New Zealand Society of Anaesthetists
The Terrace
Wellington

Attention: Dr David Kibblewhite
President

By email only

17 August 2017

Dear Dr Kibblewhite

Health and Disability Commissioner Opinion 16HDC00882

1. The New Zealand Society of Anaesthetists (NZSA) has sought our advice on a recent opinion of the Health and Disability Commissioner (the Commissioner) in which an anaesthetist, Dr B, was found to be in breach of the Code of Health and Disability Services Consumers' Rights (Code of Rights).

2. The background to the NZSA's request for this opinion is set out in a 28 June 2017 letter to the NZSA Executive from two Wellington Hospital anaesthetists; who were writing also on behalf of another 29 specialist anaesthetists. In their letter, the anaesthetists raise serious concerns about the Commissioner's opinion; express a view that the Commissioner's opinion ought to be the subject of a legal challenge; and pose three specific questions for legal advice:

   (a) If an error is not necessarily a breach of the Code of Rights, does the error in this case differ significantly from other errors, or is the finding of a breach reasonable in the circumstances?

   (b) How much weight is placed on expert opinion by the Commissioner; and was the Commissioner's response to the expert's opinion in this case appropriate?

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(c) Do the Commissioner's views on the use of electronic drug identification systems mandate their use in all anaesthetising locations in the country and in the care of all anaesthetised patients?

3. During the course of the writer's discussions with you it has become apparent that NZSA would like a legal opinion that both addresses the specific issues identified by the group of concerned anaesthetists and also provides a resource for NZSA more generally on the legal issues that arise in the context of the Commissioner reaching opinions under the Health and Disability Commissioner Act 1994 (HDC Act). Relatedly, you have asked us about the status of 'guidelines' and standards promulgated by professional colleges and associations. We will endeavour to address all these issues in this advice; albeit of necessity some issues will be addressed in more detail than other issues.

Summary

4. We think the anaesthetists have raised many important issues in their 28 June 2017 letter. However, for the reasons that follow, we do not think that the Commissioner has made any error of law, or reached an unreasonable opinion (in the administrative law sense) such that this opinion can be successfully challenged.

5. That does not mean that the arguments raised by the anaesthetists are without merit - indeed we have considerable sympathy for many of the arguments. It may be that the anaesthetists' concerns can be raised with the Commissioner during a constructive discussion.

Brief overview of the Commissioner's opinion relating to Dr B

6. It is not necessary to set out all the details of the care provided by anaesthetist Dr B to patient 'Mrs A' which then led to a complaint and a subsequent investigation by the Commissioner. It does not appear that the facts are in dispute to any significant extent. However, it is useful to record here some of the key points that are most relevant for immediate purposes.

7. During spinal decompression surgery at a private hospital, Dr B inadvertently administered an additional 6 mg of morphine into Mrs A's epidural space. The

Commissioner records Dr B as describing it as a 'slip/lapse' by him picking up the wrong syringe.[1]

8. The mistake was identified by Dr B himself. Having identified the error, Dr B took immediate action to mitigate the possibility of any harm to Mrs A. Dr B's 'open disclosure' of the mistake, and post-mistake management of the situation, appears to have been exemplary. The anaesthetists who have written to the NZSA Executive have expressed particular concern about the possibility that the Commissioner's opinion might serve as a disincentive to disclose mistakes in the way that Dr B did here.

9. Fortunately, it does not appear that Mrs A suffered any significant ill-effects as a result of the medication error; but she did spend a night in ICU as a precaution.

10. As is common practice, the Commissioner engaged an independent expert to advise him on the standard of care provided by Dr B. Key extracts from the independent expert's report include the following:[2]

> Overall the care provided by [Dr B] was good and with the exception of his error in giving a second dose of epidural morphine instead of ropivacaine/fentanyl there was no departure from accepted standards.
>
> …
>
> [Dr B's] response to his drug administration error was exemplary and his use of the [record-keeping system] did not represent a significant departure from the practice of many of his peers.
>
> …
>
> With regard to the drug administration error – although the epidural drugs had been placed in a separate tray to ensure nothing could be administered that was neurolytic it was still inappropriate to mistakenly give a larger than intended dose of epidural morphine. Notwithstanding [Dr B's] effective, timely response it is my opinion that his error represented a departure (albeit a minor one) from the normal standard of care.
>
> [Emphasis added.]

