did not need to be admitted to hospital before they could have a blood test; she had been active in developing resources and requesting the development of guidelines to ensure wider hospital and laboratory support for midwives caring for jaundiced babies in the community; and she was educating other midwives locally about jaundice.

The Commissioner did not refer to any of the midwife’s initiatives to effect change in the Final Opinion. This was unfortunate, as the midwife’s determination to turn a complaint into better services could have been a positive example for other practitioners facing a complaint. Furthermore the midwife’s attempts to avoid a similar thing happening again could have been instructive to other practitioners who were seeking to improve their own local laboratory access and hospital support, for jaundiced babies.
The Final Opinion

The Final Opinion was usually released a very short time after the midwife’s response was received. Sometimes there were alterations to the Provisional Opinion as a result of the new evidence provided by the midwife, but at other times wrong facts were not corrected. An example was in the case discussed above where the case note persists in saying the Commissioner found no evidence of the midwife’s request that the mother keep a feeding diary. This was despite the midwife having clearly documented the advice and the Commissioner accepting this evidence when it was given in response to the Provisional Opinion. Other examples of where inaccurate evidence remained unchanged were 97HDC7147/MC where there was a persisting allegation that the midwife did not take a test requested by a consultant, despite the midwife’s denial and undisclosed evidence from the consultant that she did not request the midwife to take this test. In HDC5342 the opinion states that the woman’s ‘waters were broken’ for 56 hours when they were broken for 46 hours. This was an important factor as 48 hours is a key cut off point in decision making. In HDC 8623/AD there was a statement that the midwife did not visit the woman for the first few days after the birth but the woman was in hospital hundreds of miles away under secondary care. In 98HDC11321A/VC the opinion wrongly stated that the midwife prescribed a repeat prescription despite the documentation on the script itself, the midwife’s denial, and the pharmacist’s admission that she dispensed this unauthorized three month repeat.210

Recommendations

Where there is a finding of breach of the Code, the Commissioner is empowered to make wide-ranging recommendations. These are usually aimed at providing some acknowledgement and redress for the consumer and preventing similar breach situations.

210 The pharmacist’s case and admission is contained in 98HDC11321/VC.
happening in the future. Under s 46 of the HDCA the Commissioner may request a provider found in breach, to inform the Commissioner how she or he proposes to give effect to a recommendation. The recommendations are not legally enforceable but failure to comply with recommendations can have adverse consequences for the provider. If no action is taken by the provider within a reasonable time, the Commissioner shall do several things:

a) Consider (if any) the person’s comments.

b) Inform the complainant of the recommendations.

c) Make such comments on the matter as the Commissioner sees fit.

d) Report to the Minister [of Health].

The Commissioner might also threaten to go public with the complaint.

Most recommendations of the Commissioner in the midwifery opinions were reasonable and commonly included such things as a request for an apology, a recommendation that the practitioner up-skill in some areas, improve communication, undergo mentoring, upgrade equipment, or keep better records. There was however one midwifery case where the recommendations seemed excessive. In that case, against Midwife C (See Appendix A) the Commissioner made a raft of recommendations. She required the midwife to make an apology and she recommended that the midwife be open and honest in addressing of consumers concerns (although there had been no allegation nor evidence of a lack of honesty or openness by anyone at any point). Other recommendations included the following:

• [Midwife C] discusses the opinion with the New Zealand College of Midwives ["NZCOM"] and operates under close supervision until the matter is heard before the Nurses [sic] Council or a decision made not to proceed.
• [Midwife C] informs all consumers of this opinion and that the matter is pending.
• A list of her clients should be sent in confidence to the Commissioner monthly as evidence that they have been informed.

The reference to the midwife discussing the opinion with NZCOM in the recommendation was inappropriate as NZCOM is a professional not a disciplinary body, and the matter was still sub judice.

The second recommendation being carried out even though the complaint was about a single incident and in the two years between the birth and the provisional opinion the midwife had been practising in a safe and competent manner. There was also concern with the recommendation that the midwife provide the Commissioner with a monthly list of clients. The Commissioner was advised that compliance with this recommendation would potentially breach Principles 3 and 6 of the Privacy Act 1993, as providing the clients’ names to the Commissioner could not have been envisaged when the personal information was first provided by the women to the midwife. The Commissioner was asked to withdraw the recommendation so as not to place the midwife into a potentially unlawful situation. 212

The Commissioner also recommended, two years after the stillbirth in question, that the midwife set up a stringent supervision arrangement. (This was something the midwife would have to fund herself.) A rationale for this requirement was sought but not given. The difficulty in implementing the recommendation came about as follows. Under the law at that time such supervision could only be voluntary, as the Nursing Council of New Zealand was the only statutory body able to mandate supervision for a nurse or midwife. Supervision was a penalty that was to be legally imposed after a full disciplinary hearing, a finding of professional misconduct and a decision that supervision was the appropriate penalty in the

212 The recommendation also raised the question as to whether the Commissioner planned to phone the listed clients to follow up on whether they had been told of the pending action, or to perhaps ask other information about the care they were receiving. As the prospect of further disciplinary proceedings had been raised by the Commissioner, this was a concern.
circumstances. None of these steps had occurred as no charge of professional misconduct had been laid. Arguably the Commissioner was asking the midwife to self-impose a restriction on her practice that would normally only occur following professional misconduct finding and penalty.

The midwife, due to fear following the naming of her colleague, and fear that the Commissioner would also publicly name her should she not comply with the recommendations, decided that she would voluntarily submit to supervision. She attempted to give effect to this recommendation but it proved impossible to arrange as most midwives were too busy or "scared off" by the Commissioner's recent publicity. Midwife C was unable to arrange the supervision to the level the Commissioner required. In informing the Commissioner of this in her reply to the Provisional Opinion, the midwife advised that she would give up midwifery, until the case was finalised. As the midwife was no longer practising many of the recommendations then served no purpose. However in the Final Opinion the Commissioner retained the recommendations of apology, supervision, discussion of the case with NZCOM, and that the midwife inform consumers of the complaint, something the midwife had already been doing until she stopped practice. The Commissioner withdrew the requirement for Midwife C to provide lists of names of clients but then added a completely new unseen recommendation, which was that Midwife C liaise with specialists to ensure that her [then non-existent] client's had access to urgent assessment.

Procedure After Investigation

Once an investigation is completed, the final consideration as to whether there is a breach of the Code is inevitably subjective. It is the Commissioner and only the Commissioner who makes the ultimate decision of whether an action [or inaction] amounts to a breach. There is no right of appeal for such an Opinion. The only redress for a provider or consumer who is unhappy with the Commissioner's decision is, where there are legal grounds, the costly option of judicial review or a complaint to the Ombudsman.
Under section 45 of the HDCA, where after investigation the Commissioner is of the opinion there has been a breach of the Code, the Commissioner may:

a) Report the opinion to the provider with reasons and make such recommendations as the Commissioner sees fit, including a recommendation that disciplinary actions be taken against any officer or employee of a provider.

b) Report the opinion to purchasers, any other health professional body, or any other person that the Commissioner considers appropriate.

c) Report to the Minister of Health.

d) Make a complaint to any health professional body about any person.

e) Where a person wants to make a complaint, assist them to do so.

f) Refer the matter to the Director of Proceedings.

