Medical Practitioners Disciplinary Tribunal

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DECISION NO: 43/98/22D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Director of Proceedings of the Health & Disability Commissioner pursuant to Section 93(1)(b) of the Act against **RITA EILEEN MIDDLETON** medical practitioner of Masterton

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr I D S Civil, Dr J W Gleisner, Dr B J Trenwith,

Ms S Cole (Members)

Ms G J Fraser (Secretary)

Mrs E Huse (Stenographer)

Hearing held at Wellington on Tuesday 16 June 1998

APPEARANCES: Ms K G Davenport for the Director of Proceedings

Dr R E Middleton in person

1. **IN** interim Decision No. 42/98/22D the charge was found not established and it was dismissed. Full reasons for the Tribunal's finding are explained in the Supplementary Decision which follows.

2. PARTICULARS OF THE CHARGE:

2.1 **"THE** Director of Proceedings pursuant to Section 102 of the Medical Practitioners Act charges Dr R Middleton of Masterton, medical practitioner, that her care of Ms A between April 1996 and October 1996 was inadequate.

In particular (but without limiting the totality of the Charge):

….

2. Dr Middleton failed to appreciate the significance of and act appropriately upon Ms A's continued complaint of persistent heavy bleeding.

3. That Dr Middleton failed to adequately explore Ms A's past history or iron deficiency, anaemia or to consider the severity of the complaints that Ms A was making.

4. Dr Middleton failed to test Ms A's haemoglobin levels on a regular basis.

Such conduct reflects adversely on the practitioner's fitness to practice medicine, being professional misconduct."

3. BACKGROUND:

3.1 **AS** the charge indicates, the complaint of Ms A is essentially that Dr Middleton failed to appreciate the significance of and act appropriately by reference to her persistent heavy bleeding, between April and October 1996.

3.2 **HAVING** expressed dissatisfaction with her previous GP, Ms A became a patient of Dr Middleton. The first consultation took place on 3 November 1995. There were further consultations on 12 December 1995, 16 February 1996, 18 April 1996, 13 May 1996 and 26 June 1996. It is noted that there was a history of Ms A consulting a previous GP and a specialist gynaecologist with respect to her problem of persistent and heavy bleeding.

3.3 **AT** a further consultation on 7 October 1996 Ms A asked Dr Middleton to certify her for receipt of a sickness benefit as she felt her problem of heavy blood loss was causing an inability to work. Ms A's perception of Dr Middleton's response to this request was that her problem was more likely depression than menorrhagia.

3.4 **WHEN** Ms A went out to vote on Saturday 12 October 1996 (Election Day), she fainted in the street. After seeing Ms A again Dr Middleton arranged for her acute admission to hospital. Her

Hb level on admission was 64 and she was given three units of packed cell blood transfusion. Subsequently she had an EUA and a D&C on 16 October 1996.

3.5 **SINCE** Ms A was found to have uterine fibroids with menorrhagia causing severe anaemia, a hysterectomy was also discussed. Ms A's name was placed on an urgent operating list. On 20 November 1996 Ms A underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy in xx Hospital. She had a satisfactory post-operative recovery.

4. EVIDENCE:

4.1 **FOR** the Director of Proceedings evidence was given first by A, a voluntary worker.

4.2 **DURING** her initial consultation in November 1995 relating to extremely heavy and prolonged bleeding, Dr Middleton did not take any steps to assess her haemoglobin, iron levels or other symptoms. She said *"... Dr Middleton did nothing at all"*.

4.3 **DURING** further consultations in May, June and October 1996, Ms A did not feel that Dr Middleton took her seriously or listened to what she was saying.

4.4 **SEVERAL** years earlier Ms A had seen a gynaecologist but found his handling of her physically painful. Her request of Dr Middleton to arrange a consultation with the other gynaecologist in xx was met with the response *"I could not swap specialists and that Mr B would only see me if it was an emergency"*.

4.5 **AT** another consultation on 7 October 1996 about heavy blood loss, Ms A asked to be placed on a sickness benefit because she felt she was unable to work in the condition she was in. She said Dr Middleton's response on this occasion was simply to ask if she wanted her to put down that she was suffering from depression or menorrhagia. Ms A explained *"I could not believe what I was hearing. I believe she had ignored everything I had just said. She had never raised the issue of depression with me"*.

