Annual Report of the

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

for the year ended
30 June 2001

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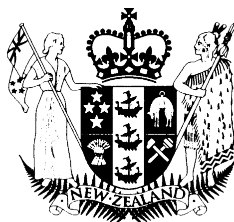

Presented to the House of Representatives
Pursuant to Section 16 of the
Health and Disability Commissioner Act 1994

E.17

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

15 October 2001

The Minister of Health
Parliament Buildings
WELLINGTON

Minister

In accordance with the requirements of section 16 of the Health and Disability Commissioner Act 1994, I enclose the Annual Report of the Health and Disability Commissioner for the year ended 30 June 2001.

Yours faithfully

Ron Paterson
Health and Disability Commissioner

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Vision

The rights and responsibilities of consumers and providers are recognised, respected, and protected in the provision of health and disability services in New Zealand.

Te Whakataunga Tirohanga

Heoi ko ngā tika me ngā tikanga whakahāere a ngā kaiwhiwhi me ngā kaituku, arā, tūturu kia arongia motuhake nei, kia whakamanahia, a, kia whakamaruhia i roto i ngā whakataunga hauora me ngā whakataunga huarahi tauawhi i ngā momo hunga hauā puta noa i Aotearoa nei.

COMMISSIONER'S REPORT

Commissioner, Ron Paterson

Introduction

This is my first report of a full year as Health and Disability Commissioner. This summary covers the following key themes of the 2000/01 year:

- Public concern about complaints and investigations
- Doctors under siege
- Patient safety in public hospitals
- Improved relationships with key stakeholders
- Investigation changes and clearing backlog.

Complaints and Investigations

New Zealand's system for regulating the quality of health care and disability services is rehabilitative, rather than punitive. It includes a number of features consistent with modern approaches to reducing error and improving safety. A publicly funded accident compensation scheme covers medical misadventure: it protects registered health professionals from damages claims, and is reflected in very modest professional indemnity levies (with no contribution to the cost of state funding for medical misadventure, even in cases of error/negligence). The Medical Practitioners Act 1995 eschews a simplistic model of medical discipline that seeks to cull "bad apples". It aims to protect the public with provisions for legally protected quality assurance activities, competence reviews, and recertification programmes, and for supervision of medical practitioners. The Commissioner's complaints resolution process seeks to resolve complaints at the lowest appropriate level, and has contributed to a dramatic decline in the number of medical practitioners facing disciplinary charges.

Mission

Our mission is to promote the rights and responsibilities of consumers and providers and to resolve complaints by fair processes and credible decisions to achieve just outcomes.

Te Kawenga

Koinei ra te kawenga motuhake a tēnei ohu, arā, ko te whakahou hāere i ngā tika me ngā māna whakahāere a te hunga Kaiwhiwhi me ngā Kaituku; hei whakatau i ngā nawe me ōna amuamu i runga i ngā whakaritenga tautika me ngā whakaaetanga tautika hei whakatau i ngā whakatutukitanga me ōna whakaputatanga.

Yet the system is perceived to be failing both patients and doctors. On the one hand, local doctors believe they are practising in the most hostile environment in the Western world, in a country obsessed with safety. On the other hand, complaints about medical practitioners are at a record high. Last year, a record 1,397 complaints were received by the Commissioner. There is a disturbing lack of confidence in the ability of the New Zealand health and legal systems to respond to concerns about health care and disability services. Injured patients report that they find the complaints process "confusing, cumbersome, difficult to access and costly, both financially and emotionally" (Cull Report, 2001). The public sees a medical profession that is shielded from damages claims for negligence, reluctant to blow the whistle on errant colleagues, and slow to discipline substandard doctors; and a publicly funded health system that underfunds public hospitals and screening programmes, and fails to monitor and evaluate the quality of care delivered. Worse, where the system does produce relevant data, there is often no follow-up. The situation has been described as a "medical emergency" (*The Dominion*, Editorial, 26 June 2001).

These concerns came to a head in September 2000, when the prosecution of gynaecologist Dr Graham Parry for substandard care of Northland woman Colleen Poutsma was highlighted in the media (see discussion page 21). In addition to concerns about delays in investigation by the Commissioner, prosecution by the Director of Proceedings, and competence review by the Medical Council, the case highlighted the lack of co-ordination between Government agencies (ie, HDC, ACC, and the Medical Council) and the need for sharing of information about practitioners. Helen Cull QC was asked to review current processes and report on how agencies can identify patterns of adverse medical outcomes to ensure prompt follow-up of incidents.

The resulting Cull Report, submitted to the Minister of Health in March 2001, made a number of sensible recommendations to improve current processes. For HDC, these include adequate resourcing to address the rising tide of complaints, greater flexibility in dealing with complaints (eg, to permit mediation prior to investigation), enforcement powers to implement Commissioner recommendations, and an audit role to permit access to relevant information about health professionals held by other agencies. These recommendations are a welcome recognition of the need to enhance the Commissioner's ability to be an effective complaints resolution agency. Cabinet has approved a number of amendments to the HDC Act which will, if passed into legislation, address many of the concerns in the Cull Report.

Although it may not be sensible for HDC to become a "one-stop-shop", given the differences in focus of ACC (rehabilitation of the injured claimant), the Medical Council (protection of the health and safety of the public), and HDC (resolution of complaints), there is clearly scope for improved co-ordination. In the past year, HDC has signed information sharing protocols with the professional registration bodies, and encouraged ACC to report all medical error findings to HDC and the Medical Council.

A related area of concern is appropriate compensation for people who suffer a medical misadventure. I have supported calls for adequate levels of medical misadventure compensation. The new accident compensation legislation, if enacted, will re-introduce lump sum payments for covered injured persons who suffer permanent impairment. Meantime, in the aftermath of the Gisborne Cervical Cancer Screening Inquiry Report, I have publicly called for *ex gratia* compensation by the Government for affected women, in recognition of the special duty of care owed to the women of Tairawhiti who were failed by a public health screening programme.

Doctors under Siege

A second theme of the 2000/01 year has been media focus on the competence of individual medical practitioners. Competence is a broad concept, and the failings of a doctor on a single

occasion may not indicate that the practitioner lacks the skills to practise medicine safely — although rehabilitation of an injured patient, and an investigation and follow-up (including disciplinary proceedings in serious cases) may be warranted. Where there is (or appears to be) a pattern of problems (whether in the area of communication with patients, or in quality of care), a Medical Council review of the practitioner's competence is indicated. This may be triggered by an HDC recommendation, because of the number or serious nature of complaints received about a doctor, or by ACC accepting a series of medical misadventure claims involving one doctor.

Doctors Graham Parry and Michael Bottrill found themselves in the media spotlight in the year under review, and many doctors experienced a sense of being under siege from the public's "hue and cry", at least as reported in the print media and on television. Overall, however, there was a dramatic decline in the number of medical practitioners facing disciplinary charges. Yet it is common to hear suggestions that New Zealand doctors increasingly face medico-legal risks similar to, or worse than, those of their foreign counterparts, and should be practising defensive medicine to manage their risk exposure. Consumer expectations have risen and there is an increasing emphasis on accountability. But an examination of the facts about current medico-legal risks shows that the fears are exaggerated.

A GP practising in New Zealand, like any health care provider, may face a complaint or legal action if a patient is unhappy or, worse, suffers physical harm or death following treatment. The worst case would be an unexpected death of a patient that leads to a Coroner's Inquiry, or even a criminal prosecution for manslaughter. More likely — but still, in the scheme of things, a rare event — is a negligence claim brought by a patient (or family, in the event of death) against a doctor, seeking damages to compensate for the harm and/or to punish the doctor. Damages of the first kind — compensatory damages — are effectively barred in New Zealand in any case where the patient has suffered personal injury (including death) covered by ACC.

Damages of the second kind — exemplary or punitive damages — are not barred by ACC, and thus are potentially available. However, the Court of Appeal has strictly limited this category of damages to cases of conscious wrongdoing by a provider (*Bottrill v A*, Court of Appeal, CA 75/00, 13 June 2001; under appeal to the Privy Council). To date, there has been only one case where exemplary damages have been awarded against a health professional in New Zealand: a psychiatrist who had been struck off the medical register for engaging in a sexual relationship with a patient whom he had been counselling for sexual abuse was ordered to pay $10,000 exemplary damages (*L v Robinson*, High Court, Christchurch, 29 March 2000).

New Zealand courts have signalled that the million-dollar damages awards seen in the United States are unlikely here. Indeed, the Court of Appeal has warned local lawyers that they "should be careful not to be associated with claims for amounts of damages which on any objective view are unattainable and give the appearance of being brought *in terrorem*" (*Ellison v L* [1998] 1 NZLR 416, 419). A High Court judge has commented that, in a negligence case, "an award of $20,000 to $30,000 would stop virtually any claim of exemplary damages" (*A v B*, High Court, Auckland, 10 May 1999). It is no wonder that annual Medical Protection Society premiums for New Zealand doctors are around $1,000–$1,500. This can be compared with professional indemnity premiums (in $NZ) for GPs in Australia ($3,440), the United Kingdom ($8,750) and the United States ($21,950). The financial risk exposure, even in serious malpractice cases, is very modest in international terms.

The scenario painted above would hearten doctors, and dismay lawyers, anywhere else in the world. If evidence-based practice applies not just to health care, but to medico-legal practice, it seems that the myth that we are headed towards an "Americanised" system — with doctors in the dock, digging deep into their pockets — is precisely that: myth, not reality. New Zealand remains one of the safest places in

the world to practise medicine. The one risk that New Zealand doctors do face, unlike many of their foreign counterparts, is being subject to a complaint to the Health and Disability Commissioner. But in the year to 30 June 2001, out of thousands of GP consultations, 397 complaints were made to HDC, 36 GPs were found to have breached the Code, and 6 GPs faced professional disciplinary hearings.

Patient Safety in Public Hospitals

Another feature of the year under review was new evidence that New Zealand hospital patients face a significant risk of iatrogenic injury, ie, unintended harm caused by a health care intervention, rather than by the underlying illness or disease. A pilot study of Auckland hospitals showed that 10% of admissions were associated with adverse events (Davis P et al. Adverse Events Regional Feasibility Study: Indicative Findings. NZMJ 2001; 114: 203–205).

Of the 538 cases investigated by the Commissioner in 2000/01, 180 (33%) involved incidents occurring in public hospitals. Two reports in particular highlighted systemic issues of concern, and were used to send an educational message to District Health Boards: the Taranaki Healthcare Report (see below) and the Gisborne Hospital Report (see page 10).

Improved Relationships with Key Stakeholders

A significant priority in the year under review has been improving relationships between the Health and Disability Commissioner and key stakeholders, notably consumer groups, provider groups and professional bodies, District Health Boards, and the Minister and Ministry of Health. I met with a wide range of these groups during the year and gave numerous speeches, including:

- Women's Health Action Cartwright Anniversary speech, Auckland, August 2000
- New Zealand Nurses Organisation educational seminar, Invercargill, August 2000
- South Auckland Health Physicians Grand Round, Middlemore Hospital, September 2000
- National Women's Hospital Grand Round, Auckland, September 2000
- Disability Information Waitakere AGM, Henderson, September 2000

Taranaki Healthcare Report

A report released in February 2001 highlighted concerns about safety in Emergency Departments. An investigation was undertaken following the death of 19-year-old Tommy Whittaker, whose father complained to HDC about the standard of care received at Taranaki Base Hospital. Expert advice from an emergency medicine specialist indicated that the hospital's staffing levels fell below international standards and that similar staffing problems existed in Emergency Departments throughout the country.

At the time of the events, in 1997, Taranaki Base Hospital had one medical staff member, often a first-year house surgeon, rostered in charge of all departments except obstetrics between 10.30pm and 8.00am. Other medical staff were available on call. Ideally such cover should be provided by a third-year or, at a minimum, second-year house surgeon. The hospital failed to provide its staff with adequate guidelines for neurological observations: observations were carried out hourly, rather than half hourly, which is the national and international standard. A system for staff to contact the on-call registrar or consultant for advice was in place but no guidance was given as to what staff could do if the on-call staff member failed to respond. The house surgeon did not know to contact the consultant when the on-call registrar failed to respond.

The Taranaki Healthcare Report (www.hdc.org.nz: opinion 98HDC13685) recommended that the Ministry of Health review the staffing levels and competence of Emergency Department staff. Following widespread media publicity, the Australasian College of Emergency Medicine called for New Zealand Emergency Departments to be brought up to international standards ("Newly graduated doctors should not be left alone in New Zealand's emergency departments", media release, New Zealand Faculty of the Australasian College for Emergency Medicine, 27 February 2001). Emergency Department experience is important for junior doctors, but they need careful supervision and should not be left in sole charge. The reality of staffing shortages, particularly in rural areas, may mean that international standards are still some way away for some departments. The Ministry of Health is continuing work to improve the standard of care in Emergency Departments.

Advocates Christine Wood (left) and Alane Nilsen (right) with Ron Paterson, at a meeting chaired by Feilding and Districts Community Health Group chairperson Barbara Robson (centre)

- Royal Australasian College of Psychiatrists annual conference, Rotorua, October 2000
- Private Hospitals Association annual conference, Auckland, October 2000
- Rehabilitation Plus 2nd national conference, Auckland, October 2000
- Australasian Faculty of Public Health Medicine, New Zealand Annual Scientific Meeting, Auckland, October 2000
- Consumer Health Forum, Feilding, November 2000
- Cancer Society, Auckland, November 2000
- Auckland University of Technology, National Centre for Health and Social Ethics opening, November 2000
- CECANZ (Continuing Education of Combined Anaesthetists of New Zealand) educational conference, Auckland, November 2000
- Social Science & Health Network seminar, Wellington, February 2001
- Auckland Healthcare senior medical staff seminar, Auckland, February 2001
- Body Positive annual retreat, South Auckland, March 2001
- Auckland College of Nurses AGM, Auckland, April 2001
- Thames Hospital senior medical staff seminar, Thames, May 2001
- Dunedin Hospital, public lecture, Dunedin, May 2001
- Auckland Faculty of Royal NZ College of General Practitioners, Auckland, May 2001
- Wellington School of Medicine, public lecture, Wellington, May 2001
- Residential Care NZ annual conference, Wellington, June 2001.