In most cases the reporting by the Commissioner included distributing copies of the opinion to the respondent(s), the consumer or complainant; the Nursing Council of New Zealand; the professional associations such as the New Zealand College of Midwives or New Zealand Nurses Organisation for educational purposes; the midwife’s employer; the Minister of Health; and various other parties such as the Maternity Services Consumer Council. In almost every case the opinions were anonymized. There was one midwifery case that was an extraordinary exception to that practice. The involvement of the Commissioner in the unprecedented publicity surrounding that case, was controversial and unexpected. Before discussing these events, it is helpful to consider the pressure the Commissioner was facing during that time.
CHAPTER EIGHT: GROWING PRESSURE ON THE COMMISSIONER

In the first years of the Commissioner's jurisdiction, health consumers, politicians and health professionals and some lawyers including this writer, were increasingly concerned at the long delays in resolving even apparently minor HDC complaints. Over the 1997-98 year the Commissioner's Office struggled with its increasing work-load and financial constraints. A target had been set that 95% of complaints would be closed within 26 weeks of receipt of complaint, but this target was dropped when only 74.2% of closures were achieved.\textsuperscript{213} As cases lingered, friction grew between provider organizations and the Commissioner. Additionally during the years 1997-1998, the Commissioner was facing parliamentary pressure about the small numbers of complaints proceeding to disciplinary hearings. In 1998 a medical defence lawyer, Gaelene Phipps, reported that while there had been an unprecedented increase in complaints against doctors, there had been a decrease in the numbers of extensive hearings. She was concerned at the amount of time that doctors had to spend on 'specious' complaints such as those directed at "a doctor's manner, tone of voice, and demeanour".\textsuperscript{214} The Commissioner replied to this criticism writing that comments such as "My doctor was rude to me" were valid in the Code environment and must be taken seriously.\textsuperscript{215} She also mentioned what she termed as "grumbles" about the HDCA process which ranged from:

\begin{quote}
concerns about apparently trivial complaints being investigated, to the system being too weighted in the consumer's favour, to claims that no right of reply is available before an opinion is finalized. On the other hand I am
\end{quote}

\textsuperscript{213} The United Kingdom Health Commissioner has a "Quickie Unit" that aims to handle 60% of the complaints in two days. In 1986 there was criticism by the Select Committee when the time to complete an investigation rose to 47 weeks. They insisted the office speed up.


sometimes criticized for not bringing enough cases before disciplinary bodies.216

While there was certainly a consumer and parliamentary concern about the lack of cases being prosecuted, the Commissioner was also coming under increasing criticism for not giving priority to significant complaints. The following are examples of these criticisms, although the final example arose after the case we are about to discuss.

(a) The Northland Amputee Service

A number of complaints had been received about the services provided to Northland amputees by their service provider, Rehabilitation Management Ltd ("RML"). The first complaints were made to the Commissioner as early as April 1997, stating that limbs had gone missing when sent for repair; that some consumers were allegedly told that repair was not possible; that repairs were not done properly or limbs did not fit well, and that there were long delays in getting care. The Commissioner promised to conduct an Inquiry into RML on behalf of consumers but after two years, nothing had been resolved.217 The complainants went to a prominent Member of Parliament, Jim Anderton, who at first attempted to use political pressure to effect action. Frustrated with the continuing lack of progress, he made a formal complaint to the Ombudsman in June 1999. Mr Anderton later described the Ombudsman’s report about the Commissioner as “damning”. He was quoted as saying:

The complaint was made back in 1997 and now it’s the year 2000. This was a matter of urgency. You couldn’t get a worse case. These people were treated terribly. I couldn’t believe I could get no action for vulnerable amputees from a Health and Disability Commissioner.218

216 Ibid.
When the Ombudsman’s decision was released the Ombudsman was quoted as saying:

To give an assessment of a completion date and not adhere to it, on the grounds that other things are occupying your time is, in my opinion, not a valid basis for failing to accord the matter the priority that was promised. I have therefore sustained Mr Anderton’s complaint. 219

Mrs Stent’s response was: “Where should the Commissioner’s priorities lie? Should I just drop everything else for a week to work on this file?” 220 The Commissioner said that she hoped to complete the report that week, her last in office. Unfortunately by that time it was too late: the RML had been wound up and the Regional Health Authority abolished.

(b) A Bogus Psychiatrist

A further criticism of the Commissioner’s priorities came from the Alliance Health Spokeswoman, Phillida Bunkle. She was critical of the investigation into “Dr Linda Astor. Dr Astor” a male posing as a female psychiatrist, who had worked at Nelson and Hutt Valley Health. Patients and their families had become concerned about the type of treatment, including shock treatment, which Astor was using. They approached Ms Bunkle in September 1997 with their concerns, and the Commissioner’s office was requested to undertake an investigation into Astor and her treatment of patients. The Commissioner apparently refused to do this. Ms Bunkle was later reported as having criticized the Commissioner’s refusal in Select Committee saying “If that case cannot be investigated by

219 “Amputee Service Complaint Upheld” The Dominion, (29 January 2000).

the Commissioner, then the way the Commissioner's office is run is very seriously flawed.”

(c) The Complaint of Mrs Colleen Poutsma

The Commissioner was also criticized for the low priority, she gave to the complaint of Mrs Colleen Poutsma against her obstetrician-gynaecologist. The Commissioner received a complaint from Mrs Poutsma who had terminal cancer in April 1998. The investigation was still ongoing when the new Commissioner was appointed in March 2000. The second Commissioner Mr Ron Paterson, investigated the file and referred it to the Director of Proceedings. Mr Paterson was also obviously concerned about the long delay when the complainant was so gravely ill. He described the delays as “inexcusable” and took the unusual step of phoning and apologizing both personally and publicly to the Poutsma family. He stated that he was committed to ensuring that in future a person in a similar situation to Mrs Poutsma would have their case dealt with as a matter of urgency.

The delays did not only concern consumers and their families, and politicians, they also greatly concerned health practitioners, who having been the subject of a formal complaint, were effectively having to put their lives, practices and family plans on hold until the

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221 Bunkle, Phillida New Zealand Parliamentary Debates, 567 (26 March 1989): 7887, 7889. Boland, Mary Jane. “The Politics of Health” The Evening Post, (10 July 1999) See McLoughlin, David. “In Face to Face – Robyn Stent” North & South, (February 2000): 100 where Mrs Stent says that she had done more than Ms Bunkle reported and that her Office was planning a big investigation, but it had taken too long to progress. See also Chisholm, Donna. “Stent bows out bullied but unbeaten.”Sunday Star Times (11 July 1999): where the Commissioner spoke of a lengthy inquiry which she made leading to a string of suggestions to hospitals and the Medical Council.

222 The MPDT got the charge in July 2000 and the chair of the Tribunal Wendy Brandon was interviewed and said “I think it is appalling that somebody who had a personal tragedy has to hang in there for two or three years for their day in court.” Calder at Large (interviewing Wendy Brandon) “Matters of Life and Death” New Zealand Herald (9 September 2000).


Commissioner allocated time to further the investigations. Delays of two, three, or even four years occurred. There was a growing concern that people would be unable to recall events, that key witnesses would move on or be lost, and that both defense and prosecution would be compromised.\(^{225}\) The cases were backlogged, and it appeared to me during that time that this was particularly true of cases that were emotionally difficult or more complex. The delays were becoming an embarrassment to the Commissioner.\(^{226}\)

In my view, a significant reason for the delays was the decision of the Commissioner to institute the Canterbury Health Inquiry. The resources committed to this lengthy investigation meant it was inevitable that other areas of the Commissioner's work would be set aside or given a lower priority.\(^{227}\)

The next section will consider the complaint against "Midwife B". At the time of this case, there was growing parliamentary pressure on the Commissioner to increase the

\(^{225}\) Paterson, R. "Notes from the first year." Womens's Health Watch, (September 2000): 8. speaking at the 12\(^{th}\) Anniversary of the Release of Cartwright Report on 2 August 1998. He said "Some very public investigations have taken two or three years. There are still far too many in the system from 1997 (a few) and 1998 (quite a lot). It is very difficult, particularly in hospital settings where staff change anyway, to investigate matters that go back to 1997 or even 1998. Getting the time down makes it so much easier, because matters are relatively fresh in people's memories". When Mr Paterson took up the position of Commissioner on 4 March 2000 he inherited a backlog of 790 cases and by November of 2000 had reduced this to under 575. A record 1,303 complaints were closed and 1,088 new complaints received. This was the first year that the Commissioner cleared more complaints than were received. (Paterson, R. "Commissioner Releases Annual Report" HDC Press Release (16 November 2000).