[1] At [2].
[2] At page 15 of the Commissioner's opinion.

11. The Commissioner reached the view that Dr B had not provided services to Mrs A with reasonable care and skill; and accordingly that Dr B had breached right 4(1) of the Code of Rights. The key reasons for the Commissioner reaching this opinion appear to be as follows:

    (a) Dr B did not scan the drugs prior to administering them; and then *"did not undertake any alternative safety check to verify that he was administering the correct drugs before doing so"*. The Commissioner described this as 'suboptimal';[3]

    (b) Dr B is recorded as having told the Commissioner that he had prepared a syringe/drugs (for a subsequent patient) which was in close proximity on the drug trolley; and this contributed to the mistake.[4] The Commissioner concluded that it was *"inherently risky"* for Dr B to place epidural syringes for two patients in close proximity on the drug trolley.[5] The Commissioner concluded that:[6]

> It is clear that Dr B's own system for ensuring that the two patients' syringes did not get mixed up was inadequate and unsafe.

12. The Commissioner acknowledged that his expert described the medical error as a *"minor departure from accepted standards"* and that Dr B's storage of syringes was not an unusual practice. Nonetheless, the Commissioner concluded that:[7]

> [In] my view, by failing to administer the correct drugs, by failing to undertake appropriate safety checks to ensure that he was administering the correct drugs, and for storing syringes for two patients in close proximity, Dr B did not provided services to Mrs A with reasonable care and skill. Accordingly, Dr B breached Right 4(1) of the Code.

13. Although it is not a formal part of his opinion that Dr B breached right 4(1), the Commissioner does make an 'Adverse comment' relating to the fact that the speaker on the record-keeping systems monitor in theatre had not been switched on (such that there was no audible identification of the scanned drugs).[8] The

[3] At [44].
[4] At [15].
[5] At [47].
[6] At [47].
[7] At [48].
[8] At [52].

Commissioner noted his own expert adviser's conclusion that the absence of a radio alert *"cannot be regarded as particularly unusual"*. Notwithstanding this advice, the Commissioner's opinion was that:[9]

> Dr B should have ensured that the equipment he was using was set up properly and functioning well. In particular, Dr B should have ensured that the record-keeping system speaker was audible.

The role of the Commissioner and the issuing of opinions

14. It is helpful to make some general comments about the Commissioner and his role under the HDC Act.

15. Where the Commissioner receives a complaint about the delivery of health services, the Commissioner has a discretion as to whether to initiate a formal investigation.[10]

16. Where the Commissioner decides to investigate, the key question for the Commissioner will be whether, in the Commissioner's opinion, any action that was the subject of the investigation was in breach of the Code of Rights.[11]

17. The Commissioner's powers to take action where the opinion is reached that there has been a breach of the Code of Rights are set in s 45(2) HDC Act. We summarise here some of the key actions the Commissioner can take:

    - Make any recommendations the Commissioner thinks fit;
    - Report the opinion to any professional body or authority (e.g. Medical Council); ACC; the Minister of Health; or *"any other person"* the Commissioner considers appropriate;
    - Refer any health professional/provider to the Director of Proceedings for the purpose of deciding whether any disciplinary proceedings before the Health Practitioners Disciplinary Tribunal, or civil proceedings before the Human Rights Review Tribunal, should be initiated.

[9] At [52].
[10] Section 40 HDC Act.
[11] Section 45(1) HDC Act.

18. We emphasise that s 45(1) (a) refers to the Commissioner being *"of the opinion that any action…was in breach of the Code"* (emphasis added).

19. The fact that this is an 'opinion', involving as it does an element of discretion, is highly relevant to the ability to mount a legal challenge by any health provider dissatisfied with the conclusions reached by the Commissioner. In reality, it is likely necessary for there to be an error of law or a breach of procedural fairness to mount a successful challenge to an opinion issued by the Commissioner.