Bi-monthly meetings occurred to brief the Minister of Health on issues affecting the rights of health and disability consumers, and regular meetings were held with the Director-General of Health and Ministry of Health staff on current issues. Effective consultation processes have been arranged with the Regional Licensing Office of the Ministry of Health, for dealing with rest home complaints. Meetings were also held with the various statutory registration bodies (including the Medical Council, the Nursing Council, the Dental Council and the Pharmaceutical Society) and protocols have been put in place to ensure an appropriate sharing of information between those bodies and the Commissioner. For example, registration bodies are now routinely notified where the Commissioner commences an investigation into the conduct of a registered health professional, and informed of the outcome of the investigation. Arrangements have also been made with ACC to ensure that relevant information is forwarded. In relation to mental health inquiries, processes were clarified with the

Gisborne Hospital Report

In June 2000 the New Zealand Nurses Organisation wrote to the Minister of Health and spoke to the media about concerns of nurses employed by Gisborne Hospital. The admitted re-use of syringes by a visiting anaesthetist and the potential risk of disease transmission to 134 surgical patients was widely publicised. In July 2000 the hospital announced that an error had been made by its laboratory in carrying out Prostate Specific Antigen (PSA) testing. One hundred and seventeen patients were notified of the error and advised to see their general practitioner about the need for re-testing. Against this background, I initiated an inquiry into patient care and quality assurance systems at Gisborne Hospital. My report (www.hdc.org.nz/opin/Gisre), following the largest investigation undertaken by the Commissioner since Robyn Stent's 1998 Canterbury Healthcare Report, found specific breaches of the Code in the operating theatre (due to the re-use of syringes) and in the laboratory (due to failures of quality control and human error in relation to PSA test results). Gisborne Hospital's failure to have adequate quality assurance and incident reporting systems in place resulted in findings of breach of its duties of care and co-ordination as a hospital provider.

Gisborne Hospital's Incident and Complaint Management Policy was unsatisfactory in a number of respects. There was no differentiation between incidents where harm could have occurred ("near misses") and adverse events where harm did occur. There were no guidelines for the completion of incident reports, no mechanism to track filed reports, and inconsistency about which incidents were drawn to the attention of senior management. Where incidents were reported, lipservice was paid to the concept of root cause analysis, but staff personally involved in the incidents experienced criticism and blame. Incident reporters often received no feedback. Quality and continuity of patient care was potentially compromised by the failure to have an effective incident reporting system. The report included extensive recommendations related to incident reporting and complaints handling, consistent with the approach of the British National Health Service report *An Organisation with a Memory* (Department of Health, London, 2000) that analysis of adverse events in health care should focus on root causes, and not simply the proximal events or human errors in isolation of wider processes and systems.

The report emphasised the need for continuous quality improvement in New Zealand public hospitals, and deliberately downplayed any blame on individual practitioners, at a time when media focus on individual practitioner error is thought to be leading to the practice of defensive medicine. A Ministry of Health follow-up audit report is expected by October 2001.

Director of Mental Health, the District Inspectors, and the Mental Health Commission. I also met with the Coroners' Council in December 2000 to clarify the interface between our respective inquiries into deaths during medical treatment.

Work has been undertaken with professional Colleges to ensure that the Commissioner has a range of suitable expert advisors to draw upon, and that investigation reports are distributed to the various specialities for educational purposes. I am grateful for the co-operation of the Colleges in nominating advisors and providing feedback on reports. The Colleges have a critical role to play in continuing professional development and supporting quality initiatives throughout the health sector. One area where I believe Colleges may be able to play a greater role is in providing confidential support and mentorship to members involved in a complaint or investigation. It is obviously important that this function is ringfenced from any College involvement in providing expert advice on quality of care issues.

It is encouraging to see the wide range of quality initiatives occurring within the health and disability sectors. The Chief Medical Advisors are a key group in promoting quality assurance activities within District Health Boards, and I have enjoyed meeting with this group to discuss issues affecting patient safety. I have been pleased to support the work of the Ministry of Health, for example the launch of the "Toward Clinical Excellence: A Framework for the Credentialling of Senior Medical Officers in New Zealand", and the National Health Committee, in developing a national framework for quality health care. I have maintained contact with Professor Peter Davis, whose research on adverse events in New Zealand public hospitals provides an invaluable platform for progress in this area, and with Professor Laurence Malcolm, who is leading (for the Clinical Leaders Association of New Zealand) important research on clinical leadership and governance in New Zealand. I have visited many public hospitals and met with their Chief Executives and quality managers over the past year, and discussed the

use of complaints and incidents surveillance for continuous quality improvement within District Health Boards.

I am in the process of forming a Consumer Advisory Group, to enable the Commissioner, Director of Advocacy, and Director of Proceedings to obtain strategic advice about issues affecting health and disability consumers, and about priorities for the Office's work in education and complaints resolution (from advocacy through investigations and proceedings). In the meantime, an excellent relationship has been established with Women's Health Action in Auckland, whose Executive Director, Sandra Coney, continues to be a leading voice for New Zealand health consumers.

Two initiatives in the 2000/01 year focused on particular groups of vulnerable consumers: victims of sexual abuse by doctors; and consumers of disability services. In November 2000 I convened a meeting in Wellington of medical groups and women's groups to discuss how to deal with sexual abuse — and complaints of sexual misconduct — by doctors. Groups who attended included the Medical Council, Medical Practitioners Disciplinary Tribunal, New Zealand Medical Association, Royal New Zealand College of General Practitioners, Doctors for Sexual Abuse Care, Ministry of Health, Women's Health Action, THAW (The Health Alternatives for Women) from Christchurch, Federation of Women's Health Councils, and staff from my Office. Two types of doctor were discussed: the sexual predator and the naïve doctor who does not communicate effectively with patients. A range of strategies was discussed to ensure support for women, recording of complaints (even if made anonymously) as a "red flag" to identify potential problems, confidential advice for doctors who seek help at an early stage, and fair processes by investigation agencies. The distinction between support persons for patients (a legal entitlement under right 8 of the Code) and "chaperones" (potential witnesses for doctors) was discussed.

In May 2001 a joint seminar was held in Dunedin with the Donald Beasley Institute, to highlight concerns about the protection of the rights of vulnerable consumers in disability services. The focus of the seminar was on possible gaps in the current law and the inaccessibility of complaints-based mechanisms for some consumers. The seminar was attended by representatives of major disability provider and consumer groups, academics, lawyers, policy advisers, and politicians. It aimed to raise awareness of the vulnerability and rights of disability services consumers; remind disability service providers of their duties under the Code; identify policy, service or monitoring strategies, and possible legislative changes to provide better protection; and share perspectives on the rights of disability consumers. The programme included a variety of presentations and opportunities for group discussions and feedback. Agreed follow-up by HDC included educational initiatives for disabled consumers (HDC has contracted DPA to facilitate a series of workshops around the country in 2001 about the Code and its application to disability services consumers); targeted use of advocates and changes to the advocacy services to better meet the needs of disabled consumers; and the Director of Proceedings taking a test case to the Complaints Review Tribunal, as a wake-up call to disability service providers.

Investigation Changes and Clearing Backlog

A number of changes have been made to the Commissioner's investigation processes, to ensure that the Office achieves its mission "to resolve complaints by fair processes and credible decisions to achieve just outcomes". The following specific changes in the past year have been introduced to ensure fairness and efficiency:

- more comprehensive assessment of complaints prior to notification of investigation, to clarify relevant issues and prevent the "mushrooming investigation"
- provision of a full copy of the complaint to providers under investigation
- earlier use of expert advisors to identify key issues for investigation focus

- regular updates to parties on progress of investigation (including comprehensive updates of current cases, for DHBs)
- inclusion of a full copy of the expert advice in provisional and final opinions
- naming of expert advisors in reports (unless previously contracted in confidence)
- sending of provisional "no breach" or "no further action" reports to complainants, with the opportunity to respond
- greater use of mediation to achieve resolution in appropriate cases.

The 2000/01 year saw a record 1,397 complaints to the Commissioner, a 28.4% increase over the previous year. This led to an increase in the number of open files to 634 at 30 June 2001, notwithstanding closure of a record 1,338 files. However, although the total number of open files remains moderately high (but well below the peak of 1,000 during April 1999), there has been excellent progress in clearing the "old" files (files more than 18 months old decreased from 20% to 10% of backlog), and in reducing (from 44 to 34 weeks) the average time taken to close a file. Details of the throughput of complaints in 2000/01 appear at page 26. Subject to necessary legislative changes to enhance the Office's flexibility to deal appropriately with complaints, and to adequate resourcing, I am confident that continued progress in clearing the backlog will be made during the 2001/02 year.

Future Directions

There remains significant work to secure HDC's vision: "The rights and responsibilities of consumers and providers are recognised, respected and protected in the provision of health and disability services in New Zealand." "Recognised" means people know what their rights are; "respected" means that their rights are enjoyed in practice; "protected" means that when their rights are breached, consumers are protected.

A key challenge in the coming year is to continue to reduce the number of open files to manageable levels, in order to meet our statutory objective to facilitate the "fair, simple, speedy and efficient resolution of complaints". My commitment to consumers and providers is to complete future investigations as promptly as possible. This is a critical issue for HDC as it enters the next phase of its development. Our aim is to ensure that our complaints resolution processes are fair and that our decisions are credible. Our ultimate goal is to ensure just outcomes for all parties. Accordingly, a major priority is the current review and re-engineering of investigation processes.

Supporting our focus on the fair and prompt resolution of complaints will be strong and effective Advocacy and Proceedings functions. Education will also continue to be a key area for HDC, as in practice systemic advocacy for consumers is even more important than the complaints resolution function. We aim to ensure that our educational activities are carefully targeted to meet the various needs of providers, consumers, and the public.

Acknowledgements

The year was marked by the departure of a number of senior staff who played key roles in the development of the Office under the first Commissioner, Robyn Stent: Moe Milne (Kaiwhakahaere, 1995–2000), Jane Doherty (Director of Advocacy, 1996–2001), Tania Davis (Director of Proceedings, 1998–2001) and David Turner (General Manager, 1999–2000). I thank them for their significant contributions.

Finally, I wish to record my thanks to all the staff of HDC, and everyone involved in Advocacy Services throughout New Zealand, for their dedication and commitment to our work in 2000/01.

REPORT OF THE DIRECTOR OF ADVOCACY

Director of Advocacy, Tania Thomas

Introduction

Key features of the fifth year of advocacy have been:

- the appointment of a new Director of Advocacy, Tania Thomas, in January 2001
- reviewing the advocacy service profile to increase consumer and provider awareness of the advocacy service and its role
- identifying advocacy service gaps in preparation for setting targets for the new operating year
- reviewing the method of data collection to improve the accuracy of information collected and the ease with which it is collected
- reviewing the method of monitoring and evaluating advocacy services to ensure a broader cross-section of consumer and provider input and more meaningful analysis of advocacy outcomes
- improving the interface with the Commissioner's Office to aid information sharing, speed up the processing of complaints, and facilitate common processes
- improving consistency in advocacy practice so that consumers receive services appropriate to their needs, advocates are responsive to their changing work environment, and all complaints are managed with high levels of competence.

Complaints Statistics

Ethnicity

- 10% of complaints closed by advocacy services were from Maori consumers. This is a 3% increase on the previous year. An increased number of Maori are using the advocacy service.
- 13% of all complaints managed by advocacy services were from Maori consumers.
- 3% of all complaints managed by advocacy services were from Pacific Island consumers (including Samoan, Tongan, Niuean and Cook Island consumers).
- 2% of all complaints managed by advocacy services were from Asian consumers (including Indian and Chinese consumers).
- The majority of complaints were from New Zealand Europeans.
- The number of both Pacific Island and Asian complainants has increased by 1% from the previous year.

Gender

- 60% of complainants were female.
- 29% of complainants were male.

- 11% of complainants did not state their gender.

Age

- People over 25 years of age made 48% of complaints managed by advocacy services.
- Across all ethnic groups, both male and female, the age group 26–60 years represented those who most frequently complained.
- New Zealand Maori, New Zealand European and Other European were the only ethnic groups that had complainants aged 61–99 years.

Ethnicity/Gender and Age

- The highest number of complaints were made by New Zealand European females over the age of 25 years.
- The second highest number of complaints were made by New Zealand European males over the age of 60 years.

Frequent Complaint Issues

Seventy-four per cent of all complaints managed by advocacy services concerned the following three issues:

1 appropriate standards
2 being fully informed
3 effective communication.

Outcome of Complaints

- 76% of complaints were partly or fully resolved with the assistance of advocacy.
- 12% of complaints were unresolved at advocacy and were referred to HDC.

Case Study: Advocacy services

Mrs A received voluntary mental health care as a result of severe depression, which followed a series of losses (her husband, mother, father and father-in-law passed away within a short time). She required a six-week inpatient stay at a mental health unit, where she encountered a problem with a male nurse. Although this nurse was not her key worker and had no responsibility for her treatment, she found that on several occasions he went out of his way to upset her.

Soon after Mrs A's admission the nurse entered her room and announced in a very authoritarian way that she had to see the doctor. The nurse was not wearing a name badge and had not introduced himself, and Mrs A found this confusing.

Mrs A had worked in the health-care industry (in rest homes and as a hospice volunteer) and wished to support others in the unit. The nurse found this unacceptable and abused her angrily, telling her that the other patients were not her business.

Mrs A had suffered from a poor appetite and found that the nurse focused on this. He told Mrs A that she was slowly committing suicide by not eating and that it was against her Catholic beliefs. One morning Mrs A awoke to find that the nurse had placed a poster of a tombstone in her room. He told her that he would put up a tombstone poster every day until she left the unit. This frightened Mrs A and caused her to have nightmares and suicidal thoughts. Throughout Mrs A's stay the nurse went out of his way to make things extremely difficult for her.

Mrs A felt that she could not complain while she was in the unit for fear of an adverse outcome, but she was able to share her concerns with a friend, who helped her to contact an advocacy service. An advocate met with Mrs A and accompanied her to an interview with the Unit Manager and to a meeting with the hospital's Clinical Director of Mental Health.

The case was then referred to the Nursing Council. Mrs A was concerned about the stress involved in this development and the possibility that she would have to be a witness. However, she received extra support from her mental health worker and physician during this period, and ongoing assistance from her advocate.

Mrs A was required to give evidence at a formal hearing, which she found very difficult as the nurse was present, but her friend and her advocate both provided support. The outcome of the hearing was that the nurse was fined and required to work under supervision in the unit.

Mrs A was determined that her complaint be heard, as she did not want future consumers to face a similar ordeal. She was concerned that should she return to the unit she would face similar situations with the nurse. Mrs A had witnessed younger nurses following the nurse's abusive management and did not want the cycle to continue. She had also heard that the hospital staff were unhappy with the nurse's behaviour.

Mrs A is pleased with the outcome and says that without the support of the advocacy service she would not have known how to approach the problem.