\(^{226}\) The injustice of delay in the criminal context was discussed in Herron v. AG for NSW (1987) 8 NSWLR 601: 607 where it was held that although there is no constitutional right to speedy trial in Australia, England and New Zealand, the common law had repaired the constitutional and statutory omission and extended it in particular cases. Reasons to avoid delay include the public interest in the due administration of justice and the enforcement of the law, and the public and private interests in a speedy trial and the avoidance, inter alia, of the kinds of prejudice to persons at risk before Courts and tribunals.

\(^{227}\) Coney, Sandra. Sunday Star Times, (22 February 1998): 6. Ms Coney was critical of the long delays over the Report and contrasted the Commissioner's decision to conduct private hearings with her actions in revealing the case of Midwife B. It should be noted that the eventual Canterbury Health Report was comprehensive and the findings vindicated the Commissioner's decision to commence an investigation.
number of disciplinary proceedings against health practitioners. The way the complaint was
dealt with also raises a number of seminal natural justice issues including whether the
Commissioner should have publicly named the midwife part way through the statutory
process, prior to charges being laid by the Director of Proceedings.

"A particularly unfortunate set of circumstances really". 228

Midwife B was an experienced nurse and midwife. She had never been the subject of
a complaint and had an excellent professional reputation. Midwife B and a colleague were
providing care for Ms X who was expecting her first baby. Ms X was hoping for a non
interventionist birth. The relationship was described by all witnesses as mutually warm and
supportive. Ms X was admitted in early labour to hospital by Midwife B and a tracing of her
baby’s heartbeat was done. There is a wide variation in the length of such tracings and many
hospitals do not even require a tracing at that stage. However in the hospital to which Ms X
was admitted it was usual to do a 20 minute trace. Midwife B was unable to trace the baby
for that long as the mother became uncomfortable. Midwife B assessed the admission tracing
and considered that, although it was not as reactive as usual, it was satisfactory and possibly
indicated a sleeping baby. She meant to repeat the tracing once she had dealt with Ms X’s
pain, which was considerable.

Ms X had a bath, and asked her midwife to leave to give her and her partner privacy.
Midwife B then arranged for Ms X to have Pethidine, hoping to trace the baby. The Pethidine
was ineffective and so Midwife B recommended the use of gas. She was closely involved,
coaching and supporting Ms X through her contractions, and attempted to place the monitor
to trace the baby’s heart beat. Midwife B was able to do this for a short time but Ms X’s
pain increased and her movements would not enable further tracing. The heart beat showed a

article the Commissioner was asked about naming the midwife. She replied “That was a particularly
unfortunate set of circumstances really. The midwives will always blame me for that public naming.
In fact the media had that story, they came to me with it. When I realized there was the potential for
misreporting, I quickly put out the opinion on the case... ".
reduced variability which Midwife B considered could be due to the Pethidine but she wanted to do a longer tracing and get Ms X sufficiently comfortable to rupture the membranes. This would enable her to see the colour of the amniotic fluid. Midwife B suggested that Ms X consider an epidural, hoping that this would give Ms X enough relief to enable her to lie still so that the membranes could be ruptured. Ms X and her husband took time to consider and discuss this option and asked the midwife to first check the cervical dilation and progress. Little progress had been made. Ms X asked the midwife to leave while they considered an epidural and she eventually agreed to the epidural. The anaesthetist was called to the hospital and Ms X was moved to a room where the epidural was placed. Initially there was some difficulty in commencing the procedure and this caused a delay. Once consent was gained, the anaesthetist sited the epidural. Midwife B assisted getting equipment and drugs, assembling infusions and carrying out the close monitoring of the maternal blood pressure that always follows the epidural insertion. She attempted to listen intermittently to the baby but the epidural was not effective and the distress of Ms X continued. It took some time for the anaesthetist to get the epidural working effectively. Midwife B assisted and continued to coach Ms X in the interim. Eventually Ms X was able to tolerate the midwife rupturing the membranes. The fluid showed worrying signs and the midwife immediately called the on-call obstetrician. (There was no 24 hour on site obstetrician at that time). There is conflicting evidence on how long he took to arrive but during this time the baby’s heart tracing deteriorated. Once he arrived, he assessed Ms X and discussed whether he would do an instrumental delivery or proceed to caesarean. A caesarean was eventually carried out some 40 minutes after his arrival, although later evidence was that the hospital should have been able to arrange this sooner.

The baby was born in a critical condition and although initially seemed to stabilise, the baby later deteriorated and was transferred to the base hospital Neonatal Unit. After some time the medical team advised that the ventilator would be turned off with the expectation that the baby would die. This was done, but the baby did not die. The medical team in consultation with the parents, advised that food and fluid should be withheld from the baby. The compounding part of this tragedy was that the baby continued to live and he was later discharged home in the care of his parents. The baby survived five weeks.
A complaint against Midwife B was laid by the attending obstetrician immediately after the birth. The hospital set in place a careful supervision arrangement negotiated with Midwife B, requiring her to be supervised at all times while she was providing midwifery care on hospital premises. Midwife B voluntarily told all her clients that she was being investigated in a case where a baby had died and gave them the option of changing caregiver. Very few did so.

Midwife B was notified by the Commissioner of the complaint on 12 February 1997. It alleged that Midwife B should have monitored the baby for longer on admission; that she did not act soon enough to obtain a longer tracing of the baby's heart; that she delayed for an inappropriate time before obtaining an obstetric consultation during the labour and that she failed to give Ms X enough information to choose her options. The Commissioner advised that an investigation had commenced and indicated that if she found a breach of the Code, she might make a report or recommendation on the matter, or might refer the complaint to the Director of Proceedings (who would decide whether action before the Complaints Review Tribunal or a health professional disciplinary body was warranted). These latter options were expressed as alternatives in the notification letter. As requested Midwife B provided a statement to the Commissioner and sent copies of the notes. In April of 1997 the Commissioner inquired about supervision and the hospital confirmed that a supervisor was present at all times during any hospital labour and birth that Midwife B attended.

During the investigation a large amount of evidence was gathered but the Commissioner did not disclose the statements of witnesses, the expert reports, (even though unbeknown to Midwife B these were also being shared with the Police and ACC for their separate investigations), some of the clinical notes, and a number of other documents. The

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229 There were also complaints about other providers including the hospital but these were later dropped.

230 Midwife B believed the Police involvement was because of the Coroner's involvement. It was only later through the media that Midwife B learned that the Police had considered criminal charges for "medical manslaughter". The Police were advised that this was not a case of criminal negligence and no charges were laid.
Commissioner's Preliminary Opinion was issued on 23 July 1997 and the midwife was given a further opportunity to comment. That opinion found that Midwife B had been in breach of the Code and the Commissioner indicated that she would send her report to the baby's parents, and to various other bodies. The Commissioner requested the midwife to discuss with Nursing Council and the New Zealand College of Midwives, whether she should continue practicing pending a possible Nursing Council hearing. NZCOM was not the appropriate body for the Midwife to be talking with as it had no role in such matters. The direction to discuss the case with the Nursing Council was also unusual. The Nursing Council had no legal jurisdiction to impose restrictions on a midwife's practice prior to a full disciplinary hearing, a finding of professional misconduct and a determination that such restrictions were an appropriate penalty.