20. The difficulties in challenging opinions of the Commissioner were illustrated in an unsuccessful challenge by a surgeon against a Commissioner's opinion that the surgeon had breached the informed consent requirements in the Code of Rights.[12] In this case, despite the Commissioner obtaining expert evidence which concluded that the surgeon's informed consent processes were adequate, the Commissioner took the view that the surgeon should have informed the patient about the relatively high failure rate of the procedure and that if there was a failure then an alternative surgical method would be adopted which would involve extra costs to the patient. In dismissing the challenge, the High Court noted:[13]

    (a) The Commissioner's opinion is *"just that, an opinion not directly affecting the legal rights or liabilities of the health care provider"*;

    (b) The processes in the HDC Act have a *"high level of 'fairness' attached"*;

    (c) The Commissioner *"has a high level of expertise in the field"*; and

    (d) The report of the Commissioner *"is an opinion albeit well informed but where there may be genuine scope of disagreement".*

21. For our part, we take issue with the first statement quoted above – that the Commissioner's opinion does not directly affect the legal rights or liabilities of the health provider. It is quite clear – from both the legislation and what happens in practice – that there can be real and direct consequences to health professionals who are subject to a Commissioner's opinion that the Code has been breached. The ultimate action is referral to the Health Practitioners Disciplinary Tribunal –

[12] *Stubbs v The Health and Disability Commissioner* HC Wgtn CIV 2009-485-2146, 8 February 2010, Ronald Young J.
[13] At [35].

and the Commissioner's opinion that the Code has been breached is a mandatory prerequisite to any such action through the Director of Proceedings' Office. More generally, referrals to the relevant responsible authorities (such as the Medical Council or the Nursing Council) can directly impact on a health professional's professional practice.[14]

22. Certainly we are aware that many health professionals would say that a Commissioner's 'opinion' and subsequent action can feel 'punitive'; and that is the language used by the anaesthetists in their 28 June 2017 letter. Even if the purpose is not, strictly, to punish, clearly the sanctioning of professional conduct (or at least the potential for such sanctioning) in response to deviations from acceptable standards of practice might be said to contain a punitive element.

23. Despite the objections we raise to some of the comments made by the High Court in *Stubbs*, it is clear that the courts will give significant deference to the conclusions reached by the Commissioner.

Breaches of right 4(1) and the concept of negligence

24. The Commissioner's opinion is that Dr B breached right 4(1) of the Code of Rights. Right 4(1) provides that:

> Every consumer has the right to have services provided with reasonable care and skill.

25. Although right 4(1) is the key 'right' for immediate purposes, it is closely linked to right 4(2) which provides that:

> Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.

26. There are concomitant responsibilities on health providers to provide services with reasonable care and skill; and in accordance with relevant standards.

27. It is widely acknowledged that the legal responsibility to provide services with reasonable care and skill reflects the well-established common law concept of 'negligence'. While there is no higher court authority directly addressing this issue, this has been accepted by the Commissioner,[15] legal academics,[16] and

[14] The serious consequences that can flow from a Commissioner investigation were recognised by the Human Rights Review Tribunal in *Gravatt v Bulmer* [2014] NZHRRT 40 (see [20]-[21]).
[15] See for example HDC Decision 05HDC16711; and Ron Paterson "Applying the Code to complementary

the Human Rights Review Tribunal; with the Tribunal describing the position in the following way:[17]

> Right 4(1) thus encapsulates the common law standard of care in negligence. In determining whether there has been a breach of right 4(1), the Health and Disability Commissioner and the Human Rights Review Tribunal will apply relevant principles of the common law of negligence.

28. As to the relevant principles of the common law of negligence:

    (a) The English case of *Bolam*[18] was for several decades the leading decision on the standard of care expected of a medical practitioner. Faced with conflicting medical views, Justice McNair stated:

    > The test is the standard of the ordinary skilled man exercising and professing to have that special skill. He need not possess the highest expert skill…It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

    And further:

    > A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in a particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion that takes a contrary view.

    (b) In a later House of Lords' decision, *Bolitho v City and Hackney Health Authority*,[19] the House of Lords qualified the *Bolam* principle in rare cases when professional opinion on diagnosis and treatment is not capable of withstanding "logical analysis". A court is entitled to hold that a body of opinion is not reasonable or responsible if a standard practice is flawed or illogical.

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therapies" (New Zealand GP, 28 June 2000).

[16] See for example Joanna Manning "The Required Standard of Care for Treatment" in Skegg and Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2015) at [4.2.1].