Maori advocates hui, Whare nui at Houmaitawhiti Marae, 2001

- 12% of complaints were withdrawn as consumers did not wish to proceed.

Referral Methods of Complaints

The majority of referrals to advocacy were through the regionally based advocacy services. Health providers, followed by friends of consumers, other agencies, and relatives made up the next most frequent referring agents.

Advocacy Contracts

The funding reduction of $600,000 experienced by advocacy services in 1999/2000 adversely affected the level of services, particularly to those who live in rural areas in Northland, Southland and Otago. Additional funding was gained from HDC, and extra services were contracted in 2000/01. Output volumes were increased in line with the additional services contracted.

However, despite this, the reduced funding affected services to consumers with complex, long-term needs, as the intensive services required are not available. Maori and Pacific Island peoples, for whom face-to-face contact with advocates is especially important, are less likely to respond well to telephone advocacy, a less costly option that has been adopted in parts of the advocacy service. Less time is now available for proactive educational and promotional activities, and the number of presentations has also been reduced.

Another area affected by the reduced funding is training and support for advocates. Training is still basic despite the increased complexity of presenting complaints and the diversity of complainants.

The advocacy service organisations have continued to work hard to meet their contractual requirements whilst actively managing the impact of the reduced funding.

The Advocacy Guidelines issued by the Commissioner and interpreted in the Advocacy Contracts Manual have been revised. The amended Guidelines have been circulated for consultation and in October 2001 the final

Case Study: Failure to ensure that services provided took into account the needs, values and beliefs of Maori

Mr A, an 81-year-old Kaumatua, was admitted to hospital for a cholecystectomy scheduled for the following day. No Maori Health Liaison Officer was contacted when Mr A was admitted, and his whanau was unaware that this was a possibility.

Because Mr A had a hearing deficit his whanau wished to be present when the doctor consulted Mr A about the operation. The whanau was advised that Mr A would be seen by doctors the next day, and that his operation was booked for approximately 11am. Mr A's whanau arrived at 9.30am the next day but found that Mr A had already seen a doctor and had signed the operation consent form. Mr A had been given an information booklet on gallbladder surgery but this did not contain any reference to the risks involved in the surgery.

During the surgery Mr A began to bleed from behind the liver, necessitating packing of the area. The packs were subsequently removed but significant bleeding occurred again. Mr A was transferred to another hospital, where the source of bleeding was identified and controlled. However, Mr A gradually deteriorated into renal failure and died.

Mr A's whanau believed he was not able to give informed consent and that Mr A and his whanau were unaware of the risks involved in the operation.

One of the cornerstones of Maori oranga (wellness) is the concept of te whanau. This deals with the linking of relationships from a common ancestor. Te whanau is encompassed in the Code's fundamental principles. Taking into account the needs of Maori means that providers must recognise the relationship between individuals and their whanau.

Another cornerstone of Maori oranga is the concept of te tinana. Maori believe that the mind, body and soul are closely inter-related and influence physical well-being; physical health cannot be dealt with in isolation, nor can the individual be seen as separate from the family.

In keeping with the hospital's policy on cultural safety, it was reasonable to expect staff to recognise the need for Mr A's whanau to be in attendance when he was visited by the doctor prior to his operation. This did not occur, and accordingly the hospital was found to be in breach of the Code.

The Commissioner recommended that the hospital utilise the services of its Maori Cultural Advisor to inform nursing and medical staff of the most appropriate ways of ensuring that the needs and values of Maori are respected. The hospital was also advised to review its patient information booklet on gallbladder surgery to include appropriate risk information.

This opinion (98HDC20993) can be found on the Commissioner's website: www.hdc.org.nz.

revision will be sent to the Minister of Health for approval.

Service Delivery

Advocacy Logo

A new advocacy logo has been launched to sit alongside the HDC logo. All advocacy service contractors will use the logo on promotional and letterhead materials. This strategy aims to promote a nationally consistent profile of advocacy services. Banners for major promotions, presentation materials and pamphlets have been developed using the new logo.

Services to Maori

- Maori advocates met for a two-day hui in April to discuss improvements to services being offered to Maori consumers, and ideas for enhancing the services' work and commitment to the Treaty of Waitangi.
- The Health Advocates Trust, which is contracted to provide services in the North and in Auckland, appointed a Kaitutaki Tangata. This is a focused Maori position aimed at ensuring that the Code of Rights and health and disability advocacy are promoted to Maori consumers and providers.

Trends

The following observations have been reported by advocacy services managers:

- An increase in the number of complaints in respect of access to services, particularly reduced home help hours.
- An increase in complaints relating to ACC. Key issues are inadequate information from ACC staff and partial rather than full examinations being completed by ACC approved doctors when the consumer is sent for review.
- A lack of discharge planning for consumers when leaving hospital.
- An increased demand for advocacy support from mental health consumers who believe health professionals do not listen to them.

- An increased number of complaints made about residential care (including community homes); complaints concern adequacy of facilities and standard of care. Consumers and their families are reluctant to complain in case this has an impact on the person receiving care.
- An increase in the number of complaints made about dental technicians.
- Difficulty in getting past prison nurses to speak directly with prison doctors about consumer concerns. Advocates have found that prison inmates do not have ready access to a second opinion as there is usually only one prison doctor.
- Financial exploitation by landlords of consumers with a disability.
- Consumers with alcohol and drug problems being viewed by staff as "drug seekers", and consequently their condition and concerns not being treated seriously.
- Delays by providers when responding to complaints.

Systemic Issues

Under section 30(k) of the Health and Disability Commissioner Act 1994 advocates may report to the Commissioner any issues they believe should be brought to his attention. A total of ten section 30(k) reports were sent to the Commissioner during 2000/01.

Monitoring and Operation of Advocacy Services

The Director monitored compliance with the Advocacy Service Contract and performance standards in the Advocacy Contract Operating Manual through quarterly and annual reports from advocacy services. The Director made six-monthly visits to all advocacy services organisations.

Audit

The audit for 2000/01 will take place at the end of 2001. Significant changes are envisaged to the terms of reference and method of collecting data. In addition to reviewing advocacy service delivery against annual plans, the Advocacy Contract, Advocacy Guidelines and the Advocacy Contracts Operating Manual service standards, the audit will include a review of the efficacy of advocacy services and a satisfaction survey of consumers and providers. Independent auditors will conduct the audit.

Consumer Satisfaction

High levels of consumer satisfaction were reported from regular surveys undertaken by advocacy services along with some suggestions for improvements:

- There was not always a choice of advocate for consumers, in terms of gender or ethnicity.
- Consumers were not always made aware of the advocacy service's internal complaints process.
- Consumers were disappointed that advocacy services are unable to assist with access to services and issues concerning ACC entitlements.

Provider Satisfaction

Satisfaction surveys from providers were positive. Comments in respect of presentations included:

- "Overall presentation and content easily understood and informative."
- "As a result of the presentation our complaint form now includes information on independent advocates."
- "Information is now printed in our marketing booklet for the service."

Complaints about Advocacy Services

Twenty-four complaints were made about advocacy services. These were all investigated and appropriate action was taken to resolve the issues. The majority of complaints were from providers. Complaints provide opportunities to improve advocacy procedures and staff training.

From left, Ron Paterson, Elaine Bycroft (Thames advocate) and Tania Thomas

Quality Assurance

All advocacy services organisations completed the following as part of their quality assurance programmes:

- case related supervision
- regular staff meetings
- quarterly staff training sessions
- review and revision of operating policies
- staff performance reviews.

Training for Advocates

In addition to the regional training for advocates, in November 2000 the Director held a "best practice" conference for all advocacy staff.

Case study: Failure to provide services in a manner consistent with needs

A psychologist was employed to tutor literacy skills to Ms A, a young woman with an intellectual disability and hearing loss. The psychologist believed that the hearing impairment was the reason for Ms A's low cognitive abilities and took it upon herself to expand her role and arrange additional training, in an attempt to prove that Ms A was of normal intelligence. The psychologist organised social outings, visits to church, speech and drama lessons, and computer lessons.

Ms A attended an IHC day centre. When the psychologist first put forward her view that Ms A was of normal intelligence, IHC asked their consultant psychologist to review Ms A's mental capacity. He formed the view that Ms A performed below the level of her peers and he criticised the appropriateness of the tests undertaken by the psychologist, and her interpretation of the results. All other psychological and psychiatric professionals involved in Ms A's care concurred that she had an intellectual disability.

The psychologist remained convinced that Ms A was of normal intelligence and launched a crusade to have her removed from the IHC centre. This created friction between the psychologist and staff at the centre, resulting in several confrontations, which Ms A found very distressing.

Ms A's mother had no doubt that her daughter had an intellectual disability and felt that Ms A was happy attending the IHC centre. Initially Ms A's mother had given her consent for the psychologist to arrange extra activities for Ms A but became concerned when the psychologist's involvement escalated and included involvement in Ms A's financial arrangements.

As Ms A became tired and stressed by the increased activities, and by the pressure placed on her by the psychologist, Ms A's mother asked the psychologist to reduce her involvement with Ms A. However, the request was refused, as were subsequent requests by both the IHC centre and Ms A's mother.

The psychologist was found to have breached rights 1(1), 4(2) and 4(3) of the Code in failing to treat Ms A with respect, in harassing Ms A and her caregivers, exploiting her professional relationship with Ms A, and failing to comply with the professional standards in the New Zealand Psychological Society's *Code of Ethics*.

The Commissioner concluded that it was unacceptable for the psychologist to have discounted the clinical data that Ms A had an intellectual disability. As a person with an intellectual disability, Ms A was entitled to services provided in a manner consistent with her needs. In continuing to push Ms A, and to access services for her on the basis that she had no intellectual disability, the psychologist failed to provide services in a manner consistent with Ms A's needs.

The Commissioner recommended that the psychologist cease all contact with Ms A, that she review her practice, and that she apologise to Ms A and Ms A's mother.

This opinion (00HDC00626) can be found on the Commissioner's website: www.hdc.org.nz.

REPORT OF THE DIRECTOR OF PROCEEDINGS

Director of Proceedings, Morag McDowell

Introduction

This year, the third for a full-time Director of Proceedings, was one of significant professional development and consolidation for the Office, particularly in internal systems and prosecutions before the various tribunals. Individuals within the Office gained experience in their exposure to proceedings, and the Office consolidated its professionalism by the employment of more experienced outside counsel for high profile or difficult cases. A number of cases attracted significant media attention, highlighting public interest in medical negligence (Dr Parry and Dr Harrild), and sexual misconduct by health professionals. It was also a year marked by change, with the appointment of full-time Legal Counsel to assist the Director, and the departure of the Director of Proceedings, Tania Davis, in June 2001.

As the new Director of Proceedings the task of commenting on the past year's achievements and progress of this Office has fallen to me. I have done so in consultation with Legal Counsel to the Director, support staff and others within the organisation.

Case Summary

Over 2000/01 the Director received 26 new referrals from the Health and Disability Commissioner (up from 21 the previous year — an increase of 23%). The Commissioner refers "matters" that are consumer based. However, as Proceedings is in the business of prosecuting providers, the statistical and working system of this Office is provider based. Accordingly, the 26 new referrals culminated in 41 matters for consideration by the Director. As at 1 July 2000, 25 matters remained open (thus 66 matters in total for the year).

Proceedings

Ten cases were concluded through the various disciplinary bodies. There were seven successful prosecutions — a 70% success rate. At 30 June 2001 a further 12 matters awaited hearing (two of these matters involve the prosecution of one provider in respect of two complainants).

Of those prosecuted (to completion):

- 3 were general practitioners (only 1 was prosecuted successfully. The Director of Proceedings has appealed one of the unsuccessful findings of the Medical Practitioners Disciplinary Tribunal (MPDT). The outcome is not yet known). An appeal to the High Court brought by the Director is also pending in respect of a general practitioner who successfully defended a prosecution and District Court appeal in 1999/2000;

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- 2 were obstetricians/gynaecologists (both successful prosecutions. In one decision (Dr Parry) the obstetrician appealed the MPDT's decision to the District Court. As a result of the District Court's decision further appeals are pending in the High Court on behalf of both the practitioner and the Director of Proceedings);
- 1 was a breast surgeon (prosecution was unsuccessful);
- 4 were nurses (all prosecutions were successful. One of the nurses appealed the Nursing Council finding to the High Court in Wellington but was unsuccessful and the finding was upheld).

The professions involved in the 12 matters awaiting hearing are as follows:

- 2 nurses
- 5 general practitioners
- 2 dental technicians (same provider being prosecuted in respect of two complainants)
- 1 registrar (obstetrics)
- 1 pharmacist
- 1 anaesthetist.

In addition to the above disciplinary prosecutions, the Director brought an appeal to the High Court from a decision of the Complaints Review Tribunal — *The Director of Proceedings v O* (Gendall J, Wellington High Court, 11 August 2000). The appeal was successful and is discussed in further detail in the 1999/2000 Annual Report of the Health and Disability Commissioner.

At the close of the financial year:

- 1 matter in which Complaints Review Tribunal proceedings were issued was successfully settled prior to hearing;
- 7 matters were in the process of having claims drafted for the Complaints Review Tribunal;
- the Director had decided to take no further action in respect of 24 matters;
- decisions had yet to be made in respect of 8 matters;
- 2 matters remained on hold pending legal advice and the outcome of settlement negotiations.

The above statistics are summarised in the following table.

	Disciplinary Proceedings				Complaints Review Tribunal			
Provider	**Successful**	**Unsuccessful**	**Pending**	**Appeal**	**Successful**	**Pending**	**Appeal**	**Total**
Medical practitioner	3	3	7	1	1	2		17
Dental technician			2					2
Nurse	4		2				1	7
Pharmacist			1					1
Mental health worker						3		3
Iwi Health Authority						1		1
District Health Board						1		1
Total	7	3	12	1	1	7	1	32
Other action								
Not for action								24
Decision yet to be made								8
On hold								2
Grand total								**66**

Quality Assessment of the Director of Proceedings and her Office

An informal quality survey of the relevant Tribunals/Councils and outside counsel (both prosecution and defence) was undertaken by the Commissioner's Office as to the Director's conduct of proceedings for the year. Specifically, the Commissioner sought comment on whether there had been professional, competent and high quality conduct of proceedings in relation to:

- presentation of Tribunal/Council documentation;
- presentation and conduct of cases before the disciplinary bodies and/or Complaints Review Tribunal;
- contact with professional bodies and external counsel.