The jurisdictional difficulties were confirmed by NZCOM and the Nursing Council and the Commissioner was advised of these views. She was also assured that the strict supervision arrangements for Midwife B, remained in place. In the Commissioner's response regarding this advice, she accepted that there was no power to impel a midwife's suspension before hearing and she appeared satisfied with the explanations. The Commissioner wrote to Midwife B that, as these matters had been discussed with the recommended bodies, she had carried out the recommendations. The Commissioner's Final Opinion was issued on 21 August 1997. It found Midwife B in breach of four aspects of the Code and advised that a case note had been prepared for education purposes. These case notes were always non-identifying. The Commissioner advised Midwife B that she was referring the complaint case to the Director of Proceedings, and that the Director would determine whether disciplinary proceedings would be brought before the Nursing Council or whether a claim would be laid with the Complaints Review Tribunal. At that stage there appeared to be no urgency from the Commissioner. There was certainly no indication that the Commissioner would publicly discuss the case or name the midwife. Instead, it seemed that in accordance with her usual practice, the Commissioner would anonymize the complaint and circulate the opinion as stated.
On 24 September 1997, significant criticism of the Commissioner was expressed in Parliament. The question was asked why the Commissioner, having received 1000 complaints in her first year, had referred none of these to the Medical Council, the Nursing Council, the Dental Council or the Pharmaceutical Society. Mr Bill English, then, Minister of Health, replied that the Commissioner had advised him that in her opinion all the complaints had been dealt with satisfactorily by advocacy and mediation. According to the Commissioner, it was up to the Director of Proceedings to decide if further disciplinary proceedings were warranted. The question was then asked why no practitioners had been taken to the Proceedings Tribunal (the correct name which was then the Complaints Review Tribunal). Mr English replied that he had been told by the disciplinary bodies there were 'some technical problems with the way the legislation allowed for transmission of complaints'.

The attacks against the Commissioner continued in Select Committee. In October 1997 the Dominion reported:

_The Health and Disability Commissioner's failure to lay any complaint with Registration Boards for health professionals — such as the Nursing Council — in its first year of office was the focus of a strong attack at a parliamentary select committee last month..._  

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231 Calder at Large (interviewing Wendy Brandon) “Matters of Life and Death:” _New Zealand Herald_ (9 September 2000). Ms Brandon said that the Medical Practitioner’s Disciplinary Tribunal had previously dealt with about 70 cases a year but in 2000 it dealt with only 5.


The Commissioner was away from her Office from 6 to 13 October, and was reported as saying that during her absence the media approached the office asking about the case of Midwife B. The Commissioner later stated that the queries were about the progress of the investigation, and that the media wanted a “comment on the case”. The Commissioner’s usual practice was not to comment on individuals. It is important to note that at this point in the proceedings, the decision whether the Director of Proceedings was going to lay charges against the midwife before the Nursing Council was still pending. The disciplinary process was incomplete and arguably the matter was sub-judice. On her return the Commissioner apparently reviewed or was advised on the HDCA, and agreed to tape an evening interview with National Radio about the case, to be played on National Radio the following morning. The Commissioner spoke with the CEO of the hospital where the birth had taken place, because she was concerned that following the broadcast, the hospital would be inundated with calls. The Commissioner did not speak with Midwife B or inform her that she was planning to publicly name her, nor did she give Midwife B an opportunity to make submissions on this publicity or to apply for name suppression.

The taped interview with the Commissioner, was played the next morning at 6am. The Commissioner did more than comment on the case: she named the midwife. She also retrospectively released the Final Opinion, making it available to everyone. The parents were not named and later said that the publicity had taken them by surprise. The Commissioner later made several different justifications for the naming of the midwife. These included that she was preventing speculation and ensuring the facts were known.235 The Commissioner

235 As the debate around the Commissioner’s publication of the midwife’s name continued, Mrs Stent made a number of changing justifications to explain why she had taken this action. Among them that other midwives might be under a cloud. Arguably the Commissioner did not need to name the midwife and could have just stated that the midwife was practising under strict supervision and had told all her clients about the complaint. This possibility was noted in a complaint to the Broadcasting Standards Authority, one of four successful complaints against the media about the inaccurate reporting about this case. The Authority noted the view of the complainant Maternity Consumer Council that that media item neglected to mention that all clients from the midwife’s practice were informed a case was pending against her and that the general public and health professionals did not need the protection allegedly provided by the disclosure of her name and identity on national television. Maternity Services Consumers’ Council v. TVNZ, 1998, 41, 30 April 1998.
also justified her action on the grounds of public safety. She was said to be concerned that Midwife B was still working, although the continuing supervision arrangements were still in place, so this concern seemed difficult to justify. Midwife B was also telling the women she cared for about the complaint and giving them the choice to have another caregiver.

During the morning of 15 October 1997 the Commissioner gave a series of interviews and made increasingly adverse allegations against Midwife B, among them the untrue and extremely damaging statement that the midwife had refused the parents’ requests to call a doctor for four hours.\(^\text{236}\) Midwife B was unable to respond while proceedings were only partially completed.\(^\text{237}\) As the media debate continued commentators challenged the

\(^{236}\) Mrs Stent made inaccurate assertions which she did not retract nor publicly correct, despite being asked to do so by a lawyer for the midwife. The Commissioner commented that it was the most serious midwifery case that she had seen, when in fact it was the only midwifery case to have progressed that far through the Commissioner’s jurisdiction. A further inaccuracy was that the Commissioner blamed the delay in bringing proceedings on the Nursing Council. When asked if nothing could be done about the long delay between the Commissioner’s finding and the Nursing Council sitting in judgement, the Commissioner said on Morning Report “Well the Nursing Council sets their own unm times for hearing these things and its over to them. You should ask them that question” Morning Report, Item: “Death of a Baby – Hutt Hospital last year.” 15 October 1997. 7.41am. In fact the Nursing Council was not to blame, as it cannot act until the Director of Proceedings actually does lay a charge. At this time the midwife had not been notified whether the Director planned to do this and the matter was still pending at the Director’s office. The Nursing Council had not received a complaint and so was unable to do anything. See also National Radio, 15 October 1997, 6am, 9am, 10am News Bulletin, where the Nursing Council confirmed that if the Commissioner had considered the case to be urgent back in August when the Final Opinion was made, she could have asked for it to have been heard.

\(^{237}\) Midwife B made a formal complaint to the Privacy Commissioner. Part of her reason for doing so was because of the effect of the publicity on the practice for whom the midwife worked. The publicity had impacted negatively on the other midwives, who were not implicated in the complaint, and on their families. The midwifery practice eventually closed. Midwife B considered that the Commissioner acted in bad faith with respect to the publication. She argued that the public is never well served by the publication of inaccurate and damaging information and that as the role of the Health and Disability Commissioner is crucial, both the public and health professionals need to have complete confidence that the Commissioner will act fairly and correctly. After an initial reply to the Privacy complaint, the Commissioner would not respond to what the Privacy Commissioner described as “valid matters”. The Commissioner refused to answer any further questions about her actions and motivations. The Privacy Commissioner did not accept the Commissioner’s argument that she was exempt from compliance with Principle 11 of section 7 of the Privacy Act 1993, but ultimately without her co-operation in the investigation, the Privacy Commissioner had insufficient evidence to conclude the Commissioner had acted in bad faith and he found that the substance of the complaint could not be established.
Commissioner, arguing that the public naming and condemnation of Midwife B jeopardized any possibility of her obtaining a fair hearing should the matter be taken further. 238 Despite the criticisms, the Commissioner remained defensive, and at least publicly, unrepentant.

Forbes notes that public knowledge of a serious disciplinary charge often exposes the subject to stress, embarrassment and prejudice, if not to immediate professional or financial detriment. 239 This was certainly the case for Midwife B. 240 The media coverage of Midwife B that resulted from the Commissioner's publicity, and the publicity that followed, resulted in the midwife being subjected to harassment and unwarranted attention and abuse whenever she ventured out from her home. 241

Publicity and the Health and Disability Commissioner Act

This section will consider whether the Commissioner was entitled to publicly name Midwife B in this manner?

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238 Assignment Programme 34, Cat. No.: Zassi 97-34. 29.10.97. As a result of the publicity the midwife voluntarily surrendered her access agreement, after indications that the hospital was coming under increasing pressure about her continuing practice. She lost her livelihood and the women she was to provide care for, had to find a new midwife. On the morning of the interview, Midwife B described herself, her elderly parents and extended family waking to a media furore. As a direct result of the Commissioner's publicity, the media laid in wait outside the midwife's home and she was secretly filmed. When broadcast, this footage was slowed down and transmitted in a manner that the Broadcasting Standards Authority later described as giving "a sinister air" to the footage. They found this to be a breach of the midwife's rights.


