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The Health and Disability Commissioner
Te Toihau Hauora, Hauatanga
Level 10, Tower Centre
45 Queen Street
(P.O. Box 1791)
Auckland 1010

xx June 2012

Attention: **The Health and Disability Commissioner and the Medical Council of NZ**

Re: **Breaches of the 'Code of Health and Disability Services Consumers' Rights', the 'Code of Ethics' of 'The Medical Association of New Zealand' and legal provisions - by General Practitioner Doctor Dxxxx Xxxxxxx**

Dear Health and Disability Commissioner, dear Madam / dear Sir,

Please take note of my complaint about breaches of the 'Code of Health and Disability Services Consumer's Rights', which are listed in section 2 of the relevant Schedule of the 'Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996'.

Equally there have been breaches of the 'Code of Ethics' of the New Zealand Medical Association, of section 8 (2) of the 'Health Practitioners Competence Assurance Act 2003', the 'Health Information Privacy Code 1994' and a breach of the 'Health (Retention of Health Information) Regulations 1996'.

Of relevance is also 'Cole's Medical Practice in New Zealand' (2011 edition) - published by the Medical Council of New Zealand, of which chapter 1 ("Good Medical Practice") is considered to be the foundation document for standards and ethics to be applied, upheld and followed by registered medical practitioners. The Medical Council has also adopted the 'Code of Ethics' published by the New Zealand Medical Association, and binds itself to other codes, statutory and regulatory provisions.

Under the 'Code of Health and Disability Services Consumer's Rights' the following of my rights have been breached by Dr Dxxxx Xxxxxxx, MBChB, General Practitioner, based at Xxxxxxxx Health Centre, Xxxxxxxx, Auckland:

Right 1 ***Right to be treated with respect***
Right 3 ***Right to dignity and independence***
Right 4 ***Right to services of an appropriate standard***
Right 5 ***Right to effective communication***
Right 6 ***Right to be fully informed***

Under the 'Code of Ethics for the New Zealand Medical Profession', published by the New Zealand Medical Association, the following principles have been breached:

Principle 1 - ***Consider the health and well being of the patient to be your first priority.***
Principle 2 - ***Respect the rights, autonomy and freedom of choice of the patient.***
Principle 4 - ***Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.***
Principle 8 - ***Honour the profession, including its traditions, values, and its principles, in the ways that best serve the interests of the patient.***

Principle 9 - ***Recognise your own limitations and the special skills of others in the diagnosis, prevention and treatment of disease*.**
Principle 12 - ***Accept a responsibility for maintaining the standards of the profession*.**

Under the 'Health Practitioners Competence Assurance Act 2003' the following provisions also appear to have been breached:

8 ***Health practitioners must not practise outside scope of practice***

Re the 'Health Information Privacy Code 1994' Dr Xxxxxxx breached following rules:

Rule 2 - ***Source of health information***
Rule 3 - ***Collection of health information from individual***
Rule 8 - ***Accuracy etc. of health information to be checked before use***

Under the 'Health (Retention of Health Information) Regulations 1996' the following sections have been breached:

5 Definition of minimum retention period
6 Health information to be kept for minimum retention period

BACKGROUND:

A) Designated doctor examination by Dr Dxxxx Xxxxxxx, Xxxxxxxx Health Centre:

Following a decision by Work and Income Case Manager Pxxxxxx Lxx on 22 April 2010, to have my medical situation reviewed, I was on 09 June 2010 referred by fellow Case Manager Rxxx Gxxxxxx to Dr Dxxxx Xxxxxxx (of the Xxxxxxx Health Centre, xx Lxxxxxx Street, Xxxxxxxx, Auckland 1xxx; ph. 09 xxx xxxx) for a "designated doctor" examination under section 44 of the Social Security Act 1964.

I only selected Dr Dxxxx Xxxxxxx from a presented short-list of 6 GPs, because he was the only designated doctor offered to me by the Case Manager, who I could reach relatively conveniently with public transport, upon which I depended. He was unknown to me, and I was given no chance to check his particular qualifications, expertise and to gather any other information about him.

On 17 June 2010 well before 02:30 pm I arrived at the Xxxxxxxx Health Centre for the examination with documents from counsellors, an intern psychologist a psychiatrist and psychotherapist, all giving evidence of specialist treatment I had received for alcohol dependency and mental health conditions.

After waiting for about 15-20 minutes to see Dr Xxxxxxx, he called me up about 5 minutes after the arranged time of 02:30 pm. He asked me to enter for the first examination I ever had of this type. Dr Xxxxxxx had Work and Income forms and a copy of a medical certificate from my own doctor lying on his desk, and once I sat down, he immediately asked me numerous specifically targeted questions.

I was presented and challenged with the following clearly targeted questions:
What benefit I was on,
how long I had been on it,
what benefit I had been on before that,
when I had last worked,
why I had not continued with that work,
what work I had been doing before and since,
why I felt I could not carry on with that work,
why I had not worked since,
why I had not considered doing any other kind of work,
why I felt I could not do any work at present,
how often and for how long I had the binge type relapses I mentioned, and
what I was doing with my time every day.

I felt overwhelmed with his very direct, one-sided questions, which more resembled an interrogation than an examination. Since virtually all questions were targeted at details re my previous work, ability or inability to work, what I was doing and my benefit receipt, rather than relating to any aspects of my existing health issues, I felt pressured to reply in a defensive manner, explaining and justifying myself.

So I explained that I had received the invalid's benefit since mid 2008, and that this was due to needing longer term treatment for addressing my alcohol dependency, bouts of depression, xxxxxxxx xxxxxxx disorder (XXX) and other related issues. I informed him that I had prior to that been on the sickness benefit since 2006, but that my doctor and Work and Income had agreed to put me on the invalid's benefit, because my ill health and treatment were expected to take an extensive time.

I referred to my failed attempt to cope with a very stressful job I had started in operations in the xxxxxxx industry right after moving back from Xxxxxxxx in late 2005. I informed him that the last longer term job I had prior to that ended in April 2003. Also did I mention my worsening ill health and that I had other serious difficulties back in Xxxxxxx then, which led to me suffering severe depression and worsening alcoholism, aggravated by long-term unemployment and social degradation. I made clear that I had returned to New Zealand for the reason of attempting a return to work and a better life here.

I mentioned that I broke down under unbearable stress, during severe depression and relapses on alcohol in Xxxxxxx 2006, which resulted in me being unable to cope and continue with my work, ending up in a severe crisis. I stated that I suffered from alcohol dependency, depression and XXX.

Dr Xxxxxxx appeared to be little impressed, stern, indifferent, and not sympathetic. He persisted with questions like why I felt I could not cope with the work. So I said that my former clerical work in xxxxxx processing was extremely stressful, due to high deadline-, output-performance- and other pressures.

When asked whether I had considered doing other, less stressful work, I informed him of attempts to start temporary jobs in late 2007 and in February 2008, but due to not being able to cope, I had suffered further bad relapses on alcohol, forcing me to immediately terminate employment again. I mentioned that I had considered doing some voluntary part time work for a few hours a week, but as my treatment progressed slowly, and as I also had great difficulty dealing with many other pressing problems at that time, I was not able to consider returning to work for the foreseeable future.

It was nevertheless my goal to achieve lasting abstinence from alcohol, and given the experienced financial problems I would rather be working, I said. It was my intention to return to work at some time in the future, but due to my ill health and other problems, this was not possible now, I added.

Asked re what I was doing with my time every day, I stated, that due to my poor health conditions there was a limit to what I could do and cope with during the day. I'd spend most of time at home, partly doing xxxxxxx xxxxxx, tidying up and keeping xxxxx on things, which was the result of my insufficiently treated XXX. I would also spend some time reading, writing and doing a bit of online studies and correspondence, I mentioned. At times I would go for walks, and I was working on getting some form of a lifestyle balance back, I commented.

I would regularly see a counsellor and focus on my recovery, while I tried to address and manage other pressing matters, I said. The struggle I had with major problems relating to my accommodation, that I had to move a couple of times, and that I had suffered a number of serious upsets and setbacks in my recovery, I mentioned. Resulting recurrent relapses had repeatedly set me back, I said.

Dr Xxxxxxx asked how often I had relapsed recently, so I mentioned three to four times over the previous months. Asked how long they lasted, I told him that they usually lasted 4 days, led to serious physical and mental deterioration, which was followed with long periods of withdrawal. When also asked about when I suffered the last one, I said that this happened about a week and a half before.