The feedback was largely positive. Presentation of pleadings, charges, submissions and other documentation was regarded as being of a high standard. Most of those surveyed considered that charges were appropriately drafted and accurately reflected the evidence presented at hearing.

Outside counsel were briefed appropriately (for serious and high profile cases) and were highly regarded by all who responded. Expert and lay witnesses were appropriate, well briefed and used to good effect.

Every respondent commented that the Director and her staff were respected, professional, empathetic to consumers, co-operative and competent.

There is room for improvement in two areas. First, the lengthy delays between receipt of the complaint and charges being laid. Only part of this delay can be attributed to the Director's Office. As new Director I will, as a matter of priority, endeavour to process matters more expeditiously.

Secondly, one respondent stated that an area for improvement (by all participants in the disciplinary process) is in increasing consciousness of the serious harm people can suffer from the processes involved in disciplinary proceedings and actively seeking to minimise that harm. This would involve the Director assisting patients and their families to gain a better understanding of the elements that lie behind what they have experienced. As new Director I am committed to this goal.

Vignettes

The year was remarkable for a number of high profile cases and, at times, controversy in respect of those cases. The following three vignettes are of cases prosecuted this past year.

Dr Parry

Most New Zealanders will recall the face of the dying Colleen Poutsma appearing regularly on television screens throughout the year. Media attention highlighted criticism of the Commissioner and this Office for the delay in bringing the matter to hearing and failure to address public safety concerns while Dr Parry continued to practise. The MPDT also attracted criticisms of bias and being inappropriately affected by media attention.

In August 1997 Mrs Poutsma had been referred to Dr Graham Parry, consultant obstetrician and gynaecologist, after presenting to her GP with post-coital bleeding. At the initial consultation Dr Parry conducted a trans-abdominal ultrasound scan of Mrs Poutsma's uterus and ovaries but did not examine her cervix and vagina. The smear taken by her GP was reported as having some abnormalities (with the suggestion for a further smear in six months' time). Dr Parry undertook no further examinations and did not ascertain the cause of her bleeding.

In December 1997 Mrs Poutsma was again referred to Dr Parry by her GP as a matter of urgency following a severe post-coital bleed. On 31 December 1997 Dr Parry examined her cervix and took another smear and a punch biopsy. In his reporting letter to the GP he stated that the cervix looked considerably abnormal and different from the last time (despite not having examined the cervix previously). Histology results reported on

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9 January 1998 showed invasive squamous cell carcinoma. On 19 January Dr Parry conducted a laser cone biopsy resulting in a severe post-operative haemorrhage that necessitated an emergency hysterectomy.

The histology from the cone biopsy reported on 6 February confirmed cervical cancer and Dr Parry referred Mrs Poutsma to National Women's Hospital's Oncology Department on 9 February. Mrs Poutsma made her complaint to the Health and Disability Commissioner in April 1998. The matter was referred to this Office in September 1999 and a charge was laid against Dr Parry in July 2000.

Dr Parry was charged with disgraceful conduct (amended from the original charge of professional misconduct) in respect of:

- his failure to conduct an adequate clinical assessment and examination (at the initial consultation); and/or
- the unnecessary/unjustified cone biopsy on 19 January 1998; and/or
- his failure to refer Mrs Poutsma to National Women's Hospital until 9 February 1998 (one month after confirmation of cancer).

At the hearing he did not dispute the facts, or that his conduct fell below acceptable standards. His defence related to the degree of culpability that should attach to his conduct. It was argued that his conduct fell at the level of professional misconduct and not disgraceful conduct.

The Tribunal found Dr Parry guilty of disgraceful conduct in respect of the first two particulars of the charge, and professional misconduct in respect of the third. It considered his failure to undertake even the most basic of investigations at Mrs Poutsma's initial consultation to be "grossly negligent" and reckless. The taking of a cone biopsy was inexplicable, showing a "grave error of judgement". In respect of other areas of Dr Parry's practice the Tribunal commented that he displayed a lack of understanding and application of modern gynaecological practice.

Dr Parry's name was removed from the medical register and he was censured and ordered to pay a fine of $15,000 and costs of $56,280.48.

He appealed to the District Court on the basis that the Tribunal was biased, that it erred in its findings, and that the penalty was manifestly excessive. Hubble DCJ upheld the findings of disgraceful conduct in respect of the first particular, but reduced the Tribunal's finding on the second particular to one of professional misconduct (*Parry v MPDT*; NP 4412/00, Auckland District Court, 30 May 2001). The judge upheld the Tribunal's finding that cumulatively Dr Parry's conduct was disgraceful.

In respect of the penalty Judge Hubble did not disturb the costs award. However, he permitted Dr Parry to practise in a limited manner (obstetrics/ultrasound only) and under supervision. The fine was reduced to $5,000. Both parties have appealed to the High Court.

Colleen Poutsma passed away on 11 April 2001.

Nurse X

Owing to suppression orders made by the Nursing Council in this case, the commentary is necessarily limited. However, the case deserves mention for the first-time finding by the Council that a nursing supervisor's disrespect for her work colleagues (such that it affected the ability of staff members to perform their functions adequately) amounted to professional misconduct that would bring discredit on the nursing profession. This finding affirms the responsibility and accountability of nursing supervisors for professional leadership.

Dr Harrild

Another recent case that received significant publicity was that of Dr Jeffrey Harrild, a Masterton obstetrician who faced charges of professional misconduct before the MPDT.

The complainant mother had been referred to Dr Harrild in August 1997, at 27 weeks' gestation, as her GP was concerned that she was carrying extra amniotic fluid. Throughout the following months she kept a kick chart at Dr Harrild's suggestion. On 30 September (at 37 weeks' gestation) the complainant felt reduced

movements and was admitted to hospital the following day on the recommendation of her midwife. Over the course of three days the complainant and her baby were monitored. On the evening of 1 October (the first day) a hospital midwife considered the CTG reading of the baby to be flat and advised the complainant that it was likely that Dr Harrild would want to perform a Caesarean section. Dr Harrild was consulted regarding the CTG reading, but he did not consider that immediate delivery was indicated.

Monitoring continued the following day with little change. The same midwife on the evening shift performed another CTG tracing and again advised the complainant that it was likely a Caesarean would be performed. However, after enquiries the midwife found that Dr Harrild was not intending to return that evening. The midwife then showed the complainant (and her husband) a CTG reading from a healthy baby and urged her to seek a second opinion. The complainant contacted her own midwife who expressed faith in Dr Harrild's abilities. Dr Harrild came in later that evening at the urging of the complainant's husband. Dr Harrild advised that the baby was best where it was and that he was not overly concerned about the CTG recordings.

On the afternoon of 3 October the hospital midwife carried out another CTG but could not detect a foetal heartbeat. Dr Harrild was called and he confirmed that the baby had died in utero. He gave some advice about delivery options to the complainant and her husband, and left the hospital. The complainant asked to be transferred to Wellington Hospital and terminated her care with Dr Harrild.

A baby girl was delivered stillborn on 6 October 1997.

Dr Harrild faced one charge of professional misconduct, with seven particulars relating variously to misinterpreting clinical signs of foetal distress (including the CTG tracings), failing to effect an immediate Caesarean, failing to communicate effectively and appropriately, and failing to offer appropriate support and information following the death of the baby.

Dr Harrild admitted those particulars relating to the clinical issues but denied the "communication" and "failing to appropriately support" particulars. He denied that any of the particulars, either separately or cumulatively, amounted to professional misconduct.

The Tribunal found that the clinical particulars (admitted) amounted to professional misconduct and commented that Dr Harrild's decision to "wait and see" was a serious error of judgement.

The "communication" particular was not proven.

The particular relating to Dr Harrild "failing to offer support and adequately inform of delivery options" was proven, but to the lower standard of conduct unbecoming which reflected adversely on Dr Harrild's fitness to practise.

At the time of writing the MPDT had not determined the penalty. However, the Tribunal did pass comment on the circumstances surrounding the offending conduct. Concern was expressed by the Tribunal that Dr Harrild was practising under an exhausting, almost intolerable burden of work as the only obstetrician and gynaecologist in the Wairarapa (for seven years). Criticism was also levelled at the "dysfunctional" maternity unit at Masterton Hospital. The Tribunal was satisfied that these (and other identified factors) contributed to the events in question.

Conclusion

In conclusion, it is appropriate to recognise the hard work of Tania Davis, the first full-time Director of Proceedings. Tania was responsible for establishing the Director's Office, systems, and proceedings, while coming to grips with unfamiliar jurisdictions and systems. That the quality assessment feedback for 2000/01 was so positive is a credit to her. Tania was well known for her empathy and commitment to consumers and her particular concern for Maori consumers. I would like to thank her for her commitment. I look forward to consolidating the Office and building on its strengths.

Case Study: Traps in repeat prescribing

Through a series of repeat prescriptions from 1995 until her death of a pulmonary embolism in 1998, Claire Lynch-Smith, a woman in her early thirties, had her prescription for the third-generation oral contraceptive pill Femodene renewed nine times. Numerous doctors at the medical centre she attended signed the prescriptions.

Mrs Lynch-Smith was never explicitly advised to have her medication reviewed throughout this period. In 1996 her general practitioner recommended an appointment for a "well woman check", but did not specify a check of her medication. Mrs Lynch-Smith had a cervical smear in April 1997 and received repeat prescriptions for almost two more years, despite the fact that no review of the continuing appropriateness of her medication was carried out.

The Commissioner concluded that the patient had not made an informed choice to refuse a medication review. She was never sufficiently informed of the need for such a review. It had not been made clear to her that a "well woman check" included a medication review, or that such a review was needed in relation to the ongoing prescription of Femodene.

The general practitioner advisor stated that women taking oral contraceptives should have their medication reviewed regularly, at least once a year as a minimum, to ensure that nothing has happened in the intervening period that indicates the medication is no longer clinically appropriate. Before renewing a prescription for an oral contraceptive, a practitioner has a responsibility to check whether a patient needs her medication reviewed. In most situations it would be sufficient to advise the patient of the need for a review and allow the patient to arrange this.

It is good practice to confirm this advice in writing. In some situations it may be appropriate to prescribe a continuation of the medication for one month to ensure that cover is maintained pending a suitable appointment. Any discussions in these circumstances should be clearly recorded in the medical notes.

The general practitioner and the medical centre ought to have known that Mrs Lynch-Smith's prescription needed to be reviewed and should have taken reasonable steps to review it, to ensure that its ongoing use was clinically appropriate. Reasonable steps include clearly informing the patient about the need for review of the medication, seeking an updated history, and performing a physical examination, including specific tests to identify whether the patient has any new risk factors or contraindications. A review consultation also provides an opportunity for the doctor to update the patient with any relevant information, such as new risk information about third generation pills.

By continuing to prescribe medication for patients without taking reasonable steps to ensure that its ongoing use is clinically appropriate, doctors fail to provide services with reasonable care and skill and in compliance with relevant standards, in breach of rights 4(1) and 4(2) of the Code. This level of care, skill and compliance is required of every practitioner who signs repeat prescriptions. Medical centres should have a policy in place that ensures repeat prescriptions are issued only to patients who have had the appropriate checks carried out. Doctors should not sign repeat prescriptions, notwithstanding pressure from patients to do so, unless satisfied that the medication remains clinically appropriate.

Mrs Lynch-Smith's general practitioner told investigation staff that refusing to renew a prescription when a review was overdue is a *"dogmatic way to retain a doctor's rights and medico legal defence [and] is not always going to be in the patient's best interest."* However, if a review of medication is overdue, it is entirely reasonable and appropriate for a doctor to require it before renewing the prescription. Doctors are not beholden to their patients' demands for services, including repeat prescriptions. The Code does not give patients, even if fully informed, the right to demand services. If a patient decides not to have a medication review, it is clinically inappropriate to renew the prescription. While patients cannot be required to undergo prerequisite reviews or checks, they equally cannot expect to receive medication on demand in these circumstances. Providing services in a manner consistent with patients' needs is not the same as providing inappropriate services in accordance with patients' wishes.

Recommendations in the Lynch-Smith case included that the medical centre review its policy and practice in relation to prescribing oral contraceptives. The centre indicated that it has made changes to ensure that patients have regular review of ongoing medication, and only one repeat between visits to the doctor. The general practitioner was asked to review her practice in light of the Commissioner's report, and to apologise to Mrs Lynch-Smith's family.

This opinion (99HDC01756) can be found on the Commissioner's website: www.hdc.org.nz.

ENQUIRIES AND COMPLAINTS

From left: Nicola Holmes (Senior Investigator, Projects), Siniua Lilo (Senior Investigator), Steve Anthony (Senior Investigator), Katharine Greig (Assistant Commissioner), Annette May (Enquiries Administrator), Kathryn Leydon (Senior Investigator)

Enquiries

The Health and Disability Commissioner classifies as an enquiry any contact with the Office that is not a complaint about the provision of health or disability services. For example, people seek general information about the Code and the Office or how to make a complaint.

Most people who make enquiries do so by telephone. A toll-free line (0800 11 22 33) enables callers to contact dedicated enquiries staff. The enquiries staff also co-ordinate responses to written queries.

The Enquiries and Complaints Database System (ECDS) is used to record details of both enquiries and complaints. This allows the Commissioner to track and monitor enquiries and complaints, both written and verbal.

During the year, 3,311 enquiries were received and 3,277 were closed. The table overleaf details the actions taken on enquiries for the year ended 30 June 2001. Calls of a general administrative nature are excluded from the statistics.

Enquiries staff assist callers by explaining options available to them, for example advocacy services, advising on other more appropriate agencies, and by sending out promotional material.

Written responses (known as formal responses) are made to written enquiries requesting information about the Health and Disability Commissioner and clarification or interpretation of various sections of the Health and Disability Commissioner Act 1994. A number of these responses are drafted by the Legal Services division. Such formal responses are an important part of the Commissioner's educational role in ensuring that the Code and the Health and Disability Commissioner Act 1994 are better understood.

The provision of general information to callers is categorised by whether the information was provided in verbal or written form.

Only callers transferred directly to an advocacy service are recorded as "advocacy referrals". While other callers may be given information about advocacy, they are included in the statistics as having been provided with verbal or written information.

Assisting callers to locate the most appropriate authority is a regular occurrence for the enquiries team, and in many of the enquiries recorded in the table overleaf ("Actions Taken on Enquiries") as "outside jurisdiction" the caller was advised of a more appropriate authority.

"Sent written information" refers to the sending of pamphlets and educational material.