4.6 **RETURNING** home after the fainting incident on 12 October 1996, when she felt better she walked home and rang Dr Middleton. Although subsequently seeing Dr Middleton at her rooms, Ms A was critical that Dr Middleton did not volunteer to come and see her at home nor ask how she was going to get to her surgery. When it was decided that admission to hospital would be necessary, Dr Middleton did not inquire how she was going to get to hospital.

4.7 **SUBSEQUENT** to her acute admission to xx Hospital, but prior to the hysterectomy surgery, Ms A consulted the second gynaecology specialist in xx, at her own instigation but on referral from Dr Middleton.

4.8 **MS** A concluded her evidence on this note:

"All that Dr Middleton did over the 11 months that I had seen her was prescribe Hormone Treatment which did nothing for me. During all my dealings with Dr Middleton she did not seem to know nor care what was wrong with me. I felt that she did not respect me, my feelings or what I said. I felt patronised by her and she seemed to spend most of her time telling me to be more assertive."

4.9 **THE** second witness for the Director of Proceedings was Michael Guy Laney of Christchurch, a Consultant Obstetrician and gynaecologist, whose expertise as a specialist in this area is accepted by the Tribunal.

4.10 **IN** summary it was Mr Laney's opinion that Dr Middleton could have taken the following steps to address the problem of heavy bleeding:

(i) Blood Tests could have been taken for blood counts and iron studies;

(ii) If the blood count and iron studies showed iron deficiency anaemia of any significance whatsoever, then immediate referral to a gynaecologist would have been indicated.

4.11 **MR** Laney was concerned that Ms A had to walk to hospital on the day acute admission was recommended by Dr Middleton. He thought this was entirely inappropriate and careless although he had been led to believe this may not have been totally Dr Middleton's fault.

4.12 **EVIDENCE** was given by Dr Middleton on her own behalf, and without the benefit of legal representation.

4.13 **DURING** the course of the initial consultation on 3 November 1995 Ms A described for Dr Middleton the problems that she had been having with menstrual bleeding. She told Dr Middleton that she had been under Mr C's care, and told her about her two previous D&C's and she told her also about the Provera that she was taking in a dose of 10 mg one tablet daily, and that she was meant to take that dosage for three out of every four weeks.

4.14 **MS** A expressed dissatisfaction with her previous GP and it was agreed that Dr Middleton would undertake her further care. Permission was requested of Ms A to write to her previous GP to obtain her medical records and she ordered a set of blood tests, and these blood tests included a CBC and iron studies.

4.15 **DR** Middleton produced a photocopy of a flow sheet on which she explained she recorded progressive patient blood test results to facilitate easy comparison. Essentially flow sheets are maintained rather than retention of the original test results. The flow sheets, once having been initialled off, are returned to the nursing staff whose job is to record the results in the flow sheets, after which the hard copy test results are discarded. Abnormal results are notated in red with normal results being notated in either blue or black, with Dr Middleton apologising that her photocopied records did not show the colourings. Testing following the 3 November 1995 consultation showed Ms A to have a haemoglobin of 110, which Dr Middleton explained is below the normal limit by 5 points. On this visit Dr Middleton appreciated that Ms A was very pale, and was probably anaemic, and she wrote a prescription for iron which she gave to her at that time. In response to a question from the Chair whether a record of the prescription for iron appeared in the notes, Dr Middleton explained she retained carbon copies of all prescriptions written, but that there was no record of the fact of the prescription in the notes. Dr Middleton explained *"I keep patient's notes together. I never take them and put them some place else. I always keep prescriptions with notes"*. Dr Middleton confirmed there was only one occasion when she prescribed iron for Ms A, because there was only one occasion on which she found her to be anaemic and iron deficient.

4.16 **THE** purpose of the consultation on 12 December 1995 was diarrhoea, associated with abdominal pain and bloating. Dr Middleton requested stools to be cultured and inspected for parasites, and referred Ms A to Mr D, a General Surgeon practising at xx Hospital, because she was concerned at the length of time the diarrhoea had gone on, and because of her anaemia. The combination made Dr Middleton concerned that there might be something more sinister in the bowel. Test results returned three days later confirmed the campylobacter infection. For this infection she was prescribed appropriately.