Increasingly concerned about his endless questions, almost exclusively revolving around work and my hypothetical ability to work, I told Dr Xxxxxxx, that due to my ongoing poor health, repeated bouts of depression, inability to deal with stressors, recent relapses and my psychological instability, I simply could not look at working in the foreseeable future. I'd need some time to recover, I made clear to him.

I mentioned that I continued to get treatment at XXXX Xxxx in Hxxxxxxxx, where I was seeing a counsellor fortnightly, after having for a longer period consulted one there weekly. My brief treatment

for XXX at St Luke's Community Mental Health Centre in 200x and my attempt to access other treatment in the meantime I did in between is endless questions re work make a mention of.

After about 8 minutes of incessant questioning, Dr Xxxxxx asked me to briefly lie down on a clinical bed. He examined my breathing, heart beat and blood pressure. While he afterwards made a few more notes, I presented him the set of documents from counsellors and specialists at XXXX Xxxx, St Luke's Community Mental Health Centre, Xxxxx House and some other documents, which gave evidence of my diagnosed health issues and treatment by mental health and addiction specialists.

I presented Dr Xxxxxxx the following documents:

1. letter from V. Bxxxxx, intern psychologist, XXX treatment at St Lukes C.M.H.C, xx.xx.2007;
2. letter from Cxxxx Hxxxxxxxx, Clinician, XXXX Xxxx, dated xx.06.2008;
3. psychiatric assessment from XXXX psychiatrist Dr Jxxx Bxxxxx at XXXX, dated 27.08.2008;
4. letter from Mxxxxxx Sxxxxxxx, Clinician, XXXX Xxxx, dated 23.04.2009;
5. letter from T. Pxxxx, psychotherapist, 'Xxxxx House Psychotherapy Service', 28.09.2009;
6. letter from Mxxxxxx Sxxxxxxx, Clinician, XXXX Xxxx, dated 29.09.2009;
7. letter from Mxxxxxx Sxxxxxxx, Clinician, XXXX Xxxx, dated 23.12.2009 (*likely but unsure*);
8. letter from Axx Mxxxxxxx Xxx, Xxxxx House Psychotherapy Service, dated 14.01.2010;
9. letter from Mxxxxxx Sxxxxxxx, Clinician, XXXX Xxxx, dated 15.01.2010;
10. letter from Lxxxx Xxxxxx, Clin. Supervisor, XXXX Xxxx, dated 16.06.2010 (*likely but unsure*);
11. letter from Lxxxx Xxxxxx, Clin. Supervisor, XXXX Xxxx, dated 06.05.2010.

Dr Xxxxxxx only glanced at two to three of the letters I presented, and then told me, that he would not need them, as I had already told him enough. I offered him to take photo copies of them, so he would have them to look at properly later, but he refused, seeing no need for that. He mentioned he'd get a report from my own doctor and told me that he would send his report to Work and Income. After this 12 minute encounter he ushered me out of his consultation room without any proper farewell.

My impression of this supposed examination was not a good one. I later that day also saw my own GP, Dr Xxxxx Txxxxxx, for a newly required Disability Certificate for Work and Income. He did upon my mention of the examination by Dr Xxxxxxx and to my astonishment confide to me, that his colleague, Dr Xxxx (in the same surgery) previously had very negative experiences with Dr Xxxxxxx, and that staff at their Medical Centre didn't get on well with him, whenever they had to deal with him.

Through requests under the Official Information and Privacy Acts I would later establish that **the following information was sent to Dr Xxxxxxx - by Work and Income and also my own GP**:

1. The Medical Certificate completed by Dr Txxxxxxx, dated 22.04.2010 (by Work and Income);
2. the designated doctor referral with assessment and report forms, from case manager Rxxx Gxxxxxx, Work and Income Xxxxxxxx (sent by facsimile, 09.06.2010);
3. a short "host doctor report" by email letter from my own GP, Dr Txxxxxxx, from 18.06.2010;
4. the first issued (partly mistakes containing) psychiatric assessment by Dr Jxxx Bxxxx, psychiatrist, XXXX Cxxxxxx, dated 27.08.2008 (1 or 2 copies) (attached to 3.).

Once back home after the examination by Dr Xxxxxxx and my consultation with Dr Txxxxxx, I immediately made detailed notes about the peculiar medical examination and also Dr Txxxxxx's comments, because I had a persistent feeling of concern about how it had been conducted.

B) Summary of diagnosis, assessment and decision by Dr Dxxxx Xxxxxxx:

1) In the **manually** completed '**Designated Doctor Report**' Dr Dxxxx Xxxxxxx of the Xxxxxxxx Health Centre did on 17 and 30 June 2010 state the following:

Under the heading '**Diagnosis**' and in reply to **question 1** he stated as "main clinical conditions or disabilities impacting on the person's ability to work": **"*Alcohol Binge Drinker*"**

In reply to question 2 he commented re "what other conditions are impacting on the person's ability to work?": **"*Motivation lacking*"**

Re **question 3** he ticked "***No***" in reply to whether "the impact of the condition on the person's **ability to work is likely to fluctuate or be intermittent**". **NO further details are provided** to **question 4** open for comments as "**additional diagnosis**".

Under the heading 'Current treatment or intervention' Dr Dxxxx Xxxxxx had ticked "*No*" for the question "is the person under the care of a specialist(s)?"

Nothing was noted in reply to question 6 asking "what treatment or intervention(s) is the person currently receiving?"

Under the heading 'Impact on ability to work' Dr Xxxxxxx has rightly ticked "***No***" at **question 7** (re total blindness). He ticked "***Yes***" to question 8 and "***No***" to questions 9, 10 and 11. According to Dr Xxxxxxx I as the patient or client should according to **question 13** be **re-assessed on 17 September 2010**.

To **question 14** asking "how do the conditions outlined in **questions 1-6** impact on the person's ability to work?" Dr Xxxxxxx noted down: **"*Unreliable*"** and **"*lacks motivation*"**.

He did claim under question 15 that I would "*now*" be able to engage in work planning, training, light/selected duties and part-time work up to 30 hours per week.

As 'Factors which impact on ability to work' he has only ticked **"*substance abuse*"** and **"*motivation*"**.

Under '**Planning for employment**' he replied to **question 17**. ("which factors have the most significant impact on the person's ability to work?"): "***Alcohol***" and "***motivation***".

Re **question 19**. he suggested that "***counselling***" and "***planning***" could address these factors mentioned above.

In question 20. he has marked it as "*likely*" that I could commence work in the coming 12 months.

The report was finally formally completed and signed 30 June 2010.

2) In a **separate, summarising and typed letter** – headed with '**<u>WINZ – Designated Doctor Report</u>**' and **dated 30 June 2010** Dr Xxxxxxx stated "***Re: Mr Xxxxxxx Xxxxxxx***":

"17 Jun 2010
IB Review.
GP Dr Xxxxx Txxxxxxx, Xxxxxxxxxx Bay
Receives IB now – past two years, SB two years before this.
Last consistent work 2003. Seven years on benefit. Some years in Xxxxxxxxx on unemployment..
Prev work – xxxxxxx fxxxxxxxxx.
Problems: Alcohol binge drinking. Occas relapses lasting 3-4 days. Attends XXXX regularly – prev weekly, now every two weeks..
Letters from XXXX veriying this sighted.
Lives alone.
Says would rather work – when under stress risk of alcohol relapse.
Feels that too much to deal with now.
PB 120/70. overweight. cvs, rs, abdo nad.
Impression: 5x yrs, minimal work past 7yrs. Seems little motivation to work.

30 Jun 2010-10-17 HDR – Personality disorder – XXX, anger issues, episodic depression and alcohol misuse. Report from XXXX psychiatrist – DR Jxxx Bxxxx.
Recommended disulfiram or naltrexone for his alhol abuse – this does not seem to have been tried. It was noted that he had no signs of self neglect, good rapport, well presented, mood appropriate and no thought disorder.

Impression: A 5xyr man who has hardly worked since 40 yrs age. He is a binge drinker, has some personality issues and seems to lack any motivation to work. There are suggested treatments that do not seem to have been tried. He presents well.

Recommendation: He is not eligible for Invalids Benefit. He can certainly work at least 20hrs per week and every effort should be made to get him off benefits and into work. SB to continue meantime.