Actions Taken on Enquiries	2000/01
Enquiry became a complaint	21
No response required	29
Open	34
Formal response provided	171
Verbal and written information provided	118
Verbal information provided	1,732
Referred to Advocacy	187
Referred to Communications Advisor/Education Advisor	1
Outside jurisdiction	370
Referred to another agency	9
Written information sent	639
Total	**3,311**

Complaints

Initial administrative actions on complaints are dealt with by enquiries staff. All complaints are then assessed by a panel of senior staff, including a senior legal advisor, a senior investigator, the enquiries administrator and the Director of Advocacy. The panel makes recommendations to the Commissioner on how to handle each complaint.

If a matter proceeds to investigation, it is allocated to one of three investigation teams (two in Auckland and one in Wellington), each consisting of up to five investigators under the supervision of a senior investigator.

Complaints Summary

In the year ended 30 June 2001 the Commissioner received a record 1,397 complaints. This is 28.4% more than the 1,088 complaints received in the previous year.

Possible reasons for the increase in complaints include the publicity surrounding events such as the Gisborne Cervical Cancer Inquiry, the re-use of syringes in Whangarei and Gisborne, inadequately cleaned endoscopes in Christchurch and Rotorua, and the case of Colleen Poutsma in Northland. Media coverage of these events caused the public to reflect on their own experiences and in some cases to take action in the form of a complaint.

There was a further increase in productivity and output over the last year, with 1,338 complaints closed in the year, representing a 2.6% improvement on the 1,303 closures the previous year.

Notwithstanding the increase in productivity, at 30 June 2001 the number of open complaints stood at 634 — an increase on the 575 open complaints at 30 June 2000.

Over the last year considerable effort has been put into reducing the time taken to close files, and significant progress was made. Closure of complaints is now being completed at a faster rate, with the average time to finalise action on a complaint decreasing from 44 weeks to 34 weeks. At 30 June 2001 only 23% of complaints were open after 12 months, compared to 37% the previous year. Only 10% were more than 18 months old, compared to 20% a year ago, and 4% were more than 2 years old compared to 8.5% a year ago.

One of the recommendations of a management review of the Office undertaken by an external consultant in July 2000 was for a consultative review of the entire process of managing enquiries, complaints, and investigations. Another recommendation was for an investment in staff training and development. Progress has been made in both areas.

Complaint Numbers	2000/01	1999/2000	1998/99	1997/98	1996/97
Open at year start	575	790	778	419	0
New during the year	1,397	1,088	1,174	1,102	1,000
Closed during the year	1,338	1,303	1,162	743	591
Open at year end	**634**	**575**	**790**	**778**	**409**

The investigation processes are currently under review, and during the year considerable effort was put into ensuring that investigations are procedurally fair. A number of changes to the investigation process have been made. In the upcoming year the review will be completed and the investigation processes will be re-engineered to ensure that investigations are undertaken in a fair and timely manner using transparent and robust processes.

All relevant staff have attended courses in the core skills required for investigations. Staff training days included consultation with staff and feedback on improvements to current processes and procedures. This year six senior investigation staff attended an investigation training course run by the Health Care Complaints Commission (HCCC) of New South Wales. The Commissioner has developed a networking relationship with HCCC, and three senior investigators visited the Sydney Office of HCCC at the time of the training course. The Assistant Commissioner also visited HCCC to see how it manages enquiries and complaints, prior to review of HDC processes.

Further investment in ongoing training and development is planned to assist with the increased numbers of complaints. While the focus this year has been on clearing old files, the increased volume of new complaints must also be managed in order to keep throughput within an acceptable timeframe.

Source of Complaints

The Health and Disability Commissioner Act provides that any person may make a complaint to the Commissioner alleging a breach of the Code. The table on page 28 sets out the source of complaints. As in previous years, complaints received directly from individual consumers are the source of most complaints (51%). A further 20% of complaints received were from relatives of consumers.

Complaints made under a health registration enactment and sent directly to a health professional body must be forwarded to the Commissioner. The health professional body must not take any action on the complaint until notified by the Commissioner that the complaint is not to be investigated further under the Health and Disability Commissioner Act, or that it has been resolved, or that it has been investigated and is not to be referred to the Director of Proceedings.

Complaints referred from health professional bodies, in particular from the Medical Council, Nursing Council and the Pharmaceutical Society, have increased significantly this year (69%, 225% and 250% respectively). Again, this may be a response to publicity surrounding events such as the Gisborne Cervical Cancer Inquiry.

Types of Provider subject to Complaint

The 1,397 complaints received involved 1,685 providers, with 28% of complaints involving more than one provider. The table on pages 30–31 sets out the numbers of complaints against categories of individual and group providers.

For the year ended 30 June 2001 the types of individual provider most commonly complained about were:

- general practitioners 37%
- obstetricians/gynaecologists 6%
- nurses 6%
- dentists 6%
- midwives 4%

In comparison with the year ended 30 June 2000, for the year ended 30 June 2001 complaints against some types of individual provider increased significantly as follows:

- general practitioners 80%
- dentists 62%
- midwives 54%
- physicians 92%
- pharmacists 54%

For the year ended 30 June 2001 the main categories of complaint against group providers were:

Health and Disability Commissioner

Source of Complaint	2000/01	1999/2000	1998/99
Chiropractic Board	1	2	3
Dental Council	9	8	9
Dental Technicians' Board	1	2	4
Medical Council	71	42	73
Medical Radiation Technologists' Board	1	–	–
Nursing Council	26	8	19
Occupational Therapy Board	5	–	1
Opticians' Board	–	3	1
Pharmaceutical Society	21	6	16
Physiotherapy Board	4	1	1
Psychologists' Board	13	9	10
Subtotal (professional boards)	**152**	**81**	**137**
Accident Compensation Corporation	7	3	39
Advocacy Services	94	40	75
Coroner	1	1	–
Disability consumer	–	1	5
Disability provider	4	2	5
Employee	8	5	3
Friend	36	14	6
Health consumer	718	748	618
Health Funding Authority	–	1	–
Health provider	34	17	37
Health Regulatory Body	3	–	–
Human Rights Commission	–	–	6
Lawyer	38	15	29
Medical laboratory	–	1	–
Member of Parliament	6	9	–
Member of the public	4	2	22
Minister of Health	–	–	1
Ministry of Health	2	3	4
Ombudsman	1	–	6
Police	2	3	3
Professional association	5	2	2
Regional Licensing Office	3	2	2
Relative	279	138	174
Subtotal (other sources)	**1,245**	**1,007**	**1,037**
Total	**1,397**	**1,088**	**1,174**

- public hospitals 57%
- rest homes 12%
- pharmacies 7%

Initial Review of Complaints

The purpose of the Health and Disability Commissioner Act is to secure the fair, simple, speedy and efficient resolution of complaints. To achieve this the Commissioner aims for resolution of complaints at the most appropriate level.

On receipt of a complaint the Commissioner is required to decide whether the matter is within jurisdiction and, if so, whether to refer the matter to advocacy, to investigate, or to take no action under section 37 of the Health and Disability Commissioner Act 1994. There are very limited circumstances in which the Commissioner can decide to take no action on a complaint that is within jurisdiction. The October 1999 Report to the Minister of Health on a review of the Health and Disability Commissioner Act 1994 recommended that the Commissioner be given greater discretion to take no further action on a complaint in order to utilise resources more wisely and in a manner that best achieves the aims of the legislation. This recommendation was supported by the Cull Report to the Minister of Health in March 2001.

As noted previously, a panel of senior staff review all new complaints and make recommendations to the Commissioner on how the complaints should be managed.

Outcome of Complaints

In the year ended 30 June 2001 a record 1,338 complaints were closed.

There are three main categories of complaint closures. First, because the Commissioner has no jurisdiction or the matter is more properly referred to another agency; secondly, the complaint is resolved either between the parties, or by advocacy or mediation, or is withdrawn; and thirdly, the matter is closed after an investigation. Each category is discussed below.

No Jurisdiction/Referred

A number of complaints are received that are outside the Commissioner's jurisdiction, either because the events complained of occurred prior to 1 July 1996 or the matters complained of do not relate to the provision of a health or disability service. Some matters are more properly dealt with by another agency and, after consultation, are referred. The table below sets out how complaints in this category were handled.

Resolved or Withdrawn

In 2000/01, 359 complaints received by the Commissioner were resolved either by the Commissioner (eg, by sending an educational letter to the provider) or with advocacy assistance, or at mediation, or by the parties themselves, or were withdrawn. Complaints may

Outside Jurisdiction/Referred	2000/01	1999/2000	1998/99
Outside jurisdiction	140	172	240
Referred to a health professional body	116	72	55
Referred to the Privacy Commissioner	45	36	28
Referred to the Human Rights Commission	7	5	3
Referred to the Office of the Ombudsmen	–	2	–
Referred to another agency	153	59	52
Total	**461**	**346**	**378**

Types of Provider subject to Complaint			
Individual Provider	**2000/01**	**1999/2000**	**1998/99**
Acupuncturist	–	–	2
Aesthetician/Electrologist	1	–	–
Alternative therapist	1	–	3
Ambulance officer	–	4	1
Anaesthetist	9	6	6
Cardiologist	3	1	1
Cardiothoracic surgeon	4	–	–
Caregiver	5	6	6
Chiropractor	4	8	6
Counsellor	3	1	6
Dental nurse	–	1	2
Dental technician	16	8	7
Dentist	63	39	46
Dermatologist	7	5	4
Emergency physician	2	–	–
ENT specialist	2	3	4
Gastroenterologist	1	–	–
General practitioner	397	220	251
General surgeon	51	31	15
House surgeon	9	4	7
Laboratory technologist	1	1	–
Medical officer	1	–	–
Mental health provider	–	–	12
Midwife	43	28	19
Needs assessor	–	–	2
Naturopath	–	3	–
Neurologist	4	3	9
Nurse	64	55	38
Obstetrician/Gynaecologist	68	26	20
Occupational therapist	14	6	3
Oncologist	4	–	–
Ophthalmologist	5	6	9
Optician	1	2	–
Optometrist	4	2	1
Oral surgeon	2	1	–
Orthopaedic surgeon	38	33	20
Osteopath	3	3	1
Other providers	21	75	116
Paediatrician	15	9	8
Pathologist	3	3	–
Pharmacist	20	13	34
Pharmacy technician	1	1	–

Individual Provider	2000/01	1999/2000	1998/99
Physician	46	24	34
Physiotherapist	24	8	8
Plastic surgeon	13	4	6
Podiatrist	–	1	2
Psychiatrist	20	16	19
Psychologist	33	25	26
Psychotherapist	1	–	–
Radiologist	7	2	2
Registrar	17	11	14
Rest home manager	2	2	17
Rheumatologist	–	–	2
Social worker	1	–	3
Specialist in occupational medicine	5	–	–
Surgeon	3	5	12
Urologist	7	11	6
Subtotal (individual providers)	**1,069**	**716**	**810**
Group Provider	**2000/01**	**1999/2000**	**1998/99**
Accident and emergency centres	12	9	8
Accident Compensation Corporation	2	10	18
Ambulance services	4	2	3
Dental providers	2	6	7
Disability providers	12	8	–
Educational facilities	2	3	–
Government agencies	–	7	–
Health professional bodies	–	3	–
Health funding services	1	7	18
Intellectual disability organisations	2	2	–
Laboratories	4	1	–
Medical centres	23	16	12
Other	33	13	58
Pharmacies	42	28	26
Prison services	14	23	15
Private medical hospitals	9	15	4
Private surgical hospitals	14	20	8
Public hospitals	351	264	269
Radiology practices	1	2	–
Rehabilitation providers	9	8	–
Rest homes	73	54	75
Trusts	6	10	–
Subtotal (group providers)	**616**	**511**	**521**
Total	**1,685**	**1,227**	**1,331**

Resolved/Withdrawn	2000/01	1999/2000	1998/99
Resolved by Commissioner	81	–	–
Resolved with advocacy assistance	77	72	95
Resolved at mediation	20	14	14
Resolved by parties	78	113	86
Complaint withdrawn	103	42	26
Total	**359**	**241**	**221**

be referred to an advocate either on receipt or during an investigation if this seems an appropriate way to achieve resolution. Since March 2001 the Director of Advocacy has sat on the panel that makes recommendations to the Commissioner on the management of newly received complaints. One of the objectives of her presence on the panel is to make recommendations on matters suitable for referral to advocacy.

Under the Act, matters may only be referred to mediation once an investigation has commenced. During 2000/01, 22 matters were referred to mediation. Of these, 20 were resolved.

Investigations

In 2000/01, 538 complaints were closed after an investigation.

During the course of an investigation the evidence collected is reviewed and considered. Having done so, in 286 cases the Commissioner decided that it was not appropriate to take further action, having regard to all the circumstances of the case. Such circumstances include successful mediation, and investigations and remedial action already undertaken by the provider where sufficient information is provided to satisfy the Commissioner that further investigation is not warranted.

The Commissioner issued reports on 252 matters. In 130 cases the Commissioner formed the opinion that a breach of the Code had occurred. In each of these cases the Commissioner's opinion was reported to the parties, and recommendations for action by the provider(s) were made. In the majority of cases the Commissioner recommended that the provider apologise for the breach of the Code, and review its practice in light of the report. In a minority of cases, specific remedial action (eg, a competence review by the Medical Council) was recommended. In 26 cases the matter was referred to the Director of Proceedings to consider whether further action should be taken. Other appropriate agencies, such as the relevant health professional body or the Ministry of Health, were sent a copy of the report. This year a concentrated effort has been made to send copies of reports, with identifying details removed, to the provider's professional college or association.

In 122 matters the Commissioner formed the opinion that the Code had not been breached. In these cases the evidence gathered during the investigation established that the matters complained of did not give rise to a breach of the Code; that the provider acted reasonably in the circumstances (which is a defence under

Complaints Investigated	2000/01	1999/2000	1998/99
Breach	130	227	144
No breach	122	284	223
No further action	286*	205	196
Total	**538**	**716**	**563**

*(includes 20 resolved at mediation)

clause 3 of the Code); or that there was insufficient evidence to establish the complaint.

Breach of the Code

As noted above, in 130 matters the Commissioner reported a breach of the Code. This represents 24% of cases investigated in 2000/01 — a decrease from 28% in the previous year.

The 26 matters referred to the Director of Proceedings represented 5% of complaints investigated, and 21% of breach reports. They involved the following individual provider types:

Acupuncturist	1
Anaesthetist	1
Caregiver	1
Counsellor	1
Dental technician	2
General practitioner	8
General surgeon	1
Midwife	6
Nurse	2
Obstetrician/gynaecologist	1
Ophthalmologist	2
Pharmacist	3
Pharmacy technician	1
Psychologist	2
Psychiatrist	1

Four matters involving public hospitals, three involving pharmacies, and one involving an Iwi health authority were referred to the Director of Proceedings.