240 By December 1997 the Commissioner had made an apparent "U turn" and was criticizing doctors who went to the media about their dissatisfaction with the Commissioner's process during investigations. She lamented their right to "free speech" while saying she was constrained by fairness and could not comment on cases before the outcome is complete. She said "Even at the conclusion [I] have to consider the impact on the provider's livelihood, on subsequent proceedings and on the vulnerable consumer before making public statements." Stent, R.S. "When the going gets tough." New Zealand General Practitioner (16 December 1998).

Section 14 (d) of the HDCA empowers the Commissioner to publish reports and make statements. The relevant subsection states:

(1) The functions of the Commissioner are as follows:

... (d) To make public statements and publish reports in relation to any matter affecting the rights of health consumers or disability services consumers or both, including statements and reports that promote an understanding of, and compliance, with the Code or the provisions of this Act:

The Commissioner had previously stated that she would not discuss the details of individual cases with the media. It had, however, been the practice of the Commissioner to publish non-identifying reports and case notes for education purposes. This was in line with the practice of the Privacy Commissioner and the Ombudsman. The publishing of such reports is a critical and important function of the Commissioner. Such reports provide a unique educative opportunity for providers so clinical practice may be improved by taking heed of the salient experiences of others. It can also reassure the public that there are consequences for poor practice, and that the Office of the Commissioner is fulfilling its functions. The issue in this case was not the provision or even the circulation of the report about Midwife B and its recommendations. Had that been done at an appropriate time and way there would have been no controversy. The issue was that, of all the practitioner’s who had been subject to the Commissioner’s jurisdiction, this one midwife was singled out and named.

Section 45 (b) of the HDCA allowed the Commissioner to report his or her opinion, with reasons, together with recommendations (if any) as the Commissioner sees fit, to all or any of the following:
When the Commissioner sent the Provisional Opinion to Midwife B for comment, the Commissioner indicated that a copy of it would be going to the purchaser (Central Regional Health Authority), the professional body (the New Zealand College of Midwives), the Chief Executive Officer of the hospital, the parents and the Police. Midwife B was able to make submissions on this Opinion and the proposed circulation prior to it being finalized in August. In the Final Opinion the Commissioner did not state that the Opinion would be sent to any other person nor did she state that she at any time intended to publicly name the midwife or make adverse comment against her in the media. The possibility of publicity was never mentioned. When the Commissioner sent out the Final Opinion to the named bodies, she did so with a covering letter stating that the midwife had been advised that a copy of the opinion was being sent. The fact that the Commissioner ensured each named body knew the midwife had been given notice that they would receive a confidential copy of the Final Opinion, makes the lack of notice of the mid October publicity even more surprising.

In justifying her decision to name Midwife B, the Commissioner at one point cited section 65 of the HDCA. This section gives the Commissioner a broad immunity from civil or criminal proceedings if it can be proven she acted in good faith. The Commissioner also relied heavily on section 59. That latter section states that an investigation under Part IV of the HDCA may be conducted in public or private and that:

(4) Without limiting any other provision of this Act, the Commissioner may, at any time, if the Commissioner considers that it is necessary or desirable in the public interest, (whether for reasons of public health or public safety or for any other reason), that any matter be brought to the attention of any person or authority, refer the matter to the appropriate person or authority.
There are two problems with the Commissioner’s reliance on this section. The first is that few would consider the media to be an appropriate person or authority in terms of addressing any public health or safety issues, if any such issues did exist. The other is that section 59 remains subject to section 67. Section 67 states:

*The Commissioner shall not, in any report or recommendation made or published under any of [sections], make any comment that is adverse to any person unless –*

(a) *That person has been given a reasonable opportunity –*

(i) *To be heard; and*

(ii) *To make a written statement in answer to the adverse comment; and.*

Section 43 of the HDCA also imposes a mandatory requirement on the Commissioner to inform the parties of the result of the investigation and what further action (if any) the Commissioner proposes to take in respect of that complaint. This section means that before making any public comments, the Commissioner was required by law to inform Midwife B of these further actions. When the Commissioner released her Final Opinion in August 1997, she had told Midwife B the names of the bodies to who she would circulate the report and the midwife was invited to make submissions, and did so. At that stage the Commissioner had clearly identified the proposed recipients of the Final Opinion. The report was sent to them and the midwife had been given a right of response. This was appropriate under the Act.

In mid October, after the conclusion of the Commissioner’s investigation and the distribution of reports, the Commissioner decided to speak to the media and publicly make new, previously unstated adverse comment and to name Midwife B. Under the above two sections the Commissioner was required to give Midwife B notice of the further action including the reasons why this action was being proposed. Midwife B should also have been given the right to make submissions on these decisions and to question why the Commissioner was in effect, taking the case back from the Director of Proceedings, and taking further action. Failure to give Midwife B notice and failure to provide her with a right to be heard on these new actions, was a breach of the HDCA and a cardinal breach of natural justice.
The naming and Commissioner's publicity about Midwife B was without precedent. The Commissioner could not point to her usual practice or to similar jurisdictions to justify what she had done. Many other providers including six general practitioners\(^{242}\) had previously been found to have breached the Code and had similarly been referred to the Director of Proceedings. Even after some of those providers had been found guilty of significant professional misconduct, none were named by the Commissioner or subjected to the publicity experienced by this midwife. This is not to say a practitioner found guilty of professional misconduct should never be named. Naming by professional bodies can and does occur where negligence is significant. The Commissioner should have been aware that publication is a frequent accompaniment to a finding of Professional Misconduct under the Nurses Act 1977 and has the effect of a further penalty. Nurses and midwives are frequently named and a summary of the disciplinary finding is always published in the professional journals and often in the media. This is done after a full hearing and after the Council has received submissions on publication, without compromising the integrity of the process.

The shifting grounds of justification for the Commissioner's decision in naming Midwife B meant that it was never clear what the Commissioner's motivation had truly been. It is possible that Midwife B was simply in the wrong place at the wrong time and that her case became a critical weapon with which the Commissioner could combat the growing criticism of the Office. It is also possible that the Commissioner made a spur of the moment decision, which she later regretted but sought to justify. Regardless of the reasons, Midwife B paid a high price for this unprecedented and unrepeated publicity by the Commissioner. It was as the Commissioner said, all very unfortunate. Fortunately, the Commissioner did not treat any other practitioner in this manner.\(^{243}\)


\(^{243}\) There was another unfortunate outcome following this action. The Commissioner’s treatment of this one midwife was perceived as so harsh and so unjust by midwives generally, that the Commissioner lost the trust and goodwill of many within the midwifery profession— a profession that had welcomed her appointment.
It is notable that when the second Commissioner was asked what he planned to do about public naming, Mr Paterson stated that while his investigations are robust, he does not have the ability to cross examine so there are not the same protections for practitioners in the HDCA process, as in a formal hearing. He stated that he does not believe the Commissioner should be “hanging someone out to dry” before they have had a chance to put their case to a formal hearing. He believed naming practitioners was a function of the disciplinary bodies and the Courts. 244

244 St, John, Penny. “Power sought over recalcitrant medics.” New Zealand Doctor (28 February 2001). In New Zealand Doctor (24 May 2000) Ron Paterson is quoted as saying that he would rather not deal with complaints in the media and he will be very reluctant to name providers in public. Opinions will be published through the normal channels, but Mr Paterson believes that naming providers should be a last resort and probably a function of disciplinary bodies or the Courts. He made a similar comment in another publication saying “It is not my practice to publicly name registered health professionals found in breach of the Code.” “Complaints to the Commissioner” New Zealand General Practitioner, (7 March 2001): 1.
CHAPTER NINE—CONCLUSIONS

The issue of publication ends this consideration of the process of the Health and Disability Commissioner. The role of the Director of Proceedings is beyond the scope of this thesis.