Yours sincerely …"

C) Diagnosis by my own GP, Dr Xxxxx Txxxxxxx, the Xxxxxxxx Bay Medical Centre:

In contrast the diagnosis and assessment by Dr Xxxxx Txxxxxx was the following:

1. **According to the new type of Work and Income Medical Certificate dated 22 April 2010**:

   When is the person likely to be capable of:

Work planning	Over 6 Months
Training	Over 6 Months
Light/selected duties	Over 6 Months
Part time work (up to 30 hrs/wk)	Over 6 Months
Full time work (over 30 hrs/wk)	Over 6 Months

Is the person totally blind?	No
Unable to work 30 hours per week or more?	Yes
Unable to work 15 hours per week or more?	Yes
Condition expected to last at lest 2 years?	Yes
Life expectance less than 2 years?	

Unable to work from	26-04-2010
When should the person's entitlement to Benefit next be assessed?	2 years

2. **According to the Disability Certificate dated 17 June 2010 (completed on the same day as Dr Xxxxxxx's assessment!)**:

   Under 'Disability Details' Dr Txxxxxx ticked "*Yes*" at question 3, where he was asked: "Does the person have a disability that meets the Disability Allowance criteria?"

   At question 4. it asks: "What is the nature of the person's disability?"

   Dr Txxxxxx did tick '**Depression** (161)', '**other cardio- vascular** (132)', '**other metabolic or endocrine disorders** (151)', '**Alcohol** (170)'.

   To **question 5** he indicated **the expected duration of the disability** as being "**permanent**".

   Re 'Items / services / treatments / pharmaceuticals' Dr Txxxxxx mentioned "prescriptions, water filters, transport, dietary supplements, garden costs, phone" that represent costs that arise from the existing health conditions and their necessary treatment.

3. The details in the above Medical Certificate and Disability Certificate were very much in line with the previous Medical Certificates issued by Dr. Txxxxxx on xx June 2008, 23 April 2008, 23 January 2008 and 03 February 2006. A Medical Certificate dated 29 October 2007 did at that time suggest that an improvement in my situation was taking place, but this prospect was short-lived and dashed soon afterwards, when an attempt by me to return to some kind of work (due to great financial difficulties) turned out to be a rushed and disastrous experience.

   Medical Certificates based on diagnosis and assessments by Dr Xxxxx Txxxxxx continued to be consistent to this date, which is in clear contrast to the one off very out of line assessment by Dr Dxxxx Xxxxxxx as Work and Income commissioned designated doctor from 17.06.2010.

   Indeed Dr Xxxxx Txxxxxx has shown an overwhelming level and degree of consistency in his reports on diagnosis and general health conditions and disabilities. They present a totally different, but due to the number, length of involvement, in-depth understanding and

professional competency he possesses, a more convincing picture of my health, than the unprofessional, flawed, incompetent, unfounded, biased one delivered by Dr Dxxx Xxxxxxx.

D) Conclusions drawn and decision made by Regional Health Advisor Team at Auckland Regional Office of MSD – solely based on wrong report by Dr Xxxxxxx:

Mr Axxxx Axxxxxx as **Regional Health Advisor** for Work and Income (Auckland Regional Office) had on **08 June 2010** by email (addressed to “OHA_Client_Query (MSD)” - CC Jxxxxx Nxxxxxx) **presented the selection of GPs that I was allowed to choose from**. It included **Dr Dxxxx Xxxxxxx**.

In an email from **12 July 2010** (08:09 am), sent to “OHA_Client_Query (MSD)”, **Jxxxxxxxx Axxx** (for the R.H.A.) **does present the following ‘Diagnosis’ about me to other staff**:

“Diagnosis: Personality disorder, XXX anger issues episodic depression and alcohol misuse”

“RHA recommends: DD recommends transition to Sickness Benefit with engagement to look for work DD states client is not eligible for Invalids Benefit he con certainly work at least 20 hours per week and every effort should be made to get hm off benefits and into work SB to continue meantime. Engagement with ECV to look at work”

“Assessed Designated Doctors report by Dr Dxxxx Xxxxxxx on 30 June 2010
Medical certificate is consistent with Sickness Benefit
Client does not meet medical eligibility for Invalids Benefit”

Hence the Regional Health Advisor and his staff did from the time of receipt of Dr Xxxxxxx’s report ignore ALL medical certificates, reports and assessments from my own regular doctor for over 4 and a half years, which were based on his own diagnosis and supported by various other specialist reports and assessments that he had relied on.

E) Consequences of Dr Xxxxxxx’s assessment and report, and the decisions made by Work and Income - on my counselling treatment, health and general well-being:

The assessment, report and recommendations by Dr Dxxxx Xxxxxxx were fully accepted and adopted by the Regional Health Advisor and other staff of Work and Income as supposedly reliable and competent. Within days I was sent letters for appointments for discussing and preparing for training, a return to work and so forth. This put me under immense psychological stress and pressure, led to a severe crisis with major upsets, and it later lead also to the breakdown in my counselling treatment. There were moments where I displayed suicidal ideations, which has been well recorded.

Instead of being enabled to focus on needed ongoing treatment, I was forced to attend to serious challenges and to defend my rights and basic survival as a sick and disabled person. It forced me to take formal steps to seek and prepare for an appeal under section 53A of the Social Security Act 1964, to address the recommendations made by Dr Xxxxxxx and decisions made by Work and Income staff. Dr Xxxxxxx’s assessment, report and recommendations were clearly not evidence based, were unprofessional, unfair and unreasonable and showed incompetence and disregard. I could no longer focus on further treatment. I had to spend all my time on legal study and paperwork.

It took months to prepare myself for a hearing before a Medical Appeal Board appeal. That was conducted by a panel, which again consisted of 3 general practitioners without appropriate qualifications or expertise in assessing persons with complex mental health illness and addiction conditions. Although the Medical Appeal Board did reach a slightly more acceptable decision than Dr Xxxxxxx, the panel did to some degree still rely on his findings and upheld them. In summary their report and decision turned out to be also partly unfounded, lacking evidence, objectivity and competent evaluation. It turned out to also contain apparent biased, unreasonable recommendations.

Consequently I was taken off the invalid’s benefit and transferred onto the sickness benefit from xx January 2011, leading to yet worse financial problems and increased pressures, as I now had to present new medical certificates from my doctor every 90 days and struggled to survive week to week.

The decision by the Medical Appeal Board and Work and Income forced me to find the assistance of a lawyer, to apply for legal aid and then file a Notice of Proceedings with a Statement of Claim and Affidavit before the High Court in August 2011. All that required huge, stressful efforts and time. This was followed by intensive, lengthy, distressing, arduous settlement negotiations to resolve particular issues and achieve a basic, acceptable outcome. *(**Note: Part of original sentence deleted for legal reasons!**)*. The legal case could likely have been pursued further, but it was eventually due to my radically worsening health, that I was weeks ago forced to agree to a minimum kind of settlement.

Concurrently I had already from April 2009 been struggling to deal with a few minor legal issues that had resulted from a neighbourhood dispute (xx April 2009), a charge laid due to alleged “disorderly behaviour” (at a xxxxxxx xxxxx on xx Nov. 2009) and another charge for alleged “offensive behaviour” (17 May 2010), while a single minor conviction would have resulted in a loss of a so-called “clean slate” I had since 200x been entitled to under the ‘Criminal Records (Clean Slate) Act 2004. Just one minor conviction would have made it impossible for me to find employment for up to 7 years, as some previous minor (alcohol related) convictions from the mid 1980s would have been “re-activated”. I spent most of my time fighting for legal aid that was initially denied, for justice and with huge stress and the help of lawyers managed to have all charges dropped or withdrawn one by one by mid 2011.

The fallout from Dr Xxxxxxx’s decision - and numerous other developments (e.g. difficulties with some boarders, whom I had due to financial pressures have to share my flat with) - severely and negatively impacted on my ability to concentrate on any urgently needed treatment of my illnesses. Instead I suffered irreparable damage, being disabled to a degree that I am struggling to do simple daily chores at my home. My recovery was severely disrupted since mid 2010, and I made no progress in addressing health issues. I would by now have recovered better and possibly would have been able to look at a return to some form of training or employment, had it not been for the irresponsible actions by Dr Dxxxx Xxxxxxx, which I will address in detail in the following chapters of this letter.