The remaining matters in which the Commissioner reported a breach of the Code, but did not consider a referral to the Director of Proceedings was warranted, involved the following types of individual provider:

Anaesthetist	5
Caregiver	3
Counsellor	1
Dental technician	2
Dentist	3
Dermatologist	3
Ear, nose and throat surgeon	1
General practitioner	28
General surgeon	12
House surgeon	6
Midwife	6
Neurologist	2
Neurosurgeon	1
Nurse	22
Obstetrician/gynaecologist	12
Oncologist	1
Ophthalmologist	1
Orthopaedic surgeon	4
Other health provider	7
Paediatrician	2
Pathologist	1
Pharmacist	6
Pharmacy technician	3
Physician	14
Psychiatrist	3
Radiologist	3
Registrar	8
Rest home manager	1
Urologist	2

Categories of "group" provider found in breach of the Code, but not referred to the Director of Proceedings, were as follows:

Accident and emergency centre	1
Diagnostic laboratory	2
Educational facility	1
Intellectual disability service	1
Medical centre	4
Pharmacy	7
Primary care organisation	1
Prison medical service	1
Private hospital (medical and surgical)	3
Public hospital	46
Rest home	6

Age of Complaints

Complaints are now being resolved at a faster rate, with the average time taken from the time of receipt to time of closure decreasing from 44 weeks at 30 June 2000 to 34 weeks at 30 June 2001.

Age of Closed Complaints

The following table shows the age of complaints closed to 30 June 2001.

Age Complaints Closed	2000/01	%	1999/2000	%	1998/99	%
Less than 5 weeks	569	42	392	30	273	23
5 to 13 weeks	226	17	188	14	254	22
14 to 26 weeks	131	10	169	13	184	16
27 to 39 weeks	105	8	105	8	106	9
40 to 52 weeks	51	4	89	7	94	8
Greater than 52 weeks	256	19	360	28	251	22
Total	**1,338**		**1,303**		**1,162**	

Complaints Open

The following table shows the age of complaints files open at 30 June 2001.

Date Complaint Received	2000/01	1999/2000	1998/99
Up to 30 June 1997	–	5	52
Up to 30 June 1998	2*	44	236
Up to 30 June 1999	24	162	502
Up to 30 June 2000	122	364	–
Up to 30 June 2001	486	–	–
Total	**634**	**575**	**790**

*In one case the Commissioner's provisional opinion was challenged unsuccessfully in the High Court by the provider — the case is now under appeal by the provider.

Age of Complaint	% of Total Complaints as at 30/6/01	% of Total Complaints as at 30/6/00
> 1 year	23	37
> 18 months	10	20
> 2 years	4	8.5

LEGAL SERVICES

Assistant Commissioner,
Katharine Greig

Overview

Once again 2000/01 was a busy and productive year for the Legal division, with legal staff providing support and advice to the Commissioner, managers and staff. This advice spanned the range of functions and activities undertaken by the Office.

Formal advice was provided to the Commissioner and staff on the interpretation of various aspects of the Health and Disability Commissioner Act 1994, the Code and related legislation. Formal written responses were prepared to enquiries from the public and other agencies on the Act and Code and many verbal enquiries were also dealt with. A significant number of submissions on legislative and policy proposals were drafted; legal overview was provided on all investigation files; educational materials were reviewed; and conference papers were prepared and delivered.

Submissions

The Legal division drafted submissions on key policy documents and proposed legislation affecting the rights of health and disability services consumers. Thirty-nine submissions were made over the course of the year. These included submissions on:

- the Foreign Qualified Medical Practitioners Bill
- the New Zealand Public Health and Disability Bill
- the Ministry of Health's "Health Professional Competency Assurance Bill 2000" Discussion Document
- the Ministry of Health's "He Korowai Oranga: Maori Health Strategy" Discussion Document
- the Ministry of Health's "Improving the National Cervical Screening Programme: Law Changes to Support the Audit Programme" Discussion Document
- the Ministry of Health's Disability Strategy Discussion Document
- the Ministry of Justice's "Re-evaluation of Human Rights Protections in New Zealand" Discussion Document
- the Ministry of Health's "Direct to Consumer Advertising of Prescription Medicines in New Zealand" Discussion Paper
- the Ministry of Social Policy's "Registration of Social Workers" Discussion Document
- the Law Commission's "Preliminary Paper 40: Misuse of Enduring Powers of Attorney"
- the Medical Council's Revised Draft Statement on Information and Consent
- the Paediatric Society's Discussion Document "Disagreements between Professionals and Families about Health Care for Children".

Interface with the Office of the Ombudsmen and the Privacy Commissioner

Consultation

The Legal division has maintained an effective working relationship with the Office of the Ombudsmen and the Privacy Commissioner, which enables consultation on individual files and useful discussion of our respective roles.

Information Requests and Investigations

Many requests for information from investigation files were received during the year (made pursuant to the Official Information Act 1982 and the Privacy Act 1993). Responding to such requests is a time-consuming aspect of the Legal division's workload.

During 2000/01 four investigations were commenced by the Office of the Ombudsmen under the Official Information Act 1982, four were commenced under the Ombudsmen Act 1975, and a number of investigations from 1999/2000 were ongoing. One investigation was commenced by the Privacy Commissioner. Such investigations are to be expected and provide quality assurance in relation to the Commissioner's decision-making.

However, as noted by the Cull Report, "a potential cause of delay identified during the Review was the complaint processes through the Ombudsman's Office". Particular difficulties arise where providers (and their lawyers) use Official Information Act requests as a delaying tactic during the course of an investigation. Issues also arise in relation to the scope of investigations by the Ombudsmen under the Ombudsmen Act. As noted by Glazebrook J in the *Culverden Group* decision (see below), "a Court would not generally interfere with any fair procedure followed by the Commissioner, given the rights of the Commissioner to regulate procedure".

Litigation

An application for judicial review of the Commissioner's actions was sought by a rest home in *Culverden Group Ltd v The Health and Disability Commissioner* (unreported), Glazebrook J, High Court, Auckland, M1143-SD00, 25 June 2001. The application was declined.

Culverden Group Ltd v The Health and Disability Commissioner

In *Culverden Group Ltd v The Health and Disability Commissioner* (unreported), Glazebrook J, High Court, Auckland, M1143-SD00, 25 June 2001 Culverden Group Ltd had been the subject of a complaint to the Health and Disability Commissioner. The complaint concerned the admission of Mr A to Culverden Retirement Centre without his informed consent; treating him there without his informed consent; and requiring him to pay for unnecessary services.

The application for judicial review to prevent the Health and Disability Commissioner issuing his final report was largely unsuccessful. The High Court held that (i) the Health and Disability Commissioner did not breach natural justice by not informing Culverden Group Ltd of the particular rights in the Code claimed to have been infringed before commencing the investigation (the Health and Disability Commissioner had to notify only the complaint; it could be seen as improper to express tentative suggestions or conclusions before investigating); (ii) the Health and Disability Commissioner erred by describing the complaint in the first provisional opinion differently from that in the original notification (the full text of the complaint, not a summary, should be put to the provider, as a summary could leave out matters later taken into account or fail to convey the full seriousness and tone of the complaint); (iii) a Health and Disability Commissioner opinion should set out the factual bases for the conclusions and opinions expressed (where a person's submissions are not accepted, the opinion should say so and why); and (iv) where there has been a breach of the Code, the complainant's motives in making the complaint are irrelevant.

The High Court held that the Health and Disability Commissioner's recommendations (refund of fees paid, a written apology, and changes to admission forms) were not unreasonable given the finding that the complainant had not been informed, in the form or otherwise, as to the fees to be paid. The High Court also held that the Health and Disability Commissioner should issue a fresh provisional opinion in the light of the High Court decision, and should allow Culverden Group Ltd an opportunity to respond.

The decision has been appealed by Culverden Group Ltd to the Court of Appeal.

EDUCATION

Education Advisor, Denise Wilson

Focus

This year the focus of the Commissioner's educational and promotional activities has been on the identified target groups of disability, mental health, Pacific Island and Maori consumers. Presentations to general providers and consumers have continued and exceeded targets by 37.5%. The diversification into web-based resources has been maintained.

Following a major review of the Commissioner's Office highlighting the need for an integrated approach to education, a strategy has been developed and will be implemented over the next three years. The plan focuses on moving the emphasis in educational initiatives from the present reactive mode to a proactive stance.

Notable Educational and Promotional Activities

- A range of new educational and promotional resources has been designed, produced and distributed. These include a simplified guide for mental health consumers and material for the Human Rights Commission's Pathway Website for Social Studies resources on Human Rights, detailing the Code and the work of the Commissioner.
- The Commissioner's monthly column in *GP Weekly*, a newspaper for general practitioners, continues to provide a forum to address a wide range of topical issues affecting medical practitioners. Topics covered this year included problems encountered in repeat prescribing, the use of alternative therapies for children, and sexual boundaries in the doctor–patient relationship. All articles are available on the Commissioner's website: www.hdc.org.nz.
- A range of articles has been written and published in targeted consumer and provider publications for groups such as the New Zealand Medical Association, Disability Providers' Network and Age Concern.
- The Commissioner's opinions, with identifying features removed, have continued to be published on the Commissioner's website for educational purposes.
- Targeted media releases produced widespread reporting of the Commissioner's activities and resulted in radio and television interviews with the Commissioner and key staff. The media conference following the release of the Gisborne Report was well attended by journalists from print, radio and television media. The Cull Report into the medical complaints system generated high levels of media interest.
- Comments about the adequacy of staffing in Emergency Departments, arising from the Commissioner's investigation of a case at Taranaki Hospital, provided an opportunity to review levels of Emergency Department staffing throughout the country.
- The Commissioner appeared as a guest on consumer programmes such as "Inside/Out" and gave regular interviews to Radio New Zealand on a range of health issues.
- The Commissioner, senior managers and staff addressed several major conferences and workshops throughout the year.

Case Study: Consent to participate in teaching

The following case study illustrates the interplay between the Code, professional standards, and the policies of an employing organisation. It highlights patients' rights to be treated with respect, to receive services of an appropriate standard, to be given information, and to give consent if they are to be part of teaching or if students are to observe or be involved in their care or treatment.

A patient attended the radiology department of a public hospital for an ultrasound. The ultrasonographer performing the ultrasound had difficulty locating the patient's left ovary, and a radiologist was called in to assist. The radiologist was accompanied by a registrar who was not involved in the patient's treatment. No explanation was given for the presence of the registrar, who observed throughout the procedure. The patient felt uncomfortable about the observer's presence and the fact that she had not been asked to consent to this. She also complained about the demeaning way the radiologist spoke to her. The Commissioner found that the radiologist had breached rights 4(2), 6(1)(d) and 7(1) of the Code, and the hospital's policy on informed consent. Right 9 states that the rights in the Code apply in teaching situations. The need for information and consent applies not only to treatment but also to observational teaching.

It was recommended that the radiologist review her practice and apologise to the patient.

This opinion (00HDC06794) can be found on the Commissioner's website: www.hdc.org.nz.

- Advocacy services continue to fulfil a vital educational role in informing providers and consumers about the Code and the role of advocates.
- Twenty-eight seminars aimed at Pacific Island consumers were presented by a contract facilitator.
- Thirty-six presentations aimed at Maori consumers and providers were held in the Auckland area.
- In May 2001 the Commissioner joined with the Donald Beasley Institute to host a seminar for disability services providers and consumers in Dunedin.

Educational Resources and Publications

In 1999/2000 the Commissioner continued to provide a wide range of educational resources to both consumer and provider groups. These are designed, first, to educate consumers about their rights under the Code and available avenues of support and complaint, and secondly, to provide information for providers regarding their obligations under the Code. This year 127,374 resources were distributed.

Educational resources distributed included:

- posters in English and Maori
- brochures in English and Maori outlining the Code in various forms, from the complete regulation to a short description of the ten rights
- leaflets providing information about advocacy services
- videos for consumers, available in English and subtitled in English, Maori, Samoan, Tongan and Niuean
- a video for providers
- audio tapes containing information about the Code and advocacy services
- bilingual pocket cards with a summary of the ten Code rights in English and another language (these currently include Maori, Samoan, Tongan, Cook Island Maori and Niuean)
- opinions, speeches, articles, media releases and other information of public interest. These were placed on the Commissioner's website (www.hdc.org.nz). This website continues to generate significant interest among consumers, providers, professional groups, the media, and the general public
- a range of formal responses by the Commissioner, through the Legal division, to enquiries relating to both Act and Code issues
- a guide to the Code and the operation of the Commissioner's Office for inclusion on the Pathway Website for Social Studies resources on Human Rights. This resource is to be used in schools as part of the social studies curriculum.

Education, Promotion and the Media

Activities involving the Commissioner continue to produce considerable interest in the print, radio and television media. Media enquiries are made to the Commissioner's Office, requesting both comment from the Commissioner on issues of public concern, and information relating to specific complaints under investigation.

Media activities have created valuable opportunities for consumers and providers to become better informed about the Act, the Code, and the role of the Commissioner. This increase in promotional and informational activity has been accompanied by a significant increase in numbers of people accessing the Commissioner's website, with 266,905 visits to the site.

The release of the Gisborne Report investigation into patient safety resulted in significant media attention, with over 40 enquiries.