[17] *Director of Proceedings v Nelson* [2013] NZHRRT 38 at [171].

[18] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

[19] [1998] AC 232.

(c) In New Zealand, the proposition that the reasonableness of standards is ultimately for the court to determine, and that it is open to the court to set a standard higher than that recognised by current practice, finds support from the leading case of *B v Medical Council*:[20]

> The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates that usual professional practice, while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards.

(d) In terms of liability under the Code of Rights, the former Commissioner has previously cited the *Bolitho* decision as support for the proposition that the Code, and in particular right 4(1), does not require the Commissioner to be bound by the *Bolam* principle. Rather:[21]

> … the HDC is expected to form an independent opinion on the reasonableness of the care provided. Rejection of slavish adherence to the *Bolam* principle, in favour of the approach taken by the Code, is consistent with the *Bolitho* decision and with the approach of courts in Australia, Canada, Ireland and indeed New Zealand.

(e) As an example of the application of this approach in practice, in a case relating to a medical practitioner found in breach of right 4(1) the Commissioner held that:[22]

> [E]ven in relation to diagnosis and treatment, medical opinion is not necessarily determinative. I am not bound to accept expert opinions

[20] [2005] 3 NZLR 810 (Elias J). Although this was a disciplinary case, it has been applied by the Human Rights Review Tribunal in the context of standard setting under the HDC Act.
[21] Ron Paterson & Deanne Wong "Ovarian cancer and expert advice" *NZ Family Physician*, February 2005.
[22] See HDC Opinion 11HDC00123. See also HDC Opinion 08HDC07350

> uncritically. It is open to HDC to hold that the standard acceptable to the profession was nonetheless not reasonable. Ultimately the reasonableness of any standards adopted by the medical practitioner is for the Commissioner to determine, taking into account usual practice, as well as patient interests and community expectations.

(f) In another case, the Commissioner noted:[23]

> The Code confirms that the Commissioner as decision-maker is expected to form an independent opinion on the reasonableness of the care provided. While I accept that there can often be a legitimate range of responsible opinion and practice, I am also conscious of my responsibility, as an independent guardian of patients' rights, to distinguish between mediocre and good practice.

29. At this point we would conclude as follows:

(a) A breach of right 4(1) can be equated with the concept of negligence. This means that conduct which falls short of negligence ought not to be sufficient to warrant a breach of right 4(1);

(b) In considering whether there has been a breach of right 4(1) the Commissioner is not required to follow the *Bolam* test. This means the Commissioner is not bound to accept expert opinions without critical analysis; and

(c) The Commissioner might well be entitled to demand a 'higher standard' when determining what is 'reasonable care' than what the expert advisors consider is appropriate.[24] Although some practitioners might find this difficult to accept, it is consistent with the legal authorities referred to above.

[23] HDC Decision 06HDC11343.
[24] See Ron Paterson "The Code of Patients' Rights" in Skegg and Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2015) at [2.6.3].

Errors of judgement and minor deviations

30. The medical negligence jurisprudence holds that errors of clinical judgement may or may not be negligent; but that if the error is one that a practitioner acting with ordinary care might have made then it is not negligence.[25] As put by one legal academic:[26]

> The real difficulty lies in determining whether injurious behaviour by a physician was negligence or merely a (non-negligent) 'error in judgement'…and it is the facts in each case which will determine the answer to this crucial question.

31. Therefore the complexity is in determining whether the mistake is one which amounts to negligence or whether it is a 'non-negligent' mistake. This is a fine distinction – and one that in a practical sense may well be more academic than real (noting that the individual facts in any case tend to 'carry the day').

32. The language used by the Commissioner will be important. We know that the Commissioner (and his experts) use phrases such as 'minor departure' and 'minor lapse'. Although we are not aware of any case where the Commissioner has definitively reached the opinion that there was a 'minor lapse' which nonetheless amounted to a breach of right 4(1), the previous Commissioner made the following comments:[27]

> The present HDC Act is a blunt complaint-resolution tool. In many cases the language of 'complaint' and 'breach' is unhelpful, but there are no gradations allowed for within the Act. A breach may result from a minor lapse or a major shortcoming. Mitigating circumstances are taken into account in determining any follow-up actions.