Breaches of the ‘Code of Health and Disability Services Consumers’ Rights’ identified:

A: Right 1 - Right to be treated with respect

*(1) Every consumer has the **right to be treated with respect**.*

Dr Dxxxx Xxxxxxx displayed a clear bias against me as referred client, and apparently also towards the medical professionals at the Xxxxxxxx Bay Medical Centre:

The conduct and manner Dr Xxxxxxx displayed during the medical examination for a second opinion, that was sought by Work and Income, was unprofessional, incompetent, not objective, biased, lacked respect, and was unfairly focussed almost exclusively on questions about work, past problems with work, why I had reservations to resume work, the type of benefits I received, how long I had been on a benefit, whether I had considered part time work and similar. Only little attention was given towards questions relating to my actual health issues. I was given very little time and opportunity to try and explain my situation and health issues.

Presented letters from specialists were only partly and too briefly glanced at, and offered photo-copies were declined with the reason that they were “*not needed*”.

When I later on 17 June 2010 met with my own trusted GP, Dr Xxxxx Txxxxxxx, he did to my surprise confide to me that his colleague Dr Xxxx, who is working at the same Medical Centre in Xxxxxxxx Bay, had very negative experiences with Dr Xxxxxxx. Dr Xxxxxxx at the Xxxxxxxx Health Centre had repeatedly showed a lack of co-operation and respect when dealing with matters that involved both clinics. He was described by some staff as arrogant. Hence I must conclude that due to past differences Dr Xxxxxxx held a biased and negative view towards doctors and staff at the Xxxxxxxxxx Bay Medical Centre, including Dr Txxxxxx.

Given that only about 10 to 12 minutes were spent with me during the “examination”, I feel that Dr Xxxxxxx was not at all sincerely interested in my problems, concerns and well-being. Even Work and Income do accept and expect that a proper medical examination and assessment should take about 30 to 45 minutes to be conducted and completed. This was certainly not the case in my examination by Dr Dxxxx Xxxxxxx. My impression was (and is) that the examination was conducted by Dr Xxxxxxx with the least, rushed efforts and a prejudicial mindset, which influenced his poor diagnosis and recommendations.

B: **Right 3 - <u>Right to dignity and independence</u>**

*Every consumer has the right to have **services provided** in a manner that **respects the dignity** and **independence** of the **individual**.*

The already mentioned "**bias**" that is apparent from certain notes made in the clinical file about me also represents a clear breach of "**right 3**", in that it is a **clear breach of my dignity**.

There were extremely important aspects of my health issues, conditions and disabilities that Dr Xxxxxxx did not sufficiently enquire about - nor in any other way show any interest in. His targeted questioning was pre-occupied with aspects of work and benefit dependence. He ignored my references to serious problems I was dealing with at the time, and he did not allow me to further explain details re this, rather pressing on with his prepared set of one-sided questions and only allowing minimal comments by me. He did not appear to attempt to properly understand my concerns re my health and other problems. This inevitably led to him not understanding or appreciating what did actually happen to me over the previous two years, and what hampered my recovery from alcohol addiction, depression, XXX and related issues.

During the "examination", and through the way he conducted it in a very questionable, inadmissible manner; it became apparent that he was not that much interested in my answers and comments. He already appeared to have made up his mind from the beginning.

Yet it was Dr Xxxxxxx's responsibility to offer due respect and give credit, to accept my right to dignity and to consider the information I attempted to provide to him in the form of medical and treatment related documents, in addition to what I attempted to communicate during his "interrogation style" interview focused on work, and only eventually a few health issues.

Last not least Dr Xxxxxxx should have informed me about the way he would conduct the examination, of the right I had as the person to be assessed (e.g. to withdraw my consent and to object to the way parts of all of the examination and interview were being conducted) and about privacy concerns, e.g. re a host doctor report he intended to request. He clearly did not.

C: **Right 4 - <u>Right to services of an appropriate standard</u>**

*(1)Every consumer has the right to have services provided **with reasonable care and skill**.*
*(2) Every consumer has the right to have services provided**, that comply with legal, professional, ethical, and other relevant standards**.*
*(5) Every consumer has the right to **co-operation among providers to ensure quality** and **continuity** of services.*

There have been breaches of "**right 4**", as the **seriousness of inaccuracies and mistakes made** by Dr Dxxxx Xxxxxxx **in his assessment** and **report** display a fundamental **failure to uphold reasonable and expected standards of diligence, care and skill**.

While examining me and completing his assessment, Dr Xxxxxxx failed to acknowledge and consider the very relevant and important information, that proved to be essential to make a true evaluation of aspects of my already well documented ill health, the various conditions, disabilities and my problematic general circumstances and situation, that had and were seriously impacting on my ability to take on and perform any work in open employment.

The primary information Dr Xxxxxxx appears to have used for making his unfounded diagnosis and biased, unprofessional assessment was apparently his personal interpretation of my answers to his very narrow selection of questions - targeted almost exclusively at facts re my long benefit history, past work, the hypothetical ability for me to perhaps do any alternative work and my personal position and concerns regarding a resumption of work. He only offered a short glance at just 2 or 3 letters from a wide range of presented, highly relevant documents; that I had received from certain treatment and assessment specialists. Apart from that Dr Xxxxxxx simply checked and measured my breathing, heart-beat and blood pressure.

A very brief, summarised host doctor report from my GP, Dr Xxxxx Txxxxxx, which was neither requested nor returned in the required form, was apparently not given that much credit and weight, same as the more comprehensive contents of an attached assessment by Dr Jxxx Bxxxx, psychiatrist at XXXX (dated 27.08.2008).

What is of particular concern, and which has already been raised as part of a separate complaint by me to the Health and Disability Commissioner (see reference C11HDCxxxxx for a complaint about XXXX counsellors, filed 08 and 09 August 2011), the host doctor report by my own GP did regrettably contain a serious mistake. It should never have been included in such a medical report, but the mention of an alleged "assault" that I committed, is likely to have also influenced the decision making by Dr Xxxxxxx, causing him to adopt a rather negative view of myself, and thus applying a degree of negative bias to the assessment.

The fact that Dr Xxxxxxx did even choose to ignore the fact that I had for some time been receiving specialist treatment (counselling, group support, XXX treatment at St Luke's Community Mental Health Centre), and that I was still engaged in ongoing counselling with XXXX Xxxx in Hxxxxxxx, does strongly suggest selective judgment.

In his Designated Doctor Report he did state that I was not under the care of a specialist(s)! This can be seen from his replies to questions 5 and 6 on the manually completed assessment and report form for Work and Income.

That is clearly completely wrong, because I have been in ongoing treatment with XXXX **(Xxxxxxxxx Alcohol and Drug Services)** AND other services **since early 2006**.

I received counselling, group therapy and other support from clinicians, practitioners and facilitators at XXXX since February 2006. XXX treatment was offered to me in form of a briefly available intervention treatment based on cognitive behavioural therapy - as well as attempted xxxxxxxx treatment - at St Luke's C.M.H.C. during 2007. Other attempts were made to access treatment elsewhere, regrettably without success, also with insufficient funding being offered by Work and Income, to get further treatment for my illnesses and conditions. It is astonishing that Dr Xxxxxxx failed to acknowledge this, even though documentary evidence was offered and delivered. He chose not to view and accept it, which is unprofessional and unethical.

Then Dr Xxxxxxx also did make a very incompetent and wrong diagnosis by confusing cause and result in questions 1 and 2 on that same manually filled out Work and Income designated doctor report form. All he writes is "***Alcohol Binge Drinker***", which is hardly a condition as such, but rather a symptom of the condition of alcohol dependency. The same applies to his comment of "***Motivation lacking***". He did not bother putting in the required **READ codes** and in question 3 ignored the fact that likely re-occurring relapses, bouts of depression and their consequences would actually mean that the impact of my conditions would certainly be "fluctuating" and/or be "intermittent" for certain longer periods.

Equally Dr Xxxxxxx gave the wrong answers to questions 9 and 10 on the form, as all evidence presented to him should have suggested that I was not able to work for more than 15 hours a week. Also are conditions like XXX and alcohol dependence permanent conditions, the latter of course being possible to "treat" in such a way to achieve lasting abstinence. The information provided to Dr Xxxxxxx did not at all support his presumptions that lasting, longer term sobriety and abstinence were likely to be achievable within a short to medium period.

Due to Dr Xxxxxxx having failed to come to the correct diagnosis and assessment of my medical problems, he naturally also incorrectly answered to questions 14, 15, 16, 17, 19 and 20. He ignored the conditions of XXX, depression and hypothyroidism, as if they did not exist.