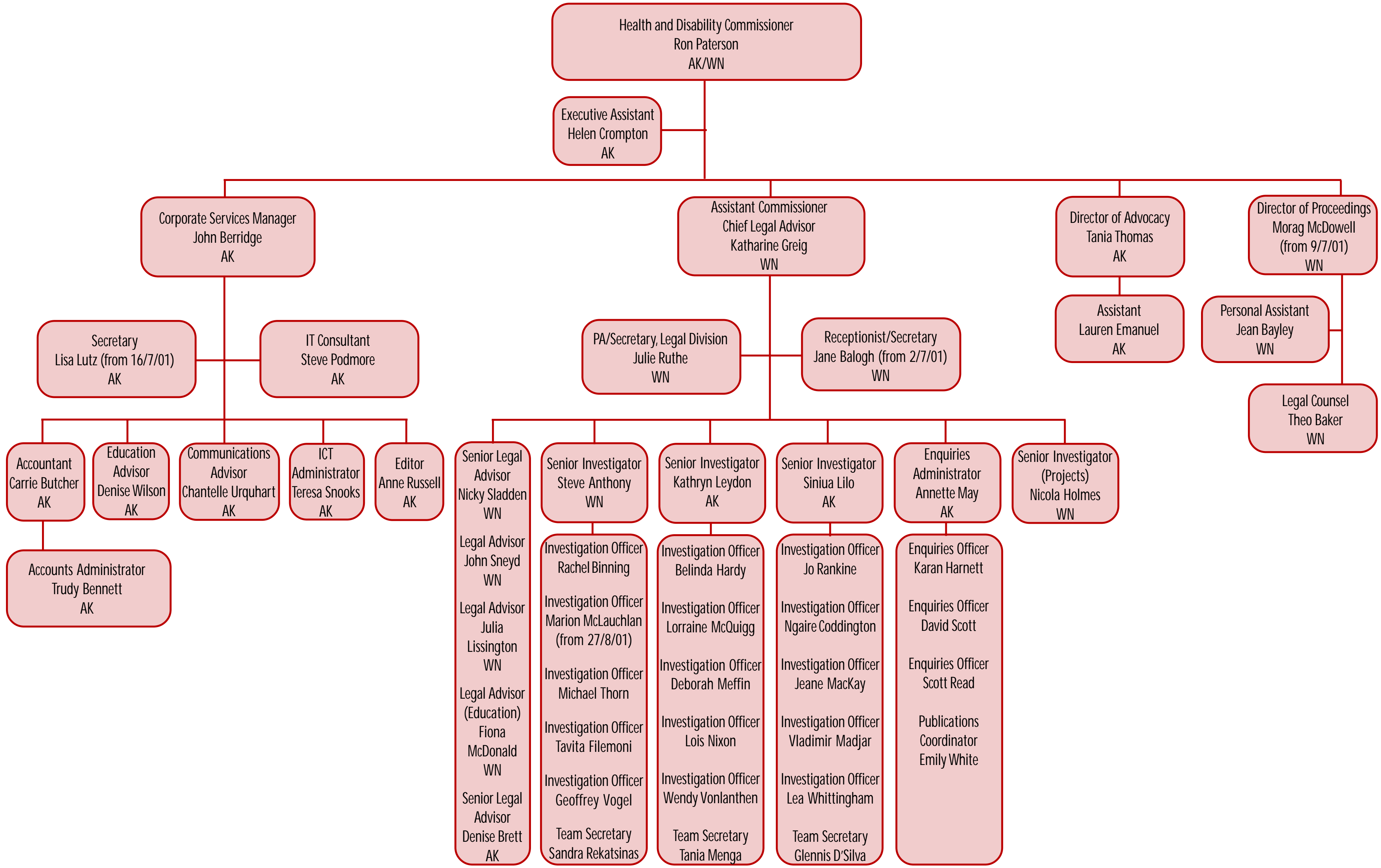
Other issues that created interest and debate throughout the year were:

- the call for a review of staffing levels in Emergency Departments following the Taranaki Healthcare Report (see page 8). This report generated 22 media enquiries
- the publication of the outcome of several high-profile disciplinary hearings and cases against health providers, which were initiated as a result of the Commissioner's investigation into breaches of the Code
- the Commissioner's comments on the recommendations of the Cull Report
- the Commissioner's comments and opinions on the risks involved in the use of third generation contraceptive pills (see page 24)
- the finding of vicarious liability against a hospital employer whose staff were not given adequate time to meet their obligations to obtain informed consent from patients (see www.hdc.org.nz opinion 98HDC15056)
- the jointly hosted seminar for disability consumers and providers. This was well attended and well received. It provided a forum for discussion of some of the issues faced by disabled consumers in accessing a complaint service such as the Health and Disability Commissioner.

HDC Training Day at Orakei Marae, 2001

Organisation Chart

(as at 30 June 2001)



MANAGEMENT AND ADMINISTRATION

Corporate Services Manager, John Berridge

Organisation

The Health and Disability Commissioner operates from two offices, located in Auckland and Wellington, with administration based in Auckland. Staff numbers total 50, of whom three are in part-time positions. The organisation chart as at 30 June 2001 is shown opposite.

The Commissioner and Assistant Commissioner are based in the Auckland and Wellington Offices respectively. The Director of Proceedings is Wellington based. The Director of Advocacy, Tania Thomas, who was appointed in January, is Auckland based.

The majority of the Legal team and one of the three Investigation teams operate from the Wellington Office.

Management

In July the Commissioner requested a Management Review of the organisation. This was undertaken by Dr Jane Bryson of Victoria University. On her recommendation a Strategic Management Team was set up consisting of the Commissioner, the Assistant Commissioner, the Director of Advocacy, the Director of Proceedings, and the newly appointed Corporate Services Manager. The team began meeting in October.

Human Resources

During the year there were a number of changes in key personnel. Jane Doherty, the Director of Advocacy, resigned in January and was replaced by Tania Thomas later that month. Tania Davis, the Director of Proceedings, completed her term of office in June and Matt McLelland replaced her on a temporary basis until the appointment of Morag McDowell in July 2001.

Moe Milne, who until recently held the Kaiwhakahaere position within the Health and Disability Commissioner's Office, led an awareness-raising and educational initiative. The Kaiwhakahaere made contact with Iwi and Maori organisations throughout New Zealand to promote the work of the Health and Disability Commissioner and to increase Maori awareness of the Code of Rights and its relevance to Maori, both as consumers and providers. Another area highlighted by the work of the Kaiwhakahaere was the need to develop, implement and evaluate practices consistent with the Health and Disability Commissioner's Office carrying out its responsibilities to give effect to the principles of the Treaty of Waitangi. A Maori Initiatives Project, which focuses on strengthening staff capability in working with Maori to ensure that their cultural values and beliefs are respected, has been commenced within the Office.

Senior management team, from left, Morag McDowell (Director of Proceedings), Katharine Greig (Assistant Commissioner), Ron Paterson (Commissioner), Tania Thomas (Director of Advocacy), John Berridge (Corporate Services Manager)

A Health and Disability Commissioner Kaumatua role was established by the Kaiwhakahaere to advise the Commissioner and his staff on issues of Maori protocol and customs for special events and everyday matters pertaining to Maori. This role has now been formalised within the Health and Disability Commissioner's Office.

David Turner, the General Manager, resigned in September and, following the management review undertaken in July, was replaced in October by John Berridge, in a new position of Corporate Services Manager. Denise Wilson was appointed as Education Advisor in March.

A number of other internal organisational changes took place during the year, largely as a result of the management review recommendations.

Staff turnover in the year was higher than expected, but a number of talented new staff were appointed both as replacements for departing staff and in a small number of new positions. Job evaluations were undertaken in June and provided useful input into the salary reviews performed later that month.

Information Systems

Significant developments in the Office's information systems this year included ongoing upgrading of the case management software to improve usability and reporting.

A Computer Use Policy preparing staff for access to the internet and external email was introduced, and existing technology was used to trial external email and voice mail for selected staff. Wider implementation originally intended for 2000/01 was delayed pending further infrastructure investment.

The Office completed an Information Systems Strategic Plan that recommended upgrades to network architecture, improved service to internal clients, wider access to the internet and external email, improved security, and the development of a knowledge management strategy.

The Office will continue to co-operate with the State Services Commission and other agencies engaged in promoting e-government.

FINANCIAL STATEMENTS

Financial Commentary

Funding

The Office is funded from Vote Health. Funding remained unchanged at **$6,148,444** (excluding GST) for this year and no change is expected for next year.

Investments

The Office invests surplus funds in term deposits lodged with creditworthy institutions. Deposits have a range of maturity dates to maximise interest income while maintaining cashflow. Interest income for the year was **$318,717** and investments totalled **$2,800,000** at 30 June 2001.

Publications

The Office produces a range of educational materials for use by the public and health and disability service providers. Members of the public receive these items free while providers are charged a modest amount to recover costs. Revenue from this source in 2000/01 was **$35,137**, which was offset by production costs.

Operating Deficit

In 2000/01 the Office budgeted for a deficit of $147,845 and reported a deficit of **$331,638.** The variance was mainly in Staff Costs, Travel & Accommodation and Operating Costs.

Expenditure by Type

Expenditure is summarised by significant categories below. Advocacy services contracts, staff costs and occupancy costs (collectively 71.76% of total expenditure in 2000/01) largely represent committed expenditure. Much of the remaining 28.24% (or $1.93 million) is discretionary.

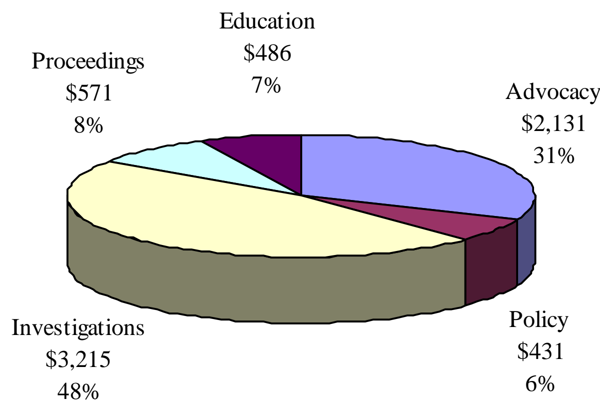
	00/01		99/00	
	$000	**%**	**$000**	**%**
Advocacy Services Contracts	1,827	26.73	1,760	30.05
Audit Fees	6	0.09	6	0.10
Bad Debts Written Off	–	–	–	–
Staff Costs	2,762	40.42	2,469	42.16
Travel & Accommodation	303	4.43	198	3.38
Depreciation	182	2.66	214	3.65
Occupancy	315	4.61	265	4.53
Communications	424	6.21	484	8.27
Operating Costs	1,015	14.85	460	7.86
TOTAL	6,834	100.00%	$5,856	100.00%

Figures GST exclusive

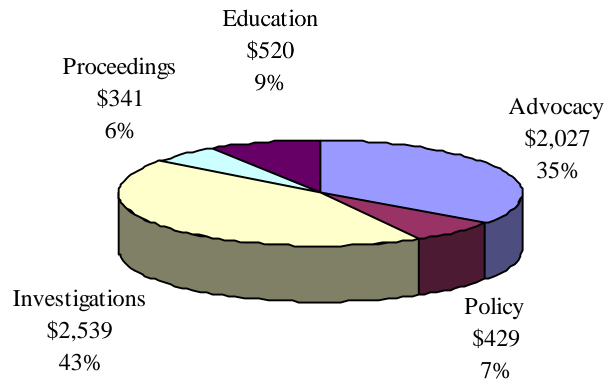
Expenditure by Output

The Office has only one output class but this has been broken down into five interrelated sub-outputs as summarised below.

Expenditure by Output 2000/01 ($000s)



Expenditure by Output 1999/2000 ($000s)



Expenditure on Investigations in 2000/01 was $3,215,190 (48% of total expenditure) and included the major Gisborne Hospital investigation. Record numbers of investigations were completed. Spending on Advocacy increased by $104,000, and remained a significant commitment of resources at 31% of total expenditure. The Office continued to look for efficiencies in administration and achieved savings in the area of Communications.

2001/2002

For the coming year the Office has budgeted for a deficit of $659,121, which will be funded from Accumulated Reserves.

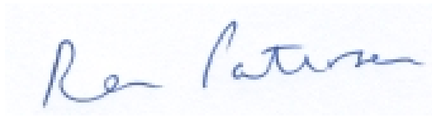
Statement of Responsibility

In terms of Section 42 of the Public Finance Act 1989:

1 I accept responsibility for the preparation of these financial statements and the judgements used therein.

2 I have been responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

3 I am of the opinion that these financial statements fairly reflect the financial position and operations of the Office of the Health and Disability Commissioner for the year ended 30 June 2001.



Ron Paterson
Health and Disability Commissioner
5 October 2001

REPORT OF THE AUDIT OFFICE

TO THE READERS OF THE FINANCIAL STATEMENTS OF THE HEALTH AND DISABILITY COMMISSIONER FOR THE YEAR ENDED 30 JUNE 2001

We have audited the financial statements on pages 49 to 63. The financial statements provide information about the past financial and service performance of the Health and Disability Commissioner and its financial position as at 30 June 2001. This information is stated in accordance with the accounting policies set out on pages 49 and 50.

Responsibilities of the Commissioner

The Public Finance Act 1989 and the Health and Disability Commissioner Act 1994 require the Commissioner to prepare financial statements in accordance with generally accepted accounting practice which fairly reflect the financial position of the Health and Disability Commissioner as at 30 June 2001, the results of its operations and cash flows and the service performance achievements for the year ended 30 June 2001.

Auditor's Responsibilities

Section 43(1) of the Public Finance Act 1989 requires the Audit Office to audit the financial statements presented by the Commissioner. It is the responsibility of the Audit Office to express an independent opinion on the financial statements and report its opinion to you.

The Controller and Auditor-General has appointed Karen MacKenzie, of Audit New Zealand, to undertake the audit.

Basis of Opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- the significant estimates and judgements made by the Commissioner in the preparation of the financial statements; and
- whether the accounting policies are appropriate to the Health and Disability Commissioner's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with generally accepted auditing standards, including the Auditing Standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

Other than in our capacity as auditor acting on behalf of the Controller and Auditor-General, we have no relationship with or interests in the Health and Disability Commissioner.

Unqualified Opinion

We have obtained all the information and explanations we have required.

In our opinion the financial statements of the Health and Disability Commissioner on pages 49 to 63:

- comply with generally accepted accounting practice; and
- fairly reflect:
  - the financial position as at 30 June 2001;
  - the results of its operations and cash flows for the year ended on that date; and
  - the service performance achievements in relation to the performance targets and other measures adopted for the year ended on that date.

Our audit was completed on 5 October 2001 and our unqualified opinion is expressed as at that date.

Karen MacKenzie
Audit New Zealand
On behalf of the Controller and Auditor-General
Auckland, New Zealand

Statement of Accounting Policies

For the year ended 30 June 2001

Statutory Base

The financial statements have been prepared in terms of Section 41 of the Public Finance Act 1989.

Reporting Entity

The Health and Disability Commissioner is a Crown Entity established under the Health and Disability Commissioner Act 1994. The role of the Commissioner is to promote and protect the rights of health consumers and disability services consumers.

Measurement Base

The financial statements have been prepared on the basis of historical cost.

Particular Accounting Policies

(a) *Recognition of Revenue and Expenditure*
The Commissioner derives revenue through the provision of outputs to the Crown, interest on short-term deposits, the sale of educational publications, and recovery of Court costs. Revenue is recognised when earned.

Expenditure is recognised when the cost is incurred.

(b) *Fixed Assets*
Fixed Assets are stated at their historical cost less accumulated depreciation.