33. We are concerned that 'minor lapses' might be sufficient to warrant an opinion that right 4(1) has been breached. Instinctively, a one-off, minor lapse of the kind that one would expect any reasonable and competent practitioner might make over the course of a career is not something for which any sanction should be imposed. Further, and following the analysis above, it is arguable that a one-off

[25] *Whitehouse v Jordan* [1981] 1 All ER 267, 281.
[26] Joanna Manning "Determining Breach of the Standard of Care" in Skegg and Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2015), at [5.1].
[27] Ron Paterson "Fine-Tuning or Overhaul: Changes to the Current Complaints Mechanisms" Paper presented to the LexisNexis Medico-Legal Conference (Auckland, May 2002).

minor lapse that falls short of the common law negligence standard cannot, as a matter of law, amount to a breach of right 4(1).

34. However, the reality of the legislation is that the Commissioner has significant discretion – and provided the Commissioner does not obviously misapply the law the courts will show him considerable deference. In exercising that discretion he will need to consider both the particular context in which the services were provided and the broader objectives the HDC Act directs him to observe.[28] In terms of the latter, this means the Commissioner needs to be broadly mindful of getting the balance right when deciding whether departures from acceptable standards warrant the quite significant opinion that there has been a breach of the Code. A breach opinion does mean something for a provider – both legally and reputationally. Fair decision-making by the Commissioner means that a breach finding should be made where, in all the circumstances, it is justified – but only where it is fair, reasonable and rational taking into account all relevant matters.

Specific questions

35. We now turn to consider the specific questions posed by the group of anaesthetists in the 28 June 2017 letter.

If an error is not necessarily a breach of the Code of Rights, does the error in this case differ significantly from other errors, or is the finding of a breach reasonable in the circumstances?

36. The first comment we make, here, is that we must approach the question as to whether the breach finding is 'reasonable' on the basis of the administrative law meaning of the term 'reasonable'. This is a complex and technical area of law; but what is clear is that the courts are reluctant to interfere with a statutory decision on the basis of it being 'unreasonable' – particularly where (as here) it is a statutory opinion made by a specialist decision-maker. Generally speaking, an 'unreasonable decision' is one which no sensible decision-maker, acting with due appreciation of his or her responsibilities, would have arrived at.[29]

[28] Sections 6 and 7 HDC Act.
[29] This is a reference to *Wednesbury unreasonableness* - see *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1947] 2 All ER 680. See also Francis Cooke QC, *Judicial Review*, Seminar for the New Zealand Law Society, May 2015, at page 41.

37. The Commissioner's expert described Dr B's medical error as a 'minor departure from accepted standards'. However, importantly, the Commissioner himself did not use the description 'minor' in reaching his opinion that Dr B did not provide services with reasonable care and skill.

38. Therefore this is not a case where the Commissioner has reached the view that there was a minor departure from accepted standards; but nonetheless there was a breach of right 4(1). For his part, the Commissioner has reached the opinion that Dr B's failure to undertake any safety checks was 'suboptimal'; and that Dr B's system for ensuring that the two patients' syringes did not get mixed up was 'inadequate and unsafe'. Accordingly, the Commissioner concluded that there was a breach of the obligation to provide services with reasonable care and skill.

39. We do not think that it can be said that the Commissioner's opinion is one that no reasonable decision-maker, in the Commissioner's shoes, could have reached. There may well be well-qualified persons who would have reached a different opinion – and the anaesthetists raising their concerns in the 28 June letter clearly see it differently from the Commissioner. However, in an administrative law sense – and with a particular eye on the possibility of a legal challenge to the Commissioner's opinion – the fact that there are others who would reach a different opinion does not take matters too far.

40. Neither do we think it can be said, here, that there has been any error of law by the Commissioner in the way he has interpreted right 4(1). As we have said, we would have concerns about an approach that concludes there is a breach of right 4(1) in circumstances where there is a minor lapse or breach that might be said to fall short of the negligence standard. However, we do not think that this is what the Commissioner has done here. As we have noted, the Commissioner himself has not concluded in the present case that this was a 'minor lapse' or 'minor departure'. If, in a future case, the Commissioner concludes that a minor, one-off departure amounts to a breach of right 4(1) then that might, in our view, raise legitimate questions of law about how the Commissioner is interpreting right 4(1); however, as always, that would be a question to be considered on the particular facts.