We have considered that it is unfortunately true that health providers in the past have shown themselves to be largely protectionist and self-interested when it comes to identification and sanction of practitioners who fall below reasonable standards. This makes the need for an independent officer critical. There will always be a need for someone who can be both a watchdog and a voice for those who are harmed while accessing health and disability services. Following the “Cartwright Inquiry”, successive New Zealand governments legislated to establish the office of the Health and Disability Commissioner. This Commissioner was to develop a Code of Rights, to act as guardian and protector of those rights, to provide an independent voice for consumers, and to receive and process complaints from health and disability consumers. Under the HDCA the Commissioner was required to ensure that complaints were resolved fairly, simply, and efficiently.

The first Commissioner was hampered by a huge task, a small team, a constant and unexpected influx of complaints and a limited understanding of procedural fairness. As a result, many of the processes and decisions within the Office were open to criticism. Fundamental protections were not in place or were overlooked. This led to serious concerns among the health professionals subject to investigations and to those trying to defend them. There was a very clear perception that the process was not fair and as a result practitioners became more guarded and less willing to fully participate in investigations.
This thesis considered in some detail the legal concept of natural justice and the importance of fair and just procedures. Under the first Commissioner, these principles were often breached and not given effect. We analysed the HDCA and legal precedents and determined that the Commissioner was required to act in accord with the principles of natural justice. In order to consider what this meant in practice, we followed through each section of the HDCA and considered whether in some midwifery cases, the midwife had been accorded natural justice. We found that there were substantial and continuing shortcomings; such as the failure to give adequate notice; the failure to provide sufficient particulars; and the failure to disclose key and adverse reports and evidence, thus hampering the midwife’s ability to make a defense. These failures caused midwives to lose faith in the objectivity of the Commissioner and in the accuracy of the opinions generated.

At the same time, the number of complaints was escalating, and the staff came under increasing pressure to process complaints and in addition to deal with large, time consuming inquiries such as the Canterbury Health Enquiry. Long delays in resolving complaints became common and caused further stress to complainants and respondents, and led to criticism of the Commissioner by parties to complaints and by parliament. By naming Midwife B, the Commissioner appeared to want to assure her critics that she was rigorously prosecuting health professionals. This naming gave the Commissioner a great deal of publicity as the public debated the rights and wrongs of her decision, but it ultimately led to increased fear and anxiety amongst health professionals and a reluctance to co-operate with HDCA investigations.

A number of salutary lessons can be learned from the term of the first Commissioner, amongst them the importance of fair procedures – of being fair and being seen as fair. It is one thing to call for openness and transparency, and for sanction and redress, but it is another to act in a manner that achieves this in a consistently even-handed manner and in accord with the principles of natural justice. The underlying tenets of the Office are promotion and protection but neither aim can be achieved without respect and “good will” from both providers and consumers.
The biggest issue facing the Commissioner during these years was the need to attract the confidence of the consumers, practitioners and government. Unfortunately much of the good work that was being done by hardworking staff was eclipsed because of the lack of commitment to open and fair processes. The Royal Commission on Arthur Allen Thomas made the following comment and it sums up the important principle.

*It is trite to say, but perhaps it needs to be said again, that to maintain public confidence in any kind of adjudication, justice must be seen to be done. While we have accepted that inquisitorial tribunals, such as this commission are not subject to quite the same strict responsibilities as courts, it is obvious that they should be scrupulous to avoid any appearance of real unfairness.*²⁴⁵

What is particularly notable is the attitude of providers found in breach of the Code. There has been a full circle. Originally midwives supported the right of women to complain and they were not threatened when such complaints occurred. However the years of delay in awaiting a decision, took a huge toll on both the midwives and the complainants. Once Midwife B was named, midwives worried that they would also be named. The unfair manner in which this was done, caused midwives to fear the Commissioner and to view her processes as arbitrary and unjust. Since the appointment of the second Commissioner there has been a “coming of age” of the Office and the perception of unfairness has lifted. The mediation, investigation and decision making processes have been well tested and can be relied on. There has been the development of objectivity and expertise among the staff, and there has been frequent and ongoing consultation between the branches of advocacy and investigation and the various stake-holders. This has led to a quiet confidence amongst providers and a greater willingness to enter fully into the process of investigation and response. Many now accept the finding, and try to learn from the complaint and change and improve their practice. This is far more positive than having practitioners feeling defensive, aggrieved and badly treated due to fundamental procedural shortcomings.

²⁴⁵ In Royal Commission on the Thomas case 1 NZLR [1982]: 278 per Thomas J.
There is certainly reason for optimism but the primary reason for this thesis is reflection. It is critical that as Commissioners are appointed and serve their term, there is constant striving for better processes. Each must learn from the early, difficult years of the Office and the mistakes that were made and ensure they are not repeated. If these lessons are learned then people will be able to come confidently to the Commissioner with the assurance that their fears and concerns will be treated sensitively and their privacy will be protected. They will know that during mediation and investigation, interviews and hearings, regardless of their individual shortcomings, they will be treated fairly and that at all times the principles of natural justice will be honoured and given effect. For it is when individuals recognize that the Office is acting in a 'good' way and producing 'good results' that parties will be willing to participate in the HDCA's primary objective which is improve the standard and delivery of health care.

By the time I completed this work many of the early difficulties faced by midwives had become historical. A great number of improvements have taken place over the subsequent years and these came about due to dedicated HDC Office staff who had developed skill and expertise in their work, and a new Commissioner committed to fair and just procedures. I therefore based my conclusions solely on what had happened in the early years and refrained from the recommendations that I might have made, had this work been finished earlier. My ultimate finding was that my concerns had been valid and that both the HDCA and the common law required the Commissioner to act in accordance with the principles of natural justice and that in the early processes of the Office, there had been significant departures from those fundamental standards of fairness.
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APPENDIX A – OTHER CASE EXAMPLES

In Case 97HDC5326/VG it was alleged that the midwife (whom we will refer to as Midwife A) did not respond to a patient concern in a timely manner. The situation was one of shared-care where Midwife A had worked closely with the general practitioner ("GP") of the woman (who we will call Ms Z) and a mentor midwife during the pregnancy. As well as her GP and midwife, Ms Z saw an obstetrician because of past difficulties with an earlier pregnancy. Ms Z’s child was recovering from vomiting and diarrhoea having suffered a stomach bug, when Ms Z developed similar symptoms. She left a pager message for Midwife A to phone her. While waiting for a reply, Ms Z phoned a GP, at what the Commissioner described as an after-hours clinic. (The “GP” was apparently the locum covering for Ms Z’s GP). Ms Z described her symptoms over the phone to this doctor. He is reported to have asked Ms Z about vaginal loss and of then telling her to take Panadol. He did not see Ms Z nor warn her of the risk of premature labour. Nor is he reported to have advised her to phone back if things did not settle, or worsened.

Soon after this Midwife A phoned, and Ms Z informed her that she had ‘phoned the doctor’ and he had advised taking Panadol. Ms Z asked Midwife A if she thought that it was safe to take the Panadol in pregnancy. Upon hearing that Ms Z had spoken to the doctor and been advised by him, the midwife reassured her about the safety of Panadol. They then discussed the symptoms in some detail. Midwife A concluded from their discussion that Ms Z was not in labour, but advised that she should ring back if she was worried or experienced regular pain. There was documentation of that discussion and of the midwife’s advice.

Ms Z was then able to sleep on and off until the next morning. She experienced worsening pain at 9.45am and phoned Midwife A who advised immediate assessment at the hospital. On arrival at hospital Ms Z was found to be in premature labour and the baby was in a mal-presentation. Despite an emergency caesarean, the baby tragically died some days later.
A complaint was lodged with the Commissioner although the midwife was unaware who had lodged this. An investigation was undertaken and the advice of an expert midwife was obtained. The Commissioner accepted that there had been a lengthy telephone conversation where Midwife A had carefully questioned Ms Z and established that she was not in labour the night before the hospital admission. The Commissioner however found that Midwife A had breached of Right 5 (1) of the Code (which deals with effective communication) because she had made an assumption that when Ms Z told her she had phoned and spoken to the doctor, she had spoken to the shared care GP, (when in fact she had spoken with the GP’s locum, who the Commissioner described as an after hours doctor) The Commissioner found this was a genuine and understandable mistake but it was still a breach. The Commissioner also found the midwife in breach of Right 6 (1) (which provides a consumer with the right to receive information about their condition), because although Ms Z primary concern was the safety of taking Panadol, Midwife A did not specifically inform Ms Z of the possibility of diarrhoea triggering premature labour. The Commissioner accepted that Midwife A had instructed Ms Z to ring back if the pains increased or worsened. The Commissioner also concluded that she could not determine when the premature labour had actually started nor if anything would have changed the outcome.