The report completed by Dr Xxxxxxx is in stark contrast to the historic and even following medical assessments by my own doctor, which have shown a high degree of consistency and are supported by assessments; sundry reports and letters form other specialist medical practitioners and health professionals. It should have been the duty of Dr Xxxxxxx to apply diligence, care and skill and thus give the other information the due credit and consideration.

The clear inability of Dr Xxxxxxx to make a correct diagnosis is evidence that he as a registered general practitioner with specialist knowledge in obstetrics and gynaecology was not sufficiently and appropriately qualified to conduct the assessment of a client with my particular complex medical conditions. My particular and complex illnesses include alcohol dependence (commonly referred to as "alcoholism"), which has by XXXX staff repeatedly been assessed and acknowledged as being at a high to severe level. Also do I suffer from

depression and the disabling disorder XXX. It requires a person with sufficient expertise in mental health (psychiatry, psychology or psychotherapy) and also sufficient competency in the assessment of addiction illnesses to conduct an expert assessment of a person like me.

In view of this, Dr Xxxxxxx should clearly have acknowledged and accepted his professional limitations and refrained from conducting the assessment and examination sought by Work and Income. As he did not do this, he clearly acted outside his scope of practice, which I consider to be a serious matter.

As Dr Xxxxxxx also failed to inform my own usual doctor about the outcome and report of his assessment, he did not provide any assistance to ensure transparency and continuity in treatment and support for my recovery.

Consequently professional, ethical and legal standards were not upheld by Dr Xxxxxxx during and after the examination and assessment conducted on me on 17 June 2010 - and completed by way of a final report on 30 June that same year.

D: **Right 5 - <u>Right to effective communication</u>**
*(2) Every consumer has **the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively**.*

There has been a breach of "**right 5**" under the Code. I was as the assessed person given insufficient chance to exercise the right to **communicate** in an environment that enables both consumer and provider to **communicate openly, honestly, and effectively**.

Dr Xxxxxxx did from the start of the examination NOT inform me properly about the way he intended to conduct it. No mention was ever made of my right to object to him conducting the assessment, nor about my right to withdraw from it, once I started to feel uncomfortable, suspicious and no longer had any trust in the process applied by him. I was also not consulted about any privacy questions that should have been relevant to discuss.

His "examination" did resemble a kind of "interrogation" rather than a respectful, fair, balanced and objective interview. His focus was almost solely on getting answers about past work I did, how long I had received the types of benefits I had been on, why I did not continue with started work in 2005/2006, why I could not consider alternative work, what I was doing with my own time while not working and why I felt I could not return to any kind of work for a longer time.

I was not given sufficient opportunity and time to explain matters of my concern about my health issues, and instead I was being rushed through a forceful and one-sided interview, so that there appeared to be only a secondary concern and emphasis on matters re my health.

The supposed "examination" was in the end not a proper examination at all, and it appeared, that the result was pre-determined by his personal impression of me, and the restricted range of questions and possible answers I could give to them. I left the examination with no trust in it.

Only later would I learn through an Official Information Act request, that the host doctor report sent by Dr Txxxxxx to Dr Dxxxx Xxxxxxx also contained reference to an "***assault***" that I had allegedly committed and was trying to defend with legal aid before the courts. I had never committed, nor been charged for an assault, and it should in any case have been expected that Dr Xxxxxxx would show professional conduct in not paying too much attention to such non medical information, which instead appears to have led to him adopting a biased view of me. I was certainly given NO chance to respond to any of the information sent to him by my doctor.

E: **Right 6 - <u>Right to be fully informed</u>**
(1) **Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive**, including –
(c) advice of the estimated time within which the services will be provided; and
*(e) **any other information required by legal, professional, ethical, and other relevant standards**; and*
*(g) **the results of procedures**.*

Dr Xxxxxxx is also responsible for a breach of "**right 6**", as he did not fully inform me about:

1. The way he was going to conduct the examination and assessment;
2. I was never informed about any legal rights that I had to object to his approach, his qualifications and possible lack of expertise, and to withdraw from the examination;
3. he never consulted me about the assessment/report he was going to prepare and what recommendations he would make to Work and Income, so I was given no input at all;
4. I was not asked about what any steps or measures that could be considered to assist me to plan and prepare for a return to work, again I had no input at all to that part of the exam;
5. Dr Xxxxxxx did not discuss with me, nor did he indicate, that he was also supposed to send a copy of his final assessment and report to my own doctor (see expectations on pages 13 and 24 in the 'Guide for Designated Doctors' from Work and Income - and points 16 and 17 in the statement issued by the Medical Council of New Zealand: 'Non-treating doctors performing medical assessments of patients for third parties').

As I already explained and elaborated on most of these points under chapter "D:" and other parts in this complaint, there is no need to deliberate on this too much further, but it is clear, that Dr Xxxxxxx did not at all make any reasonable effort to inform me about the aspects of the examination, assessment and processes he would follow during its course and afterwards.

Breaches of the Code of Ethics of the New Zealand Medical Profession (by the NZMA):

I Principle 1 - *Consider the health and well being of the patient to be your first priority*.

Even though the relationship scenario between Dr Xxxxxxx, as the Work and Income commissioned assessor and me as the assessed person did not represent the usual practitioner – patient relationship, Dr Xxxxxxx did according to the 'Code of Ethics of the New Zealand Medical Profession' and various legal requirements and other standards have to give proper, sincere considerations for ensuring the health and well being of myself.

Sadly this was not what he did, because due to the already mentioned, and also in following parts to be stated failures; he acted irresponsibly and put my well being and safety at grave risk by not giving due consideration to relevant health information and not completing an objective, evidence based and reasonable report. He allowed bias to influence his decisions.

By making a flawed, inappropriate and misleading assessment, and by passing on a report to Work and Income, that ignored factual medical information and did not seek any proper input from me as the assessed person, he put at risk my health and well being. Staffs at Work and Income were consequently caused to rely on incorrect medical information and to make decisions based on this, which led to very serious, harmful consequences that I suffered.

II Principle 2 - *Respect the rights, autonomy and freedom of choice of the patient*.

Due to the way the "examination" and "assessment" was conducted, with me being "targeted" with an array of one-sided questions, primarily asking me about past benefit receipt, past work, problems re maintaining work, questions about why I did not continue with work, what my objections were to resuming work, and only in the end placing rather secondary emphasis on what my actual health problems were, what my disabilities were, and what incapacitated me from coping with work, let alone very basic day to day chores and challenges, Dr Xxxxxxx did not sufficiently respect any of my rights, autonomy and freedom. He certainly ignored my limited input and even discouraged it. He did not properly stress any of my mental health conditions in his report, and dismissed my serious alcohol addiction as mere "binge drinking". That is not conduct that meets the standard expected under principle 2 of the Code.

III Principle 4 - *Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity*.

One should have expected Dr Xxxxxxx, as a qualified general practitioner, with a specialisation in obstetrics and gynaecology, registered under the vocational scope with the Medical Council, to be aware of, mindful of and responsible enough of the requirement to perform his tasks and responsibilities with integrity, compassion and respect for my dignity.

As already mentioned under "II" above, he failed to do so, and he conducted an assessment that he himself was not really sufficiently qualified and experienced enough to perform. It would have required a medical practitioner experienced with appropriate in-depth understanding of mental health conditions and with sufficient expert ability and knowledge of assessing persons with addiction problems, to properly and competently assess me in an examination of that type. Indeed Dr Xxxxxxx should have declined making the assessment, as he was not suitably qualified for doing it. At no time did he show any compassion towards me.

IV **Principle 8** - ***Honour the profession, including its traditions, values, and its principles, in the ways that best serve the interests of the patient***.

Regrettably Dr Xxxxxxx did his profession - and the principles persons working in it are supposed to follow - a great and serious disservice, by conducting an assessment of a person he should with his markedly different qualifications and expertise not have assessed at all. He also did not follow numerous guidelines set under the Code, statutory and regulatory provisions. He did treat me disrespectfully as a client/patient (to be assessed) and let down his profession by not abiding to values and principles that should be maintained at all times.

I must and can only refer to what has already been stated in regards to breaches of the Code of Health and Disability Services Consumers' Rights', and of other standards, to simply emphasise the failings by Dr Xxxxxxx.

V **Principle 9** - ***Recognise your own limitations and the special skills of others in the diagnosis, prevention and treatment of disease***.