41. We have considerable sympathy for Dr B – particularly given the exemplary way he identified the mistake he had made and raised it. That was, of course, consistent with his obligations under the increasingly entrenched principles of

‘open disclosure’ – and any practitioner who chooses not to disclose a known mistake that has adversely affected a patient runs the risk of criticism that is likely to be more severe than what would be made in relation to the initial mistake.

42. Further, there is no doubt that it would have been open to the Commissioner to conclude that Dr B’s mistake did not amount to a breach of right 4(1). The anaesthetists mount a strong argument in their 28 June letter that it is better to respond to mistakes of this nature without a punitive response; and that the educational opportunities from this type of case could have been satisfied without a breach finding. It is not clear from the formal report what arguments were put to the Commissioner on these and other issues. However, regardless of whether or not these arguments were put, the Commissioner has reached an opinion that we think, on the facts of this case, is not one that can be successfully challenged legally.

How much weight is placed on expert opinion by the Commissioner; and was the Commissioner’s response to the expert’s opinion in his case appropriate?

43. It is clear from the Commissioner’s report that he has paid careful attention to the views expressed by his expert. As we have noted, the expert concluded that there was a departure from accepted standards – albeit one that he described as ‘minor’. Again as commented on, the Commissioner did not himself categorise this as being ‘minor’; although nor did he describe it as ‘moderate’ nor was the deviation graded by the Commissioner in any way.

44. We think that the Commissioner has been more critical than his expert of Dr B. By way of example, the expert advised that *“it is not unusual”* to have syringes on the trolley that may not be intended for use on the current patient; with the Commissioner describing this as *“inherently risky”* and that Dr B’s system was *“inadequate and unsafe”*.

45. However, the analysis of the law earlier in this opinion demonstrates that the Commissioner is entitled to deviate from the expert opinions he receives; although clearly he will need to have good reasons for doing so. It will be harder for the Commissioner to justify departing from expert advice on highly technical matters relating to diagnosis and treatment.

46. We do not view the Commissioner's analysis of the present issues (such as whether it is reasonable to have more than one syringe for different patients on the same trolley) as being in the category of highly technical matters of diagnosis and treatment which the Commissioner ought to be reluctant to depart from his own expert.

47. Even if these are properly considered to be highly technical and specialist issues, we do not think the extent of the Commissioner's differences with his own expert in the current case are sufficient to categorise this as an error of law, or the Commissioner acting unreasonably. It may well be that, in another case, there might be an error of law in the way the Commissioner applies the expert opinion; but we do not see one here on the present facts.

48. Finally, we note here the Commissioner's references to Dr B stating he has changed his practice following this incident.

Do the Commissioner's views on the use of electronic drug identification systems mandate their use in all anaesthetising locations in the country and in the care of all anaesthetised patients?

49. We do not read the Commissioner's report as mandating the use of electronic drug identification systems in all locations and in the care of all patients.

50. It is possible that there are other standards that have been promulgated that might be said to mandate use of such systems; or that the time may come (or has already arrived) where a responsible body of specialist anaesthetic opinion would conclude that no reasonable anaesthetist or hospital would not be using such systems – but we are not in a position to comment on whether that is currently the case.

51. We do think that the Commissioner's opinion can be taken as mandating that the anaesthetist is responsible for ensuring that the system used is safe - and that the system includes safety checks to ensure that the correct medication is being administered. However, the precise system for ensuring that is not mandated by this opinion.

52. Based on the Commissioner's opinion, if anaesthetists have at their disposal safety equipment that will assist with drug identification, an anaesthetist who chooses not to use that equipment will need to be able to explain coherently the

reasons for not using that equipment. Such an explanation will be complicated by the inevitable reality that it will most likely be required in circumstances where something has gone wrong.

53. We are a little troubled by the Commissioner's suggestion that the individual anaesthetist carries the personal responsibility for ensuring that the equipment used is properly set up and functioning well.[30] We do not disagree with the suggestion that the individual anaesthetist might have some responsibility here; but that might more fairly be a responsibility shared with the hospital (and potentially others).