Ms Z had also told the GP about the pain and diarrhoea and he advised her to take Panadol. He did not inform her that diarrhoea could trigger a premature labour. Despite his making the same omission as Midwife A, there is no record in the decision of the GP being investigated or of being found in breach of any of Ms Z’s Rights. This failure is surprising given under the Code, each practitioner has an individual responsibility to provide accurate and appropriate information to health consumers.

This case may be compared to Case 97HDC6141 where a GP failed to diagnose an ectopic pregnancy. This is a pregnancy where implantation occurs in the fallopian tube.

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246 The Commissioner then used this midwifery case in an article for GP’s where although she was critical of the midwife and her advice, was not critical of the GP providing the same or less advice. Stent, R.S. “The Perils of Simple Assumption.” *New Zealand General Practitioner*, 25 August 1999: 13.
rather than in the uterus and it can be life threatening should the tube rupture. A pregnant woman who we will call Ms Y. had a pregnancy history of two abortions and a miscarriage. Ms Y went to her GP with a history of old vaginal bleeding. The GP reassured her that this was normal but as Ms Y was worried about the blood loss and the status of her pregnancy, the GP arranged an ultrasound scan. The radiologist who did the scan said there were no signs of pregnancy and that it was likely Ms Y had miscarried. Ms Y asked the radiologist about the possibility of an ectopic pregnancy and was advised that the tubes seemed clear but that she should have another pregnancy test. Ms Y returned to her GP with the scan results and a letter from the radiologist. The GP confirmed that there had been a miscarriage. Six days later Ms Y returned to her GP with lower abdominal cramps, sweating, pain and nearly fainting when trying to stand. The GP, apparently without a further scan, diagnosed retained products of conception. She prescribed antibiotics and queried the need for a dilatation and curettage of Ms Y’s uterus, if the medicine didn’t help. After a further six days, the pain recurred. Ms Y attended an Accident and Emergency department where she was diagnosed as being pregnant and having internal bleeding from a ruptured fallopian tube.

A complaint was laid about the GP and the Commissioner investigated. In her Report she complimented the GP on the high standard of care at the initial visit and found that (despite the radiologist’s advice), there was no reason for a pregnancy test after the scan. She did consider a pregnancy test should have been done when Ms Y returned 6 days later. As a result of that omission the GP was found to have breached Right 4 (2), (which provides the right to have services provided that comply with legal, professional, ethical and other relevant standards). However the Commissioner, softened her finding against the GP, by stating that she had been told by her advisor that ectopic pregnancy is extremely difficult to diagnose and manage.

In defense the GP had stated that the radiologist did not communicate to her the possibility of an ectopic pregnancy, the limitations of the ultrasound scan in detecting these pregnancies, nor the requirement for a repeat pregnancy test. Despite these allegations of poor communication between the GP and radiologist about the scan, and what was described as a misleading radiology report, the radiologist was not found in breach of the Code. Instead
of the Commissioner requiring clearer communication between radiologists, consumers, and GPs, the Commissioner advised that radiologists should consider using a disclaimer to protect themselves from later criticism. This encouragement to use defensive practice as a means of protection - instead of requiring better communication or documentation between providers including radiologists - seemed out of step with the underlying philosophy of the Code.

There are fundamental differences in the way that these two cases were dealt with. The first was the higher priority given to the GP case. While the midwifery complaint was received on 16 April 1997 and completed on 12 October 1998, the GP complaint was received on 17 June 1997 and completed by 30 November 1997, almost a year before the earlier midwifery complaint. In the both cases the Commissioner relied on the advice of independent experts about the reasonableness of the care, but the tenor of the Commissioner's opinion was generally far more supportive in the case of the GP. In both cases there was arguably poor communication from other providers. But neither the locum GP in the first case (who was required by contract to communicate with midwife when seeing a pregnant consumer and who did not), nor the radiologist in the second case were found in breach of the Code. This was particularly surprising in the midwifery case where the GP omitted to advise Ms Z on the possibility of diarrhoea triggering premature labour. The same omission, for which Midwife A was found to have breached Right 6(1). The Commissioner did not accept the midwife's evidence that the GP was acting as locum for the shared care doctor and had taken on a duty of care for that practitioner's maternity clients. Instead the opinion persists in describing his role only in terms of an apparently random 'after-hours clinic' doctor.

Case 97HDC9767/JW illustrates a number of procedural shortcomings. It was a case involving Midwife C (the partner of Midwife B, see Chapter Nine). Midwife B had a
The complainant who we will call Ms Y became pregnant for the third time at 39 years of age and she requested midwifery care at around 20 weeks of pregnancy. Prior to that she was under the care of a GP. Midwife C was the primary midwife caring for Ms Y and she was supported by two colleagues, Midwife B and Midwife D who were available for back up. These latter two midwives had small, superficial roles in the care of Ms C. During one visit with Midwife C, Ms Y reported that three days earlier her baby had had a quiet movement period for a short time, but that the movements had been normal following that time. The baby’s movements were discussed and assessed, and the baby’s heart-beat was heard and all seemed well.

Later in the pregnancy, Midwife B, had a visit with Ms Y. (It was usual for each midwife to visit and give the mother an opportunity to meet them prior to the birth). Midwife B also discussed the baby’s movements, which were normal, and while palpating Ms Y’s abdomen to determine the baby’s position, she felt the baby moving beneath her hands. This was documented. Midwife B questioned the position of the baby and arranged a scan. Later that day she informed the primary caregiver, Midwife C, that she had done this. When Ms Y attended the hospital for the scan, it showed the baby was in a head-down position and was smaller than average. The scan report gave conflicting advice about the amount of amniotic fluid present. It was either normal or slightly reduced. The report was sent to Midwife C who spoke to Ms Y about the scan. Midwife C advised that, although there was nothing in the scan to indicate the situation was urgent, she felt that Ms Y should see a specialist. Midwife C phoned for an appointment with a specialist but he had been away and the earliest

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The primary complaint was actually against the Midwife C 97HDC9767/JW and Midwife B had a minor role. However Midwife B was being investigated in the case discussed in chapter nine. That was to be a critical ‘test case’ for the Commissioner and part way through those proceedings the Commissioner’s embarked on an unprecedented publicity campaign related to Midwife B’s involvement. It was in the course of this ongoing publicity that this second complaint arose.
appointment with him was in 10 days time. Midwife C initially accepted this appointment but on reflection rang back and managed to get an earlier appointment with him for the Monday, in a week’s time. Over the weekend before the appointment, a family member asked Ms Y about her baby’s movements. Ms Y realized that she had not been feeling her baby move for some time. Midwife C was away, so she phoned Midwife B and told her about the lack of movements. When Midwife B received this call she was out of the immediate area, but was immediately concerned. She knew that the other back up midwife was at home and could assess Ms Y sooner than Midwife B could get back to Ms Y’s home. Midwife D was contacted and arranged to meet and assess Ms Y at the hospital. Sadly her baby was later found to have died in-utero some days before. This occurred in June 1997 but no complaint was laid at that stage.