4.17 **AT** this point in her evidence Dr Middleton referred us to number 11 of the bundle of documents, Mr D's report to her of 13 February 1996 which makes mention of:

"There is a story of some acrimony between herself [Ms A] and a male acquaintance and this resulted in Mrs A feeling certain that she had been poisoned. This apparently took place with her male acquaintance adding something to a drink of wine. It is not known what the substance added was. At the time of ingesting the substance, Mrs A vomited and there was a small amount of blood in the vomit". Dr Middleton went on to explain there was a slight difference between Mr D and her understanding of the situation. Essentially Dr Middleton's understanding was that the male acquaintance was in fact Ms A's partner whom she was still living with at the time. Consequently Dr Middleton explained this actually gave her quite some concern about Ms A's mental state and about her safety. It was because of the *"poisoning story"* that on subsequent visits to her rooms Dr Middleton said she made a point of asking how Ms A was, or if things were okay because *"… I felt that she wasn't in a very good situation if she was still living with somebody who she believed had poisoned her".*

4.18 **ALTHOUGH** the purpose of the 16 February 1996 consultation was a complaint of bronchitis, in addition Dr Middleton did a follow-up set of blood tests to see how Ms A had got on after the treatment for her iron deficiency and anaemia, which she had picked up in the November 1995 consultation. Dr Middleton referred us to column number three on the flow sheet, dated 26 February 1996, where the haemoglobin by this time was 130, Ferritin 116, iron 19 and percentage of saturation 28 with an iron binding capacity of 68.

4.19 **THE** next visit that Ms A made to Dr Middleton's rooms was on 18 April 1996. At this time the bleeding problem was reviewed again. Ms A was taking her Provera daily and cyclically at that stage, and finding that she was having difficulty controlling the flow. It was Dr Middleton's desire to refer Ms A back to the gynaecologist at the Gynaecology Clinic at xx Hospital, but she was prevented from doing so by Ms A's reluctance to see Mr B. Dr Middleton sought to clarify for the Tribunal the situation at xx Hospital which she said made it difficult for her to send Ms A on to the other gynaecologist. She explained *"We have two gynaecologists – Mr B and Mr A. Mr B is a very good gynaecologist. He makes good clinical decisions but he tends to be fairly abrasive and patients frequently come away from there feeling that they have been traumatised and are reluctant to return to him. Mr A, on the other hand, is very personable and pleasant, and makes patients feel very much at home. Unfortunately, he feels that he can't cope with all of the patients who want to be referred over to him after they have seen Mr B.*

On occasions I have referred patients to Mr A specifically who were previously under the care of Mr B and I've been phoned up and told in no uncertain terms that these are Dr B's patients and they should have been referred back to him, hence my reluctance to send Ms

A to Mr A when she refused to see Mr B. I in fact urged her to see him privately because that's always an option available to patients, and she was reluctant to do so, and it was only after her reluctance – she refused to have me phone Mr B and speak with him and get further advice, and she was reluctant to see Mr A privately, and I appreciate that that would have been an expense that she probably thought she couldn't bear. But I did get her permission at that time to ring Mr A and get some advice from him about her management, which is what I did at that point in time."

4.20 **DURING** the same 18 April 1996 consultation Dr Middleton decided to do another CBC of the haemoglobin. The iron studies were not repeated at that time because only two months previously they had been normal. Dr Middleton wanted to see how much Ms A's haemoglobin had fallen in the course of two months given the amount of bleeding that she was describing to her. When the test results came back, by Dr Middleton's interpretation the haemoglobin was clearly within normal limits of 124. By reference to Ms Stent's opinion (Page 6 Bundle of Documents) that *"… 124g/l which is towards the lower end of the normal scale"*, Dr Middleton explained *"In our own laboratory … if this haemoglobin had come back at 119 I, too, would have said: "This is lowish and needs to be watched more closely.", but in point of fact, in the laboratory that I use, 115 is the lower limit and 124 is considered to be perfectly normal. Certainly, I've presented this case to my peers and that was all of their conclusions, as well, that that was a normal haemoglobin."*

4.21 **HER** next consultation on 13 May 1996 was again about persistent bleeding and flooding. Dr Middleton decided to try some HRT along with the Provera to try and control the continual bleeding, and Dr Middleton said she elected at that time not to repeat her haemoglobin testing

on the simple basis that there had been two normal haemoglobin's done two months apart, the last of which had been less than four weeks previously.