Possible discussion with Commissioner

54. It will be clear from the above analysis that we do not think the Commissioner has made any legal errors in his opinion. However, we do want to emphasise that we have some sympathy with many of the points made by the anaesthetists in their 28 June letter. The facts in this case, and/or the Commissioner's reasoning, might not have needed to be too different for us to reach a different view on the legal issues.

55. Quite aside from the technical legal issues, we think it would likely be a matter of some interest to the Commissioner that a well-respected body of specialist anaesthetists has such a different view to that reached by the Commissioner.

56. We think there is merit in NZSA seeking a meeting with the Commissioner and raising the concerns. The particular details of the present case might simply be a backdrop to a more general discussion about how the Commissioner undertakes his investigations, the impact of breach findings, and identifying the right balance between an approach by the Commissioner that enables him to meet his statutory functions while encouraging reporting and learning without the sense that punitive action will be taken.

[30] At [49] – 52].

Status of standards and guidelines

57. You have also asked us to comment about the status of standards and guidelines. This request is not directly related to the Commissioner's opinion discussed above; but can nonetheless be addressed here. This, in itself, is a topic on which much might be said; but for immediate purposes we will endeavour to keep our comments relatively brief.

58. The short point is that there is the potential for standards, and even guidelines, promulgated by the likes of professional colleges and associations to be elevated to 'legal standards' that health professionals are expected to follow.

59. As we have referred to above, under right 4(2) of the Code of Rights health professionals are required to comply with *"legal, ethical, and other relevant standards"*. This sits alongside the obligation under right 4(1) to provide services with reasonable care and skill.

60. With respect to 'Code liability', the Commissioner's consideration as to whether there has been a breach of either right 4(1) and/or right 4(2) might well involve measuring the individual's actions against 'relevant standards' promulgated by reputable bodies such as the applicable medical college or association. Where a health professional has fallen short of any relevant standard, that might well form the basis for a finding that there has been a breach of right 4(2). Through this way, professional standards, statements and even guidelines can be elevated to 'legal standards'.

61. If a guideline is considered to be aspirational and an expression of best practice (rather than setting a minimum standard), then its non-fulfilment is unlikely to amount to a breach of right 4(2).[31] However, despite this, the High Court has found that even best practice standards promulgated by an industry group may be *"standards that the Commissioner could have regard to"*.[32]

62. The status and authority of the body that issued the guidelines will also be relevant. If issued by a Responsible Authority under the Health Practitioners Competence Assurance Act 2003 (such as the Medical Council) the publication is

[31] Ron Paterson "The Code of Patients' Rights" in P Skegg & R Paterson *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) at [2.6.3].
[32] *Culverden Group Ltd v Health and Disability Commissioner* HC, Auckland, M1143-SD00, 25 June 2001, at [86].

likely to carry particular weight; although there are examples of the courts taking a different approach to that set out in Medical Council statements.[33]

63. The extent of the uptake of the guidelines among practitioners is another relevant factor. For example, the Commissioner has found that referral guidelines published by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists were considered to be 'relevant standards' for the purpose of the Code; but the Commissioner noted that there was *"no evidence of how widely the RANZCOG guidelines are followed in general practice".*[34]

64. In professional disciplinary cases, standards and guidelines are relevant evidence in relation to disciplinary charges of professional misconduct – particularly charges based on malpractice or negligence. The High Court has stated:[35]

> Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent ethical and responsible practitioners.

65. The Health Practitioners Disciplinary Tribunal has referred to relevant codes of ethics, standards and guidance as:[36]

> helpful indicators of proper practice and ethical standards, and as such [are] important when exercising judgement as to whether in the particular circumstances there has been professional misconduct.

66. The conclusion, here, is that anaesthetists should assume that standards and guidelines promulgated by well-respected organisations such as the anaesthetists' own college or association might well be adopted by decision-makers as being reflective of the standards of practice expected of anaesthetists. If an individual anaesthetist is not complying with such

[33] See *Director of Proceedings v Medical Practitioners Disciplinary Tribunal* [2003] NZAR 250.
[34] Opinion 08HDC07350.
[35] *Collie v Nursing Council* [2000] NZAR 74 at [21].
[36] *Re Casey* HPDT 334/10/144P, 22 October 2010.

statements, he or she might well need to justify the reasons for that non-compliance if the matter falls for consideration.

Yours sincerely,

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