The Commissioner went public about Midwife B’s other case in October 1997. (see Chapter Nine) In November 1997 Midwife B received a letter notifying her that a complaint had been received from Ms Y. The midwife and her colleagues requested mediation and resolution. The Commissioner commenced an investigation. A concern for the midwives throughout the interviews and in the opinions, was the persistence of the Commissioner, against clinical and documented evidence, in describing this as a situation of longstanding reduced movements. The midwives did not receive the Commissioner’s Provisional Opinion until around 19 July 1999. (It must be emphasized that a Provisional Opinion is always preliminary and is frequently modified when further evidence is adduced). This opinion showed that the Commissioner had taken advice from ‘an’ independent midwife and she had made preliminary findings on the basis of this advice. The midwives also wanted to know who the expert midwife had been, and what she had said about their care. The Commissioner had also had expert advice on the scan arranged by Midwife B. No responsibility had been placed on the radiologist for the internal inconsistencies in the report which had misled Midwife C with respect to the adequacy of the liquor volume.

248 97HDC 9767

249 The midwives also had to respond to an ACC claim alleging medical error but this was claim was declined as the various ACC experts found that medical error had not occurred.
When the Provisional Opinion was sent to Midwife C for comment, it contained several issues that were completely new to the midwives. It also had extensive recommendations, (see 97-98). Midwife C made an extensive reply. The Final Opinion was dated 14 October 1999 and the Commissioner upheld several breaches of the Code against Midwife C and referred the matter to the Director of Proceedings. The Final Opinion also included new information which the midwives had not seen before nor been given an opportunity to comment on. When this occurred in the Provisional Opinion, the midwives provided further information and the Commissioner modified her Provisional Opinion. When new information was placed in the Final Opinion, the midwives had no opportunity to answer this prior to the Final Opinion being released and circulated.

In the Final Opinion the Commissioner found that Midwife C had breached Right 4 (2) because she failed to show sufficient concern about the [ambiguous] scan and that she should have sought urgent referral to an obstetrician. There was a finding of a breach of Right 4 (5) because the Commissioner considered that the midwife's failure to organize an earlier specialist appointment, demonstrated a lack of co-operation to ensure appropriate care. She felt that Midwife should have arranged for another specialist to see Ms Y. There was also a finding of breach of Right 6(1), and while the Commissioner accepted that Midwife C had advised Ms Y to monitor her baby's movements and report any concerns, she felt that this advice was insufficient when the baby was small for dates (even though it was later disclosed that in at least one expert's opinion the small size was marginal). The Commissioner felt that because of these breaches of the Code, Ms Y had not been able to make informed choices.

The case with respect to Midwife C was referred to the Director of Proceedings. The Director quickly recognized that the issue was not one of prolonged reduced movements. Midwife C exercised her right to be heard and attended an interview with the Director. The

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250 The Commissioner had held the midwives responsible for not discussing the possibility of amniocentesis with Ms C but this test can only be done early in the pregnancy. During that timeframe Ms C was under the care of a GP and the midwives were not involved.
midwife then discovered that the Commissioner had contracted two expert opinions. The second after the midwives had made their final submissions and just before the Final Opinion was completed. As indicated in the earlier discussion of the case law surrounding disclosure of key documents, the failure to disclose these reports was totally inappropriate and a breach of natural justice. The Director acknowledged that the midwives had not been given the right to see or comment upon the expert reports, and that other matters had also not been properly put to Midwife C. She therefore gave Midwife C an opportunity to make submissions on these additional matters and on the contents of both expert opinions. After additional expert midwifery advice the Director notified Midwife C on 11 December 2000, that she was taking no further action. This was three and a half years after the baby’s stillbirth.

Let us now consider this same complaint and investigation as experienced by Midwife B.

Midwife B

The aspect of the complaint relating to the care provided by Midwife B could have been expeditiously resolved. It is difficult to understand why this part of the complaint was not referred immediately for mediation, or why the case against her was not quickly closed. Following the Commissioner’s investigation into the complaint of Ms Y, the Commissioner issued a Provisional Opinion about Midwife B’s care. Due to the new issues arising in this Opinion, Midwife B requested a copy of Ms Y’s letter of complaint. The Commissioner advised that there had not actually been a written complaint but that a verbal complaint had arisen during a phone conversation between Ms Y and the Commissioner on 7 November 1997. (This was very soon after the Commissioner’s initial publicity against Midwife B). Ms Y’s primary complaint had been against Midwife C, but following the call, there were apparently a number of complaints against Midwife B. The Commissioner summarized these oral allegations in the Notification Letter to Midwife B. These included that Ms Y had
reported to Midwife B that she was having contractions during the pregnancy, and that
Midwife B advised her that these were caused by the uterus getting ready for the birth. A
further allegation was that Midwife B had not told her colleague Midwife C that she had
arranged a scan.

Midwife B responded to the Commissioner by saying that it was difficult for her to
respond specifically to the allegation about the contractions as the Commissioner did not
provide any particulars about when these comments were allegedly made. She explained to
the Commissioner that it was normal for women to experience ‘Braxton Hicks’ contractions’
in pregnancy and that these tended to increase in frequency in the last month of pregnancy as
the uterus readied for birth. Midwife B felt that Ms Y’s statement that she said that these can
indicate that the uterus was getting ready for birth was physiologically correct and that she
probably had said something like that to Ms Y.

Midwife B also confirmed that she did request a scan but that it was non-urgent. A
point she later discovered had been recognized by the first expert midwife but this opinion
was not disclosed. Midwife B also confirmed that she had told Midwife C about the scan,
when the two midwives saw another client together, soon after Midwife B had seen and
assessed Ms Y.

Midwife B received the Commissioner’s Provisional Opinion dated 19 July 1999.
That finding also included entirely new allegations that had never been put to Midwife B.
The first was that an expert midwife had apparently noted an increase in Ms Y’s blood
pressure during Midwife B’s visit. The expert felt that as a result of this elevation, Midwife
B should have done certain things such as repeating the blood pressure and doing a urine test.
This was a bizarre conclusion, as the stated blood pressure sat squarely within Ms Y’s normal
pregnancy range and was not elevated by any standard criteria. A urine test had been done
and was documented by Midwife B as normal.

The Commissioner’s Opinion then referred to the Sunday morning when Ms Y had
phoned Midwife B about the lack of movements from the day before. She wrote: [Midwife
C] was away and [Midwife B] was too busy so [Ms Y] spoke to [Midwife D]. This was at odds with the facts. Midwife B replied that she had not been ‘too busy’ to assist Ms Y. Midwife B reported to the Commissioner that when Ms Y phoned with the report that baby had not been moving over the previous day, she was immediately concerned. She was out of Ms Y’s immediate area and so knowing that Midwife D was at home and close at hand to assess Ms Y, Midwife B suggested that this be done.

Midwife B repeated that, on the day that she had seen Ms Y, there were no reduced movements; normal movements were clearly present and documented, and the scan had been arranged to check the baby’s position. Midwife B made strong submissions regarding the impropriety of the shifting allegations and what she perceived as an apparent bias against her. The Commissioner accepted the midwife’s submissions that the movements had been normal on the day of the assessment and that Midwife B had informed Midwife C about the scan. The Commissioner additionally removed her comment about the blood pressure and the comment that Midwife B was ‘too busy’ to respond to Ms Y. The Commissioner formed a Final Opinion that Midwife B was did not breach the Code.

The investigation of the complaint, with respect to Midwife B, could have been mediated or screened out by the Commissioner. The prolonged and extensive investigation and the decision of the family to go to the media about her involvement in the complaint, added to the enormous pressure that Midwife B was suffering as a result of the earlier case. Although the complaint of Ms Y against Midwife B was eventually not upheld, the allegations were never retracted in the media by Ms Y. Unlike the earlier case, the Commissioner did not go to the media when Midwife B was found to have provided reasonable care. 251

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251 The same reporter who had published earlier damning allegations against Midwife B, and named her in conjunction with this complaint, did not retract these and let the public know that Midwife B, had been completely exonerated of any wrongdoing. Instead the earlier allegations against Midwife B were allowed to remain in the public mind and Midwife D was additionally named. The earlier article was by Claire Guyon, “Third mum complains over midwife care.” Evening Post, 3 April 1998, p 1,3. The second woman did not make a formal complaint, the third was Ms Y. The later article naming Midwife C was also by Claire Guyon, “Midwife’s Care Not Adequate – Report.” Evening Post, 2 November 1999.