4.22 **DR** Middleton explained the pressure GP's are under not to over-utilise laboratory facilities, that doctors think twice before doing a haemoglobin on every visit made by a patient. The next time Dr Middleton would have planned to carry out the haemoglobin tests would have been about three months later, having had two normal results two months apart, unless the patient had indicated to her that her bleeding pattern had changed. In fact that had not been indicated to her. Doctors are monitored very closely about blood tests that they do, and to do two haemoglobin's so close together would probably not have been appropriate.

4.23 **DR** Middleton commented that her impression of the extent and persistence of the bleeding from consultation descriptions, were never as graphic as described in the evidence given by Ms A before the Tribunal.

4.24 **THE** primary reason for the consultation of 26 June 1996 was not Ms A's bleeding but flu and she was wheezing. In view of her history of asthma her lungs were listened to and there was discussion about what needed to be done at that stage. Note was made that Ms A was still bleeding. Primolut was added to her HRT, which had been prescribed on the previous visit.

4.25 **THE** next visit to her rooms was not until October. Dr Middleton had not repeated Ms A's haemoglobin from April. She explained she would probably have done it in the interval, but unfortunately it was not until October that Ms A appeared in her rooms again.

4.26 **AT** the visit in October the bleeding was clearly continuing and Ms A was alarmed by it. The referral to Mr A was discussed and Dr Middleton said she explained she would be happy to make the referral. Ms A phoned the rooms on 10 October 1996 and said that she would accept the offer of a referral to see Mr A. Dr Middleton provided a letter of referral to that effect.

5. DISCUSSION AND FINDING:

5.1 **SPECIFICALLY** the Tribunal will address the essence of the charge, which is that Dr Middleton's care of Ms A between April 1996 and October 1996 was inadequate. In the process there will be references at times to the specific particulars of the charge numbered 2, 3 and 4. However those particulars will receive attention only to the extent that the primary focus requires.

5.2 **THE** Tribunal regards the first consultation which took place on 3 November 1995 as pivotal in context of the quality of the commencing and on-going care of Ms A. That consultation would, as it were, set the tone for Ms A's future care.

5.3 **MS** A's assertion that at that first consultation Dr Middleton did not take any steps to assess her haemoglobin, iron levels or other symptoms, simply cannot be sustained on examination of the evidence. Nothing could be further from the truth of Ms A's contention *"… Dr Middleton did nothing at all"*.

5.4 **FIRST** the Tribunal accepts the uncontradicted evidence of Dr Middleton as to her awareness of Ms A's complaint of persistent heavy bleeding. Permission was given to obtain medical

records of Ms A's former GP, with whom she was dissatisfied. Secondly, a set of blood tests was ordered, those blood tests including a CBC and iron studies.

5.5 **APPRECIATING** that Ms A was very pale, and was probably anaemic, Dr Middleton wrote a prescription for iron. Although mention is not made of this prescription in the notes, the Tribunal is satisfied that Dr Middleton's practice is to keep carbon copies of prescriptions which she writes for her patients. It transpired the prescription for iron was not required, apparently because Ms A was already taking iron medication.

5.6 **AT** the first consultation Ms A also made clear to Dr Middleton that she had not been particularly happy with Mr B and that she was not prepared to return to his care.

5.7 **ON** 3 November 1995 Ms A was found to have a haemoglobin of 110, which on Dr Middleton's assessment was below the normal limit by five points.

5.8 **THE** Tribunal does not accept that Dr Middleton failed to explore adequately Ms A's past history of iron deficiency and anaemia. Dr Middleton obtained medical records from Ms A's previous GP. Those records make clear the previous difficulties Ms A was experiencing. These records were produced in the course of Dr Middleton's cross-examination of Mr Laney.