By accepting a referral from Work and Income to perform and conduct an examination and assessment of a person with established mental health issues and clear addiction conditions, and by proceeding with it, despite of lacking the appropriate, sufficient qualifications and in-depth knowledge and understanding in the fields of mental health, psychology, psychiatry and addiction diagnosis and treatment, Dr Xxxxxxx did as a general practitioner with specialisation in obstetrics and gynaecology clearly act outside his vocational scope of practice.

The result of his assessment and his report clearly show that he lacked a solid enough understanding and insight in those areas of medical practice. He allowed himself to be misled by personal misinterpretation and apparent bias, and he made a diagnosis and took further conclusions, which were totally wrong, mixing cause and result, falsely confusing symptoms and conditions, merely noting down "personality disorders" and a "lack of motivation", etc..

That is not professional conduct to a standard that should be expected of Dr Xxxxxxx, and he should instead have realised his limitations and refrained from conducting the examination.

VI **Principle 12** - ***Accept a responsibility for maintaining the standards of the profession***.

Dr Xxxxxxx has not lived up to his responsibility and the standards of his profession. The only logical step for him would be to in hindsight accept his failures, to apologise for his wrong actions and conduct, and to accept full responsibility for what happened in consequence.

That is indeed what I expect from Dr Xxxxxxx now, as he has thus far not lived up to any level of responsibility for misdiagnosis, professional misconduct, biased behaviour, breaches of rules, guidelines, laws and regulations, and for causing a very serious amount of damage to my health and general well-being, last not least also severely upsetting my prospects for a successful recovery, which has led to a set-back of over two years, and resulting loss in income that I could have earned by now.

Under the 'Health Practitioners Competence Assurance Act 2003' Dr Xxxxxxx breached the following provisions:

8 Health practitioners must not practise outside scope of practice

(2) *No health practitioner may perform a health service that forms part of a scope of practice of the profession in respect of which he or she is registered unless he or she—*
- (a) *is permitted to perform that service by his or her scope of practice; and*
- (b) *performs that service in accordance with any conditions stated in his or her scope of practice.*

As a medical practitioner Dr Dxxxx Xxxxxxx has been and still is registered with the New Zealand Medical Council. He is a qualified Bachelor of Medicine and Bachelor of Surgery (MBChB, University of Auckland 1976) and also has a Diploma of the Royal College of Obstetricians and Gynaecologists from the Royal College of Obstetricians and Gynaecologists, England. He was a member of the Royal College of General Practitioners in the UK since 198x, and he has been a Fellow of the Royal New Zealand College of General Practitioners since 200x.

Dr Xxxxxxx's qualifications clearly are in general practice and represent that of a traditional physician, with a specialisation in obstetrics and gynaecology. I appreciate he has a vocational scope of practice.

There is no evidence of Dr Xxxxxxx having any substantial, formal qualifications (i.e. post graduate) in the areas of psychiatry, psychology or in the areas of assessment and/or treatment of addiction.

As my illnesses, conditions and disabilities clearly primarily are alcohol dependency ("alcoholism"), depression and xxxxxxxxx xxxxxxxxxxx disorder (XXX) as an anxiety disorder, worsened by also diagnosed hypothyroidism; it appears that Dr Xxxxxxx did not have the required, appropriate professional qualifications and expertise to competently conduct a thorough examination and assessment of a person with my particular complex health issues and conditions.

By having accepted a referral from a Work and Income case manager to examine and assess me as a client with primarily mental health and addiction illnesses, and by proceeding with it, he appears to have acted outside of his scope covering registered general practice. As a well educated and qualified professional Dr Xxxxxxx should have realised and acted upon this conflict from the outset, and thus refused to accept examining and assessing me with my known complex medical background.

His actions put him in breach of the Health Practitioners Competence Assurance Act 2003, which is a serious matter, and which should prompt the New Zealand Medical Council to take necessary action. Only proper, evident and certified additional qualifications in mental health and addiction should allow a general practitioner to assess a person with a complex medical picture as the one I have.

Under the 'Health Information Privacy Code 1994' Dr Xxxxxxx ignored following rules:

Rule 2 - Source of health information

Provided that Dr Dxxxx Xxxxxxx from the Xxxxxxxx Health Centre would, as an assessing medical practitioner acting for a third party, have been acting within his professional scope of practice, then he would likely have had the authority to lawfully collect health information from me for the purpose of the medical examination and following assessment that he was expected to complete.

That would certainly have been the case, had I given my approval of this and consented to it in full knowledge and awareness of my rights as a patient or client to be assessed. I agreed to provide certain information, but I was never asked whether I agreed to Dr Xxxxxxx seeking a host doctor report from my own GP. Instead Dr Xxxxxxx simply stated, that he would ask my doctor for that, without asking me for my position re this. As I wasn't informed of my rights, I did feel to have no input.

In any case, Dr Xxxxxxx should according to rule 2 of the H.I.P.C. 1994 primarily have relied on the information that I provided him during the interrogative interview, and that I was willing to provide to him in the form of additional letters from counsellors, a psychiatrist, a psychologist and psychotherapist, who had been involved in my treatment and/or previous assessments.

Dr Xxxxxxx breached sub-rule (2) (a) of rule 2, because he did unreasonably assume that I would consent to a report from my GP to be requested and accessed. He did not make any appropriate effort to seek my consent. Matters re rule 3 (1) were never ever raised by Dr Xxxxxxx. It appears that sub-rules (2) (c) to (h) did not apply in that scenario, so there was no reason and justification for Dr Xxxxxxx to act in the manner he did, thereby ignoring my autonomy as a person being examined.

Rule 3 - Collection of health information from individual

Dr Xxxxxxx did at no time before, during or after the examination and his consequent assessment inform or consult me re questions covered by provisions under sub-rule (1) (e), (f) and (g). One should strictly also expect that he would have informed me of sub-rule (1) (a) to (c), but given the fact that I was aware what the examination was conducted for, that may not have been considered necessary.

The rushed, somewhat forceful way of interviewing by Dr Xxxxxxx did not give me any chance to consider raising any questions concerning privacy issues, same as I was limited in the scope I could have given answers to his specifically targeted questions I was confronted with.

Most certainly Dr Xxxxxxx breached sub-rule (2). Sub-rules (3) and (4) do not appear to apply to the particular examination scenario I was exposed to.

Rule 8 - Accuracy etc. of health information to be checked before use

By at least partly ignoring medical diagnosis- and related information that was contained in a medical certificate completed by my own GP, Dr Xxxxx Txxxxxx of the Xxxxxxxxxx Bay Medical Centre, on 22 April 2010, by insufficiently considering information given in an assessment by XXXX psychiatrist, Dr Jxxx Bxxxx, dated 27.08.2008, by not taking reliable photo copies of further medical records in the form of letters from professional, registered alcohol and drug clinicians ("counsellors"), an intern psychologist from St Luke's Community Mental Health Centre and a psychotherapist from Xxxxx House, Dr Xxxxxxx acted in serious neglect, not even attempting to ensure that the information that was made available AND offered to him, was correct and complete.

As already sufficiently explained, the interview conducted during the medical examination on 17 June 2010 consisted of almost exclusively questions about work, benefit status, ability and availability to resume work, my reservations to taking up work and only secondarily related to questions about my complex health conditions and disabilities. No attempt was made to establish my true health situation.

The assessment from XXXX psychiatrist Dr Bxxxx may have appeared to be insufficiently "current", hence it should have been the duty of Dr Xxxxxxx to thoroughly examine and consider more current and relevant information, which were made available and offered in the form of the additional documents, as well as information that was communicated in the host doctor report from Dr Txxxxxx. It appears that Dr Xxxxxxx did at no time see a need to contact my own GP by telephone, to perhaps discuss particular details that he may have felt uncertain about. There is no record of a consultation.

By failing in ensuring currency, relevancy and accuracy of information, Dr Xxxxxxx relied on insufficient and wrong information, thus making an assessment and report, which actually exposed me to substantial harm, as later developments after the examination and presentation of his report show.

<u>Under the 'Health (Retention of Health Information) Regulations 1996' Dr Xxxxxxx breached the following sections:</u>

5 Definition of minimum retention period
6 Health information to be kept for minimum retention period

Under the '**Health (Retention of Health Information) Regulations 1996**' Dr Xxxxxxx is also expected to keep ALL medical records relating to the examination **for at least 10 Years** (**see sections 5 and 6 re of the Regulations re "*minimum retention period*"**).