(c) *Depreciation*
Fixed assets are depreciated on a straight line basis over the useful life of the asset. The estimated useful life of each class of asset is as follows:

Furniture & Fittings	5 years
Office Equipment	5 years
Communications Equipment	4 years
Motor Vehicles	5 years
Computer Hardware	4 years
Computer Software	2 years

The cost of leasehold improvements is capitalised and depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is shorter.

(d) *Goods and Services Tax (GST)*
All items in the financial statements are exclusive of GST, with the exception of accounts receivable and accounts payable, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

(e) *Debtors*

Debtors are stated at their estimated net realisable value after providing for doubtful and uncollectable debts.

(f) *Leases*

The Health and Disability Commissioner leases office premises. These costs are expensed in the period in which they are incurred.

(g) *Employee Entitlements*

Annual leave is recognised on an actual entitlement basis at current rates of pay.

(h) *Financial Instruments*

All financial instruments are recognised in the Statement of Financial Position at their fair value.

All revenue and expenditure in relation to financial instruments is recognised in the Statement of Financial Performance.

(i) *Taxation*

The Health and Disability Commissioner is exempt from income tax pursuant to the Second Schedule of the Health and Disability Commissioner Act 1994.

(j) *Cost Allocation*

The Health and Disability Commissioner has derived the net cost of service for each significant activity of the Health and Disability Commissioner using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged to significant activities. Indirect costs are charged to significant activities based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs

"Direct costs" are those costs directly attributable to a significant activity.
"Indirect costs" are those costs that cannot be identified in an economically feasible manner with a specific significant activity.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to activities is allocated as overheads using staff numbers as the appropriate cost driver.

(k) *Budget Figures*

The budget figures are those approved by the Health and Disability Commissioner at the beginning of the financial year.

The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Health and Disability Commissioner for the preparation of the financial statements.

Statement of Changes in Accounting Policies

There has been no change in Accounting Policies. All policies have been applied on a basis consistent with the prior period.

Statement of Financial Performance

For the year ended 30 June 2001

Actual 99/00 $		Actual 00/01 $	Budget 00/01 $
	Revenue		
6,148,444	Operating Grant Received	6,148,444	6,148,444
120,634	Interest Received	318,717	193,067
31,975	Publications Revenue	35,137	30,000
6,301,054	**TOTAL OPERATING REVENUE**	**6,502,298**	**6,371,511**
	Less Expenses		
1,760,446	Advocacy Services Contracts	1,827,225	1,861,000
5,792	Audit Fees	5,520	5,500
–	Bad Debts Written Off	–	–
2,469,161	Staff Costs	2,761,838	2,461,324
198,181	Travel & Accommodation	303,404	257,981
213,916	Depreciation	181,670	221,177
264,756	Occupancy	314,862	313,875
483,891	Communications	424,372	534,175
459,577	Operating Costs	1,015,045	864,324
5,855,720	**TOTAL OPERATING EXPENSES**	**6,833,936**	**6,519,356**
445,334	**NET SURPLUS (DEFICIT)**	**(331,638)**	**(147,845)**

The accompanying accounting policies and notes form an integral part of these financial statements.

Statement of Financial Position

As at 30 June 2001

Actual 99/00 $			Actual 00/01 $	Budget 00/01 $
	Crown Equity			
2,510,461	Accumulated Funds	**(Note 1)**	2,178,823	2,362,616
788,000	Capital Contributed		788,000	788,000
3,298,461	**TOTAL CROWN EQUITY**		**2,966,823**	**3,150,616**
	Represented by			
	Current Assets			
14,771	Bank Account		47,821	50,000
3,300,000	Call Deposits		2,800,000	3,063,993
2,547	Sundry Debtors		70,479	2,000
3,317,318	**Total Current Assets**		2,918,300	3,115,993
	Non Current Assets			
353,159	Fixed Assets	**(Note 3)**	358,238	406,094
353,159	**Total Non Current Assets**		358,238	406,094
3,670,477	**Total Assets**		3,276,538	3,522,087
	Current Liabilities			
39,636	GST Payable		42,325	51,057
332,380	Sundry Creditors	**(Note 2)**	267,390	320,414
372,016	**Total Liabilities**		309,715	371,471
3,298,461	**NET ASSETS**		**2,966,823**	**3,150,616**

The accompanying accounting policies and notes form an integral part of these financial statements.

Statement of Movements in Equity

For the year ended 30 June 2001

Actual 99/00 $		Actual 00/01 $	Budget 00/01 $
2,853,127	Opening Equity 1 July 2000	3,298,461	3,298,461
445,334	Net Surplus /(Deficit) (Total Recognised Revenues and Expenses)	(331,638)	(147,845)
3,298,461	Closing Equity 30 June 2001	**2,966,823**	**3,150,616**

The accompanying accounting policies and notes form an integral part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2001

Actual 99/00 $			Actual 00/01 $	Budget 00/01 $
	Cash Flow from Operating Activities			
	Cash was provided from:			
6,148,444	Operating Grant		6,148,444	6,148,444
120,634	Interest on Short Term Deposits		251,915	193,067
(2,547)	Income Received		(3,677)	–
31,975	Publications Revenue		35,137	30,000
6,298,507			6,431,819	6,371,511
	Cash was applied to:			
(2,342,102)	Payments to Employees		(2,312,332)	(2,303,846)
(3,056,112)	Payments to Suppliers		(4,399,843)	(3,994,333)
(5,398,214)			(6,712,175)	(6,298,179)
	Net Cash Flow from			
900,293	**Operating Activities**	**(Note 4)**	**(280,356)**	**73,332**
	Cash Flow from Financing Activities			
	Cash was provided from:			
–	Capital Contribution		–	–
–	**Net Cash Flow from Financing Activities**		–	–

The accompanying accounting policies and notes form an integral part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2001 — continued

Actual 99/00 $		Actual 00/01 $	Budget 00/01 $
	Cash Flow from Investing Activities		
	Cash was provided from:		
–	Sale of Fixed Assets	514	–
	Cash was applied to:		
(205,856)	Purchase of Fixed Assets	(187,108)	(274,110)
(205,856)	**Net Cash Flow from Investing Activities**	**(186,594)**	**(274,110)**
694,438	**NET INCREASE/(DECREASE) IN CASH**	**(466,950)**	**(200,778)**
2,620,333	Cash brought forward	3,314,771	3,314,771
3,314,771	Closing Cash carried forward	**2,847,821**	**3,113,993**
	Cash Balances in the Statement of Financial Position		
14,771	Bank Account	47,821	50,000
3,300,000	Call Deposits	2,800,000	3,063,993
3,314,771		**2,847,821**	**3,113,993**

The accompanying accounting policies and notes form an integral part of these financial statements.

Notes to the Financial Statements

For the year ended 30 June 2001

Actual 99/00 $	Note		Actual 00/01 $
	1	***Accumulated Funds***	
2,065,127		Opening balance	2,510,461
445,334		Net Surplus (Deficit)	(331,638)
2,510,461		**Closing balance**	**2,178,823**
	2	***Sundry Creditors***	
220,738		Trade Creditors and Accruals	139,451
54,047		PAYE	59,739
57,595		Annual Leave	68,200
332,380			**267,390**
	3	***Fixed Assets***	

00/01	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	560,157	402,876	157,281
Computer Software	234,135	221,893	12,242
Communications Equipment	28,408	28,408	–
Furniture & Fittings	167,480	135,596	31,884
Leasehold Improvements	281,706	180,166	101,540
Motor Vehicles	42,280	42,280	–
Office Equipment	101,385	46,094	55,291
Total Fixed Assets	**1,415,551**	**1,057,313**	**358,238**

Notes to the Financial Statements

For the year ended 30 June 2001 — continued

Note

99/00	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	493,710	341,703	152,007
Computer Software	222,467	189,075	33,392
Communications Equipment	28,408	28,392	16
Furniture & Fittings	156,804	115,699	41,105
Leasehold Improvements	199,618	132,358	67,260
Motor Vehicles	42,280	42,280	–
Office Equipment	90,132	30,753	59,379
Total Fixed Assets	**1,233,419**	**880,260**	**353,159**

4 ***Reconciliation between Net Cash Flow from Operating Activities and Net Surplus/(Deficit)***

Actual 99/00 $			Actual 00/01 $
445,334	Net Surplus/(Deficit)		(331,638)
	Add Non-cash items		
213,916	Depreciation		181,670
	Movements in Working Capital Items		
39,852	Increase/(Decrease) in Sundry Creditors	(64,988)	
13,486	Adjustment for Other Creditors	–	
167,658	Increase/(Decrease) in GST Payable	2,688	
(2,547)	(Increase)/Decrease in Sundry Debtors	(67,932)	
6,942	(Increase)/Decrease in Prepayments	–	
225,391			(130,232)
15,652	Net Profit on Disposal of Assets		(156)
900,293	Net Cash Flows from Operating Activities		**(280,356)**

Notes to the Financial Statements

For the year ended 30 June 2001 — continued

Note

5 ***Commitments***

(a) Advocacy Services Contracts:

The three performance-based contracts, which commenced on 1 July 1999 for a period of 24 months, were extended for a further 12 months. The maximum commitment for the 12 months from 1 July 2001 is $1,866,000.

(b) Leases on Premises including Leasehold Improvements:

Auckland	$193,988 per annum until March 2002
Wellington	$ 76,000 per annum until March 2006

(c) Rental Agreements:

Telecommunications equipment $42,630 per annum until January 2004

Actual 99/00 $	(d) Classification of Commitments	**Actual 00/01 $**
2,067,999	Less than one year	2,178,618
271,400	One to two years	126,730
303,598	Two to five years	233,868
57,000	Over five years	–
2,699,998		**2,539,216**

6 ***Contingent Liabilities***

As at 30 June 2001 there were no contingent liabilities (99/00 Nil).

Notes to the Financial Statements

For the year ended 30 June 2001 — continued

Note

7 ***Financial Instruments***

As the Health and Disability Commissioner is subject to the Public Finance Act, all bank accounts and investments are required to be held with banking institutions authorised by the Minister of Finance.

The Health and Disability Commissioner has no currency risk as all financial instruments are in NZ dollars.

Credit Risk

Financial instruments that potentially subject the Health and Disability Commissioner to credit risk principally consist of bank balances with Westpac Trust and sundry debtors.

Maximum exposures to credit risk at balance date are:

Actual 99/00 $		Actual 00/01 $
3,314,771	Bank Balances	2,847,821
2,547	Sundry Debtors	70,479
3,317,318		**2,918,300**

The Health and Disability Commissioner does not require any collateral or security to support financial instruments with financial institutions that the Commissioner deals with as these entities have high credit ratings. For its other financial instruments, the Commissioner does not have significant concentrations of credit risk.

Notes to the Financial Statements

For the year ended 30 June 2001 — continued

Note

Fair Value

The fair value of the financial instruments is equivalent to the carrying amount disclosed in the Statement of Financial Position.

Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. The average interest rate on the Health and Disability Commissioner's investments is 6.16%.

The Health and Disability Commissioner does not consider that there is any significant interest exposure on investments.

8 ***Related Party***

The Health and Disability Commissioner is a wholly owned entity of the Crown. The Crown is the major source of revenue of the Health and Disability Commissioner.

There were no other related party transactions.

9 ***Exceptional Item***

The Commissioner completed a major investigation into Gisborne Hospital (Tairawhiti Healthcare Ltd) at a cost of $561,935.

10 ***Employee Remuneration***

Total remuneration and benefits	*Number of Employees*	
$000	*99/00*	*00/01*
100–110	–	1
120–130	1	–
160–170	1	1

The Commissioner's remuneration and allowances are determined by the Higher Salaries Commission in accordance with the Higher Salaries Commission Act 1977. The Commissioner's remuneration and benefits are in the $160,000 to $170,000 band.

STATEMENT OF SERVICE PERFORMANCE

Key Result Area 1: Education and Communications

Objective: *Educate health and disability services consumers and providers about the provisions of the Code of Health and Disability Services Consumers' Rights and Advocacy Services.*

Education

Presentations to:	Target	Actual
General consumers, providers and public groups	50	80
Maori, Pacific Island and disability consumers and providers	60	60

Promotion

	Target	Actual
Units of educational resource conveyed to the public in a range of appropriate languages with all requests for resources dispatched within five working days of receipt.	100,000	259,103

Communication

	Target	Actual
Key information on the Code, Act and advocacy services conveyed using the internet website and quarterly newsletters.	4 newsletters	deferred
	website maintained	up to date

Key Result Area 2: Advocacy Services

Objective: *Operation of a New Zealand-wide advocacy service from 1 July 2000 designed to assist health and disability consumers resolve complaints about alleged breaches of the Code at the lowest appropriate level.*

	Target	Actual
Enquiries closed	6,519	8,247
Complaints managed	3,865	5,102
Presentations to consumers and providers	1,679	1,826
Contacts	2,515	3,402
Independent, high quality, consistent nationwide services	Satisfactory audit reports for all advocacy service organisations	Satisfactory audit reports received for all advocacy service organisations

Key Result Area 3: Investigations

Objective: *Assess and investigate complaints concerning breaches of the Code of Rights.*

Volume Estimates

	Target	Actual
Enquiries processed	Estimated 5,000 enquiries 90% closed within 48 hours	3,311 94.8%
New complaints	Estimated 1,123 new complaints	1,397
Closed complaints	1,246 complaints closed in the year	1,338
Complaints still open	496 open complaints at 30 June 2001 [575 at 30 June 2000]	634
	Made up of:	
	• 93 open non-investigation files	136
	• 403 open investigations at 30 June 2001 [503 at 30 June 2000]	498
	Age of investigation files:	
	• 0 open files more than 2 years old [42 at 30 June 2000]	26
	• 20 or fewer files open for 18 months to 2 years [65 at 30 June 2000]	40
	• 80 or fewer files open for 1 year to 18 months [95 at 30 June 2000]	82

Key Result Area 4: Proceedings

Objective: *Initiate proceedings in accordance with the Health and Disability Commissioner Act.*

	Target	Actual
Professional, competent and high quality proceedings	Professional/disciplinary bodies and external counsel report competent conduct of proceedings.	An informal quality survey of professional/ disciplinary bodies and external counsel showed that proceedings were conducted competently and professionally.

Key Result Area 5: Finance and IT

Objective: *Support the efficient and effective delivery of services.*

	Target	Actual
High quality and accurate support services	Improve internal controls as measured by Audit Reports.	An unqualified opinion was issued on the Commissioner's financial statements on 24 October 2000. The opportunities for improvement identified by Audit NZ have either been completed or are still being progressed.