5.9 **THE** records in question indicate admission of Ms A to xx Hospital on 14 February 1994 for a D & C EUA carried out on that date with discharge of 16 February 1994. On 18 May 1994 Mr B informed Ms A's GP by letter of 18 May 1994 that she had cancelled her appointment for follow-up for her prolonged PV bleeding in January and February because she stated she was

OK. Mr B noted that histology of the curettings showed necrotic decidua. On 8 March 1995 Mr B reported to Ms A's GP that a scan performed with vaginal probe had found an enlarged uterus with a thickened endometrial lining. Moderate uterine curettings performed on 4 May 1994 showed no evidence of malignancy.

5.10 **IN** a letter of 8 June 1995 to Ms A's GP Mr B recorded advising Ms A the alternatives of no treatment and observing her loss over some months, cyclical Progesterone therapy and endometrial ablation, and hysterectomy. Mr B noted Ms A was not keen on any of the other alternatives. Mr B recorded Ms A was unhappy about the idea of a hysterectomy at age 50 although he said he thought a hysterectomy at this age was more sensible with removal of both ovaries. In a further letter to Ms A's GP on 5 September 1995, Mr B again raised the prospect of a hysterectomy and of Ms A's resolute preference for cyclical Provera.

5.11 **ALL** attempts by Dr Middleton to cross-examine Mr Laney on Ms A's reluctance to submit to a hysterectomy were resisted by Ms Davenport, primarily because this aspect had not been raised in cross-examination of Ms A by Dr Middleton. In the event the objection was meaningless because Dr Middleton succeeded in raising the issue in her evidence in chief. In cross-examination Mr Laney conceded to Dr Middleton his comment that a haemoglobin of 124 to be in the low normal range, was based on the opinion of others. For himself Mr Laney said he regarded a haemoglobin of 124 as being normal, and that this would be the general opinion of other gynaecologists and other doctors as well.

5.12 MR Laney, by implication, conceded his brief of evidence statement *"… blood counts were never ordered by Dr Middleton"* was made on the basis of information supplied to him, rather than as a result of his own inquiry.

5.13 THAT Dr Middleton failed to test Ms A's haemoglobin levels on a regular basis cannot be sustained. This is clear from the flow chart evidence supplied by Dr Middleton. Although the Tribunal may see a need to question the desirability of record re-construction per flow charts in place of retention of original hard copy records, the fact remains that Dr Middleton acted prudently and responsibly in ordering blood tests on three occasions following consultations on 3 November 1995, 16 February 1996 and 18 April 1996. All the test results on 26 February 1996 were considered to be within normal limits – so too was the haemoglobin result of 18 April 1996.

5.14 FOLLOWING questioning of Dr Middleton by members of the Tribunal, she explained it was her invariable practice to obtain and go through the medical notes of transferring patients to see what sort of medical history they have. The Tribunal comments that this is a commendable practice.

5.15 MS A's perception of Dr Middleton misunderstanding her condition is implicit from some of the evidence. Although it is unfortunate it may be explainable. No doubt Ms A is correct in her evidence that Dr Middleton had never raised the issue of depression with her. However it seems plain enough from Dr Middleton's evidence that she was concerned as to Ms A's mental state on occasions. Dr Middleton explained to the Tribunal, by reference to the poisoning episode

mentioned in Mr D's letter of 13 February 1996, that she had real concern about the mental state of a person who continued to reside with someone whom they believed had poisoned them.

5.16 **DR** Middleton explained to Tribunal members that she initiated informal peer review of her handling of Ms A's case following the complaint. The peer review group is a collection of GP's in xx who meet on the third Tuesday of every month - all of them seeking accreditation by the College of General Practice. Having made available all relevant medical records to the peer group, Dr Middleton said they supported her in much of what she had done, and all agreed that what could have been done was done. Although Dr Middleton did not provide any corroboration of this evidence, the Tribunal records that generally it was impressed by the sincerity and straight forward manner in which Dr Middleton presented her evidence.