Dr Xxxxxxx has evidently failed to do this, as my recent applications under the Privacy Act 1993 (and the above mentioned 'H.I.P.C. 1994') revealed, only the manually completed designated doctor assessment and report form for Work and Income, and a request letter from him to my own GP (asking for a Host Doctor Report) were being kept in the form of document copies in his files. That at least is all that he presented to me as the only documents he had on file about me.

Dr Xxxxxxx had though been sent a summary host doctor report by email from my GP on 18 June 2010, which he should have kept on file, but this was not done. This was also not done in regards to

“letters” from XXXX, my GP, Dr Txxxxxx, referred to in his report letter of 18 June 2010, which clearly includes the assessment by Dr Jxxx Bxxxx, psychiatrist for XXXX, which was at that time the only document my GP could according to records have had on file from XXXX. As there were two copies of that, one initial one with some mistakes, and another one that was partly corrected, it could be; that both copies were sent to Dr Xxxxxxx. According to Dr Xxxxxxx none of these were kept on his file.

Dr Xxxxxxx also failed to keep any record of his notes or transcripts that he must have made during the examination consultation and re phone calls made, or received in relation to the examination under section 44 of the Social Security Act 1964. There have been no copies kept of an email he received from Work and Income case manager Rxxx Gxxxxx on 09 June 2010, or of any other correspondence.

I have a copy of the report dated 18 June 2010, which my doctor sent to Dr Xxxxxxx, and information contained in it clearly refers to letters from XXXX from 2008.

The fact that Dr Xxxxxxx has not kept all the mentioned documents, correspondence and records clearly puts him in breach of the Health (Retention of Health Information) Regulations 1996’.

As a member of the Medical Council of New Zealand, Dr Xxxxxxx should also have been familiar with the Council’s statement in its document ‘**The maintenance and retention of patient records**’ from August 2008. That statement with the recommendations and expectations of the Medical Council from its members, which includes sufficient references to the ‘Health (Rentention of Health Information) Regulations 1996’, appears to have been ignored, or at least not properly followed by Dr Xxxxxxx.

Other relevant issues to consider:

Requirements set by Work and Income and the Ministry of Social Development, particularly by way of the resource manual ‘Guide for Designated Doctors’ (2008 issue):

Since 2008 the Ministry of Social Development (MSD) has followed a new approach for appointing and working with designated doctors, who are almost exclusively general practitioners (GPs). ‘Health and Disability Coordinators’ closely liaise and cooperate with selected practitioners, themselves being overseen, instructed and mentored by the so-called Principal Health Advisor and Principal Disability Advisor employed by MSD since late 2007.

The Ministry relies on GPs as designated doctors for conducting examinations, reviews or reassessments under sections 54B (3) and 44 of the **Social Security Act 1964**.

Case Managers directly dealing with health affected clients also have direct contact with medical practitioners (mostly GPs but also specialists) when seeking clarifications re medical certificates and other medical documents about a client’s health conditions and disabilities, which may affect their ability to work and will determine what kind of benefit is appropriate.

In certain cases Regional Health Advisors (RHAs) and Regional Disability Advisors (RDAs) working at the Ministry’s and Work and Income’s Regional Offices actively work with GPs, discussing specific cases, and to some degree assisting in the areas of training and/or consultations between the Principal Health Advisor and practitioners.

Since 2008 the Ministry has conducted regular training sessions for medical practitioners (mostly GPs) accepted as designated doctors. These sessions were held all over the country, involved introductions, presentations, active scenario discussions and informal conversations (used for “bonding”) by MSD staff - like the Principal Health Advisor Dr David Bratt himself.

Dr David Bratt, a long term general practitioner from Wellington, has been implementing, managing and even himself conducting the “designated doctor training”, since he was appointed by the Ministry to his new position in 2007. He is well known for his very pronounced, firm view and position in regards to sick and disabled persons’ “work ability”.

Given my own experiences, what I learned through other affected persons and the media, there appears to be a justified reason to be very concerned about the degree to which some medical practitioners may possibly be influenced in their supposedly “independent” decision-making, by the very training they receive as designated doctors from the Ministry.

Some training and related presentation material that I obtained under the Official Information Act 1982, by way of online research and through other channels give reason to suggest that more scrutiny and caution should be applied in regards to the content and applied approach provided by the Ministry for this training, which may under certain circumstances result in biased perception and even conduct by medical practitioners exposed to it.

In any case Dr David Xxxxxxx would at least have been expected by the Ministry to act and adhere to standard and basic expectations, requirements and guidelines set out in a so-called '**Guide for Designated Doctors**' (**see attached copy from 2008**), which is the main resource manual published by the **Ministry of Social Development** for designated doctors conducting examinations and completing a designated doctor assessment and report form.

Dr Xxxxxxx was expected to do the following during and after the examination he conducted on me on 17 June 2010:

1. Show respect for me and treat me fairly as a patient to be examined and assessed for 'Work and Income' as a third party (belonging to the Ministry of Social Development);
2. give competent, professional, objective, fair and reasonable consideration to any medical information that was or appeared relevant to the examination (incl. client comments; letters, assessments, other information from other medical professionals and specialists involved in my treatment and support); see questions 5 and 6 in report;
3. follow the instructions on page 13 of the Guide, titled "***Completing the Designated Doctor Report***" (see emphasis on course and priorities under "***Report Form***"), which state that he first should have thoroughly established illness and disability information;
4. consulted and asked me prior to completing questions 17 to 21 in the Assessment and Report form, relating to '***Planning for employment***';
5. request and consider a Host Doctor Report by my own GP, Dr Xxxxx Txxxxxx of the Xxxxxxxxxx Bay Medical Centre (see page 13 of the '***Guide for Designated Doctors***');
6. upon completing the examination and final assessment to also send a copy of his report or assessment to my own GP, Dr Xxxxx Txxxxxx (see pages 13 and 24 of the '***Guide for Designated Doctors***');
7. Dr Xxxxxxx was expected to discuss the report with me, prior to sending it to Work and Income (see page 13 of the '***Guide for Designated Doctors***').

An examination of the assessment and report by Dr Xxxxxxx proves the following:

1. Dr Xxxxxxx did not show the due respect and fairness to me as a patient to be assessed by a third party (Work and Income). He did not explain to me details and aspects of the examination and the way he intended to conduct it with me, before questioning me almost exclusively about my benefit situation, past work, inability to work, what I was doing with my time, and so forth. He instead displayed a bias and degree of incompetence, making a wrong, dismissive and irresponsible diagnosis.

2. Dr Xxxxxxx ignored information supplied in the form of the Medical Certificate issued by my own GP, Dr Txxxxxx (fr. 22.04.2010, sent by WINZ), psychiatric assessments from XXXX psychiatrist Jxxx Bxxxx (sent by my GP), a summarised host doctor report from my GP (sent 18.06.2010) and also largely ignored submissions by me during the consultation, as well as in the form of documents from counsellors and specialists treating me. He did to questions 5 and 6 in the assessment and report form tick a box indicating that I was NOT "under the care of a specialist", while it was evident that I was getting specialist treatment at XXXX, same as earlier at St Lukes C.M.H.C.. He acted irresponsibly, incompetently, unprofessionally, failed to be objective, fair and reasonable by not giving the due consideration to all this in his diagnosis on the form.

3. He also failed to follow the prescribed form for completing his assessment and report by not adhering to the particular and carefully worded guidelines on top of page 13 of the form - under "Report Form". Instead of first establishing an in depth picture of my illness and disabilities, Dr Xxxxxxx focused primarily on questions about my past work, reasons for not working or being able to work, my view about past and alternative employment, and attempting to press for reasons why I felt I could not work, before he even asked me about aspects of my health conditions and treatment.

4. I was at no time during the assessment and examination by Dr Xxxxxxx ever asked about what could or should be done to assist me to plan for a return to work. There was no idea that I could have had that he would decide to complete answers (without seeking my input) to questions 17 to 21 on the assessment/report form.

5. Although Dr Xxxxxxx did appear to request a 'Host Doctor/Usual Practitioner Report' from my GP, Dr Txxxxxx, it does not have happened in the prescribed form, as my own doctor also only felt prompted to respond by way of an ordinary email letter. Regrettably Dr Txxxxxx's report contained a mistake referring to me seeking legal aid while facing a charge for an alleged "assault" (wrong information apparently passed on by XXXX counsellor), which never happened, but otherwise it mentioned relevant details re my long standing alcoholism, relapses and need for intensive counselling at XXXX. He mentions depression and XXX as conditions/ disabilities.