5.17 **IN** making this assessment of Dr Middleton's evidence, the Tribunal does not wish Ms A to think that its assessment of her evidence is in any way untoward or unbelieving. The simple fact of the matter seems to be that Ms A had declined to have a hysterectomy. Her completely justifiable personal preference was to persist in trying to control a severe heavy and persistent bleeding problem by methods alternative to surgery. In so doing it is undeniable that Ms A suffered extreme distress, discomfort and at times plain and simple embarrassment. Given the unremitting nature of the problem, it is understandable that Ms A may not have fully appreciated the efforts which were being made on her behalf by Dr Middleton. Also, given the inconsistencies between the evidence of complainant and attendant medical practitioner, the Tribunal is minded to comment in passing, that maybe Dr Middleton failed on occasions to communicate adequately to Ms A her concern for her condition and what she was trying to do to alleviate it.

5.18 **THE** Tribunal is relieved that it is able to reconcile (to some extent) the face value of the evidence of Mr Laney against his later understanding following production of earlier medical records by Dr Middleton. Those records provided Mr Laney with some explanation for why such apparently conservative management of Ms A was pursued for so long. Having been made aware by Dr Middleton that Ms A had had two previous D&C's and had also had a hysteroscopy, Mr Laney's assessment was *"… We know now we'll never improve the period pattern"* and a belief that significant care had been taken to exclude the possibility of malignancy or dysplasia, or abnormal cellular development in the endometrium of the uterus in a woman of Ms A's age.

5.19 **SOME** better understanding of Ms A's plight was elicited in questioning of her by Dr Gleisner, a psychiatrist member of the Tribunal at this hearing. Dr Gleisner put to Ms A her conclusion: *"During all my dealings with Dr Middleton she did not seem to know nor care what was wrong with me"* may have been reached at the end of her problems when looking back on them, rather than from the very beginning. Ms A's response indicates to us that this is in fact what may well have happened.

5.20 **MS** A seems justified in her complaint that Dr Middleton would not allow her to swap specialists and that her preferred specialist could only see her if it was an emergency. Now that this apparent anomaly has been explained, Ms A may be able to better understand the quandary Dr Middleton faced in a small town where there were only two specialists of choice. It was an unfortunate situation. Again the Tribunal sees the problem as probably being one of a communication break down.

5.21 **FINALLY** on the subject of communication, noted is Dr Middleton's comment that at no time when Ms A was consulting her did she give as graphic a description about the extent of her bleeding as she gave in her evidence. The problem was obviously one of a discreet personal nature and perhaps its boundaries did inhibit Ms A when she was discussing it with Dr Middleton – a communication short-fall can obviously affect the way in which two parties separately view a particular problem.

5.22 **DR** Middleton was criticised for not visiting Ms A at home after she fainted on 12 October 1996, and for not arranging transport to her surgery or to the hospital. Dr Middleton's evidence provided quite a detailed explanation why her duty doctor responsibilities on the day prevented her from making a home visit. Dr Middleton said she raised alternative transport possibilities but they were ruled out by Ms A on account of cost. Answering Ms Cole's question how she remembered the circumstances so clearly, Dr Middleton said it was a very dramatic situation, and because she was very concerned that this patient should not have been walking. In Dr Middleton's words *"It was not my best advice that she walk to my surgery; it was my last resort advice that she rest and drink before she came, and I remember it very clearly because I was concerned about her"*. The Tribunal accepts the explanation given by Dr Middleton on the transport aspect of the complaint.

5.23 **DR** Middleton expressed regret that Ms A's haemoglobin went as low as 65. She said she did not believe that if she had done a haemoglobin in May or in June that it would have been nearly so low. Dr Middleton said she suspected the haemoglobin got rather precipitous at the time in question. In conceding the possibility that earlier iron studies might have indicated that Ms A was

getting into trouble, Dr Middleton felt, as Ms A was taking iron she bought over the counter, that possibly they would not have shown any change either.

5.24 WITH the benefit of hindsight the possibility exists that Dr Middleton could have been more pro-active in her management of Ms A's bleeding problems. However the Tribunal is quite satisfied the essential focus of the charge, that Dr Middleton's care of Ms A between April and October 1996 was inadequate, has not been established. Consequently it is not necessary to go on to consider whether the conduct in question was conduct unbecoming, as statutorily qualified, or professional misconduct.