6. Having obtained copies of my medical files from both Dr Xxxxx Txxxxxx and Dr Dxxxx Xxxxxxx, it is evident, that Dr Xxxxxxx never sent a copy of his assessment and report to my own GP, as no record at all has been kept and found on file with either one of them. This is a serious breach of the guidelines set out in the Guide for Designated Doctors, where on page 13 Work and Income (and MSD) expect a designated doctor to keep any medical information on file, that has material impact on the formulation of his/her opinion. Consequently my own doctor was never informed about Dr Xxxxxxx's diagnosis, assessment and final report.

7. Contrary to the strong recommendation and thus expectation by Work and Income at the bottom of page 13 (and the top of page 24) of the Guide, Dr Xxxxxxx never discussed his assessment and report with me. He therefore acted very negligently and made no effort to apply a fair level of transparency in the matter, leaving me as the assessed person totally in the dark about his considerations and recommendation.

<u>'Non-treating doctors performing medical assessments of patients for third parties', an official statement by the 'Medical Council of New Zealand' from December 2010</u>:

Naturally one would expect that Dr Xxxxxxx, as a general practitioner registered with the Medical Council of New Zealand (under the vocational scope of practice), would have been informed of - and been following - the guidelines in the document '**Non-treating doctors performing medical assessments of patients for third parties**'.

It appears that Dr Xxxxxxx did not follow guidelines given in that document. Dr Xxxxxxx indeed failed to adhere to the statement's recommendations and expectations:

1. Dr Xxxxxxx failed to inform me properly about the way he intended to conduct the examination, my right to object to it being conducted by him, whether in part or wholly. He did not comply with recommendations and expectations as outlined under point 10 of the statement. During his "interrogation style" interview, he did not give me sufficient opportunity and space to explain matters of my concern, which actually related to aspects of my complex health situation, conditions I suffered from and what the disabilities I have meant in view of coping with various experienced challenges, including problems with accommodation, legal issues to be resolved and a hypothetical return to some form of work. Instead I felt being rushed through an overly enforced, almost coercive kind of questioning that almost exclusively revolved around work, my long term benefit dependency, my ability to work, my view towards past types of work and why I had reservations to resuming alternative work.

   Dr Xxxxxxx did not explain to me the different role that he was performing, which was clearly different to that one of my doctor. Indeed no explanations were given from the start of the examination, only that he and I were aware that it was to be completed for Work and Income. As a client of Work and Income I was then not at all aware about the specific role of a designated doctor, and I had no knowledge of the expectations Work and Income has from designated doctors (as outlined in their "Guide" for them).

At NO time during the examination was I informed if my right to withdraw from it, and I was also not given any information about any policy the third party he conducted his assessment for would follow.

2. Most certainly Dr Xxxxxxx totally ignored points 13 and 14 in the statement, as he refused to take photo copies of the specialist counsellor and assessment documents that I offered to him, which was highly relevant for his considerations. He showed no or little interest in meeting the expectations and recommendations under those paragraphs of the statement issued by the Medical Council.

3. Also did Dr Xxxxxxx make recommendations to Work and Income, which resulted in a radical deterioration of my mental and emotional well-being, even leading to me considering self harm or suicide, which is well documented in file notes kept by Work and Income. He dismally ignored the expectations under point 12 of the statement. His assessment and report were clearly not made by applying due diligence and abiding to accuracy, objectivity and true evidence. Instead there are signs of bias and speculative presumptions, which may have been caused by information about an "assault" I was alleged to have committed in the host doctor report. Work and Income was fully relying on Dr Xxxxxxx's unproven, flawed, biased and incorrect recommendations, and in due course sent me 5 to 6 letters within 4 days, to prepare for training and work. At that stage I had not even learned about their decision based on Dr Xxxxxxx's assessment, to transfer me onto the Sickness Benefit. On 16 July 2010 I felt harassed and was driven to despair, where I indicated in an upset state, on the phone to a call centre staff member, that I "*may as well make an end to it all*".

   This was interpreted as an intention to commit self-harm or suicide, and it led to Work and Income calling the police, who threatened to kick in my door, and who finally took me to the Mt Wellington station for a forced assessment by clinical crisis team staff from Cornwall House of the Mental Health Services of the A.D.H.B..

   For months my health would deteriorate, for fear of being intimidated, treated unfairly, unreasonably and feeling unable to cope. This led to many relapses on alcohol and worsening health. An already difficult counselling relationship to a counsellor at XXXX Xxxx deteriorated radically, leading to a breakdown and me having to terminate it.

   I was forced to take an appeal under section 53A of the Social Security Act 1964 to a Medical Appeal Board, and as their decision was also not meeting legal and other requirements, I had to take the matter to the High Court at Auckland. After struggling to interest a lawyer and to also get a grant for legal aid, I was in Xxxxxx 2011 applying for judicial review proceedings. Only over 10 months of resulting settlement negotiations could it just weeks ago be achieved, that I was finally *offered a settlement solution that was reasonably acceptable.* (***Note: Original text edited and partly replaced for legal reasons!***)

   Dr Xxxxxxx is responsible for a grave escalation of harm, and his actions resulted in a degree of harm to my mental health, general well-being and financial circumstances also, which should make him liable for damages under the laws of New Zealand.

4. Point 6 in the statement does raise the question of suitable qualification and whether there may be any conflict of interest an assessing medical practitioner may have. It leaves the decision-making about this up to the practitioner to make. Yet it is firmly advising a practitioner, who may be approached by a third party to conduct and assessment, to decline a referral, should the practitioner not consider her-/himself suitable for conducting the assessment.

   Given the fact that Dr Xxxxxxx is a qualified general practitioner with specialisation in obstetrics and gynaecology, he should have been aware of the fact that he was not suitably qualified to assess me as a person with mental illness and disabilities that lie outside his own scope of practice. Therefore the serious question arises again, why he did proceed with the assessment of a person, who clearly has illnesses and disabilities that lie outside his scope of practice. It appears that Dr Xxxxxxx followed either very poor judgment, or he unjustifiably regarded himself as sufficiently qualified,

experienced and competent to make an assessment about a mental health sufferer with complex conditions, including XXX, addiction and alcohol dependence.

In any case, the results of Dr Xxxxxxx's assessment and report do in this regard speak for themselves, as he failed badly in conducting and completing a competent assessment upon a flawed examination. He did not follow sound judgment and thus failed badly in regards to the recommendations and expectations of this statement.

5. Naturally Dr Xxxxxxx also failed in meeting the expectations set in him under point 5 of the same document and statement published by the Medical Council. He failed to provide an evidence based, correct and objective assessment and recommendation. Submissions form my own doctor; my own verbal submissions and letters of evidence from other specialist medical professionals were simply ignored or held as irrelevant. Such conduct is not meeting the standards of professional conduct.

6. As the "findings" by Dr Dxxxx Xxxxxxx that he noted down in his assessment report to Work and Income were substantially different to the ones of my usual doctor, one would have expected that Dr Xxxxxxx would have followed the expectations under points 16 and 17 of this document, and consequently informed my own GP, Dr Xxxx Txxxxxx, about his different assessment outcome. Dr Xxxxxxx apparently never supplied Dr Txxxxxx with a copy or transcript of his report; so again, he also neglected his duties in this regards.

The result of the totally unacceptable, irresponsible and in part illegal conduct of Dr Dxxxx Xxxxxxx did result in an indescribable course of events causing disastrous consequences and serious harm to my mental and physical health, general wellbeing, financial, personal and other living circumstances. Immeasurable damage was caused, and had Dr Xxxxxxx acted responsibly, competently and professionally within his scope, all this very serious amount of damage could have been avoided.

By taking these steps to raise the very serious matters that went wrong in the course of his conduct and following it, I am resorting to the last means I have to address these wrongdoings and most sincerely hope that you will fairly and reasonably assess, investigate and act upon these complaints in due course.

Appreciating your acknowledgement and consideration of the concerns raised in this letter, I remain

Yours sincerely,

Xxxxxxxx Xxxxxxx

P.S.:

Please be advised that a separate, complete list with all the submissions and relevant documents of evidence will be sent as a further attached document to this letter/email!