5.25 FOUR other matters require brief mention, two of which relate to the charge.

5.26 FIRST the Tribunal considers the charge should have been framed in accordance with either sub-section (1)(a), (b) or (c) of Section 109. It will always be open to the Tribunal to determine the actual level of offending, if any, after conducting a hearing on a charge laid under Section 102 of the Act.

5.27 SECONDLY the Tribunal recommends to the Director of Proceedings that charges laid before the Tribunal do not contain recitals of breaches of rights under the Code of Health and Disability Services Consumers' Rights. The responsibility of forming an opinion as to a breach of the Code rests with the Commissioner. Thereafter the functions of the Director of Proceedings are those listed in Section 49 of the Health and Disability Commissioner Act 1994. There is no reference in Section 49 of that Act to breaches of the Code.

5.28 **THE** third matter requiring comment relates to non-compliance by the Director of Proceedings with the following Order which was made by the Tribunal prior to the hearing:

*"**1.1** **OF** its own motion the Tribunal orders the Director of Proceedings under the Health and Disability Commissioner Act 1994 forthwith to supply it with a copy of any report or advice given by a peer review GP to the Health and Disability Commissioner.*

1.2 ***THIS** order is made in reliance on Clauses 5(3) and 7 of the First Schedule of the Medical Practitioners Act 1995.*

2. REASONS FOR ORDER:

2.1 ***BY** letter dated 12 June 1998 the Health and Disability Commissioner has declined to comply with the Tribunal's request that the Director of Proceedings provide a copy of any report given by a peer review GP to the Commissioner.*

2.2 ***IT** is acknowledged by the Tribunal that there is outstanding an issue defining the separate requirements of the Health and Disability Commissioner and the Director of Proceedings to provide discovery to counsel acting for a respondent medical practitioner. This issue may be clarified by declaration of the High Court following determination of certain review proceedings.*

2.3 ***THE** Tribunal considers the request which has been made of the Director of Proceedings in this case is entirely different to and separate from the issue involved in the Judicial Review proceedings, in the following respects:*

2.3.1 ***FIRST*** *the request is made by the Tribunal, not counsel for Dr Middleton (whom the Tribunal believes is not legally represented).*

2.3.2 ***SECONDLY****, the request has been made for one specific document, as opposed to disclosure inter partes in a general sense.*

2.3.3 ***THIRDLY****, the request emanates from a genuine concern that the Tribunal be fully able to discharge its obligation to observe the rules of natural justice.*

2.4 ***IN*** *noting that Dr Middleton will not have legal representation at the hearing, the Tribunal considers it must be able to access all medical information which arises out of or is incidental to the hearing of the charge against Dr Middleton."*

5.29 PRIOR to commencement of the hearing Ms Davenport explained her reasons for non-compliance with the order. While those reasons are noted, they are not necessarily accepted by the Tribunal. The Director of Proceedings should know the Tribunal's position on the matter as it affects the charge which was faced by Dr Middleton.

5.30 IN the event of the Tribunal having found against Dr Middleton, the Tribunal would have deferred announcement and delivery of its Decision pending either compliance with or appeal of the Order. Given that the charge against Dr Middleton has been dismissed, compliance with the Order

became academic. However the Tribunal wishes the Director of Proceedings to be aware of its position should a similar situation arise in the future.

5.31 **FINALLY** the Tribunal considers it is not appropriate for certain of the materials comprising the file of the Health and Disability Commissioner to be placed before it. Taking Dr Middleton's case as an example, the Tribunal considers it should not have been supplied with copies of either the opinion of the Health and Disability Commissioner, or Dr Middleton's letter of apology of 28 January 1998. The Tribunal must always be alert to a distinction between evidence and conclusions. The Tribunal should not be privy to the Commissioner's opinion, which is a conclusion. Likewise concerning the letter of apology written by Dr Middleton, apparently on the insistence of the Commissioner, the Tribunal should not be privy to anything which could reasonably be regarded as part of a settlement process. It is not the responsibility of the Tribunal to review the Commissioner's process of complaint investigation.

DATED at Auckland this 13th day of July 1998

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal