



PROFESSIONAL STANDARDS COMMITTEE INQUIRY

CONSTITUTED PURSUANT TO PART 12 DIVISION 1
of THE MEDICAL PRACTICE ACT 1992 to HOLD AN INQUIRY INTO
A COMPLAINT IN RELATION TO

DR ROSS STEWART HARON

Date of Inquiry:	Wednesday 16 September 2009
Committee members:	Dr Arthur Glass, PhD, Chairperson (Legally qualified, not a registered medical practitioner) Dr Victoria Sutton (Registered medical practitioner) Dr Irene Rotenko (Registered medical practitioner) Mr David Jackett (Lay person)
Legal Officer assisting Committee:	Ms Domarina Azad, Legal Officer
Appearance for Health Care Complaints Commission:	Ms Lisa Fackender, Hearings Officer
Appearances for Dr Haron:	Dr Hugh Aders from Avant Law Pty Ltd Ms Francesca Davis, Solicitor, from Avant Law Pty Ltd
Date of decision:	29 October 2009
Publication of decision:	Refer to pages 12 and 13 of this Decision for details of non-publication directions

SUMMARY

The Professional Standards Committee found the Complaint against Dr Ross Stewart Haron proven, and that he is guilty of unsatisfactory professional conduct within the meaning of section 36 of the *Medical Practice Act 1992*. The Committee has ordered that Dr Haron be cautioned.

INTRODUCTION

1. The NSW Medical Board constituted a Professional Standards Committee under the *Medical Practice Act 1992* to inquire into a complaint dated 6 March 2009 against Dr Ross Haron, a registered medical practitioner.
2. The complaint concerned an elderly patient, Patient A, who came under Dr Haron's care during her admission to Glen Innes District Hospital between 3 September 2007 and 7 September 2007.
3. The patient's daughter wrote to the HCCC (and others) on 10 October 2007 complaining of "the lack of professional care" her mother received over these five days in Glen Innes Hospital. The HCCC investigated this complaint and obtained an opinion from peer reviewer Dr Geraldine Duncan.
4. The Particulars of the Complaint set out a number of specific ways in which Dr Haron is said to have departed from the accepted standards of care. In making these claims the HCCC have relied on its peer reviewer.
5. Prior to the hearing Dr Haron conceded some of the factual matters set out in the Particulars. This is discussed below in paragraph 14.
6. A hearing was held on 16 September 2009 and evidence was taken from Dr Duncan and Dr Haron.

COMPLAINT

7. A complaint dated 6 March 2009 against Dr Ross Stewart Haron was referred by the NSW Health Care Complaints Commissioner to be dealt with by a Professional Standards Committee. It was prosecuted before this Committee by the Director of Proceedings acting as nominal complainant. The complaint against Dr Haron is as follows:

Dr Haron has been guilty of unsatisfactory professional conduct within the meaning of section 36 of the Act in that:

- (i) *He has demonstrated that the knowledge, skill or judgment possessed, or care exercised, by him in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.*

PARTICULARS OF COMPLAINT

8. The Particulars of the Complaint are as follows:

Patient A, an 81 year old female patient, was admitted to Glen Innes Hospital on 3 September 2007 suffering from nausea, vomiting and upper abdominal pain. She was reviewed by the practitioner on admission, who considered gastroenteritis, hiatus hernia or gastro – oesophageal reflux disease as provisional diagnoses. The practitioner ordered a chest x-ray, blood pathology and treatment with analgesic, antispasmodic and antacid medications. Throughout her hospitalisation, Patient A continued to experience episodes of abdominal pain, nausea and vomiting. The practitioner reviewed Patient A daily. On 7 September 2007 Patient A was discharged home with a referral for an abdominal ultrasound.

At all relevant times the practitioner was a General Practitioner, Visiting Medical Officer at Glenn Innes Hospital. He was responsible for the medical care of Patient A from 3 September to 7 September 2009.

The practitioner:

- 1. Failed to review his provisional diagnosis of gastroenteritis, hiatus hernia or gastro – oesophageal reflux disease, in view of Patient A's persistent symptoms of nausea, vomiting and abdominal pain.*
- 2. Failed to read the nursing entries in the medical record for 6 and 7 September 2007, prior to authorising Patient A's discharge from hospital on 7 September 2007.*
- 3. Failed to review the results of Patient A's biochemistry tests prior to authorising her discharge from hospital on 7 September 2007.*
- 4. On 7 September 2007 failed to :*
 - (a) Conduct a further physical examination, of Patient A and/or*
 - (b) Document the findings of a further physical examination, of Patient A, in the medical record prior to Patient A's discharge from hospital on 7 September 2007.*

THE MEANING OF UNSATISFACTORY PROFESSIONAL CONDUCT

9. Section 36 of the Medical Practice Act 1992 states

"Meaning of "unsatisfactory professional conduct"

For the purposes of this Act, unsatisfactory professional conduct of a registered medical practitioner includes each of the following:

(a) Conduct significantly below reasonable standard

Any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

10. The phrase "significantly below" is not defined in the Act. However in the Second Reading speech when this legislation was introduced to Parliament it was stated that:

"The first main purpose of the bill is to refocus the Health Care Complaints Commission (HCCC) on investigating serious complaints about health service providers. To achieve this, Commissioner Walker recommended that unsatisfactory professional conduct be redefined so that only significant instances involving lack of skill, judgment, or care will result in an investigation or disciplinary action. the reference to 'significant' in that context may refer to a single act or omission that demonstrates a practitioner's lack of skill, judgment or care, or it may refer to a pattern of conduct. In any individual case, that will depend on the seriousness of the circumstances of the case."

STANDARD OF PROOF

11. For the Complaint to be proved, the Committee must be reasonably satisfied on the balance of probabilities that Dr Haron's conduct satisfies the statutory definition of unsatisfactory professional conduct. As stated in *Briginshaw v Briginshaw* (1938) 60 CLR 336

"Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the Issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences"

These remarks, of course, focus the decision-makers' attention upon the nature of the evidence required to establish the case. They do not change the standard of proof - which remains that of reasonable satisfaction.

EXHIBITS

12. The Committee has considered the following documents which were provided by the parties prior to the hearing: One volume of documents (tabbed 1 to 17) from the HCCC and one volume of documents (tabbed 1 to 8) from Dr Haron. In accordance with Orders made at the conclusion of the Inquiry, the HCCC and Dr Haron also provided the Committee with written submissions.

ISSUES

13. The issues to be determined by this Committee are:
- Is the Committee comfortably satisfied the Particulars of the Complaint are proven?
 - If yes, the Committee must then decide whether the complaint against Dr Haron is proven.

- If yes, the Committee must decide whether orders or directions made by way of Division 4 of Part 4 of the *Medical Practice Act* are appropriate.
14. With regard to the Particulars of the Complaint, prior to the hearing Dr Haron admitted the facts of Particular 1, Particular 2 in so far as it refers to the entry of 6 September 2007 and Particular 4(b). He conceded that these failings show that he fell below the standards expected of him; but he did not consider that he fell "significantly" below these standards. In other words, he did not admit that he is guilty of "unsatisfactory professional conduct" within the meaning of section 36 of the Act.

BACKGROUND

15. Dr Haron, born on 14 April 1961, graduated MBBS from Sydney University in 1986 and was first registered in New South Wales on 17 December 1985. He did anaesthetic training in the UK between 1988 and 1990 and in 1989 he obtained a Diploma in Anaesthetics from the College of Anaesthetists in London. For almost 20 years (since 1990) he has been in General Practice in Glen Innes. Since 1990 he has been a Visiting Medical Officer (VMO) at Glenn Innes Hospital.
16. He has an interest in anaesthetic services and emergency medicine. In 1999, he became a Fellow of the Australian College of Rural and Remote Medicine. He is also a Member of the Australasian Society of Anaesthetists and the Australian Society of Emergency Medicine. He was an executive member of the Rural Doctors Association from 2005 until 2008.

EVIDENCE AT THE HEARING

17. **Dr Geraldine Duncan** HCCC peer reviewer. Dr Duncan is the Head of Campus and Senior Lecturer at UNSW Rural Clinical School Wagga Wagga. She has been a rural General Practitioner and VMO at rural hospitals since 1977.
18. Dr Duncan spoke to her two reports before the Committee of 31 March 2008 and 23 October 2008
19. She was asked to comment on the Hospital Progress Notes for Patient A. She considered that Dr Haron's initial examination on 3 September and his documentation of this was reasonable. His provisional diagnosis was possibly "limited" but in the context of the situation his initial diagnosis (basically gastroenteritis) was not unreasonable.
20. Dr Duncan discussed the pathology report for 3 September. All that stood out was that the patient was low in sodium and that ischemic heart disease could be excluded. The pathology report for 4 September showed that the patient's renal function was satisfactory but the reduction in sodium was a concern especially as she had been vomiting; and the accompanying urine analysis suggests dehydration. Dr Duncan conceded, however, that the above biochemistry did not at this stage show anything that called for a revision of the initial diagnosis. Although in her view in the light of the patient's tiredness and vomiting re-examination was called for daily, or possibly every second day.

21. Dr Duncan said that the pathology report of 6 September showed low sodium, potassium and chloride. This indicated a metabolic shift due probably to persistent vomiting and in an elderly patient this should have raised questions as to what was happening. The full blood count report of 6 September (raised white cell count) suggested that there was a bacterial infection going on. In an elderly person shifts like this within a few days are significant.
22. It was Dr Duncan's view that it was significant that the patient's symptoms persisted from 3 September to 6 September. She had persistent pain and continued to vomit. This showed that the condition had not settled and that caution should be exercised. This was additionally worrying as the patient was in her eighties.
23. Dr Duncan commented on the nursing notes of 6 September at 19:30 where reference is made to vomit which appeared "faecal and odorous". In her view this clearly suggests a bowel obstruction. The notes also refer to "gurgling sounds" the significance of which is unclear and a stomach "bloated and tender". At this stage the diagnosis and management plan should have been reconsidered. Further tests should have been done within the resources of the Hospital and consideration given to transferring the patient.
24. The nurse who made this entry should have brought this to the attention of Dr Haron. As this did not happen, Dr Haron should have put these steps in place after reading these notes on 7 September. Dr Haron's failure to review his provisional diagnosis on the basis of the material before him on 7 September was in Dr Duncan's view a significant departure from the expected standards.
25. Dr Haron did not make a record of any examination of the patient on 7 September prior to her discharge. If there was no examination Dr Duncan regarded this as a significant departure from standards. If there was an examination, the failure to record it was a significant departure from standards. In particular, Dr Duncan considered Dr Haron's failure to read the nursing notes of 6 September (especially the notes of 19:30) prior to discharge as a significant breach of the expected standards.
26. Dr Duncan was cross-examined by Dr Aders. Dr Duncan conceded that her criticism was not as to the initial diagnosis. Dr Haron had entertained a number of possibilities. And he did order a number of tests. But Dr Duncan's criticism was that over the patient's hospitalisation the patient's underlying problem was not identified. Dr Aders suggested that the evidence suggested that the patient was more likely to have had a partial bowel obstruction. Dr Duncan pointed out that the patient's symptoms did deteriorate. Dr Aders pointed to Dr Haron ordering a post-discharge ultrasound but Dr Duncan commented that there was no indication that this was seen as a matter of urgency. With reference to the nursing notes of 6 September, Dr Duncan considered that if the nurses did not bring this to Dr Haron's attention they had let him down. But "while nothing happens in isolation" it was Dr Haron's responsibility to read the nursing entries himself. The nursing observation of vomit that appeared "faecal and odorous" was highly significant.

27. Dr Haron gave evidence. He discussed his C.V before the Committee. He provided anaesthetic services as well as emergency and general practitioner services to the Hospital. He noted that he has continued to do this work while other doctors in the area have become less involved. Only one other doctor provided the anaesthetic services and when this doctor does obstetrics Dr Haron provides the anaesthetic assistance. He said that he has for many years been in a 3 person practice. In an area of about 10,000 persons there is another group practice of 4 persons and 3 solo practitioners.
28. Dr Haron discussed his initial examination of the patient on 3 September. His note that she looked well meant that she was not suffering from severe pain. From his observations at that time he assumed that nothing acute was going on. And the results of the tests he ordered on 3 September showed nothing unusual. When he saw her later on 3 September (18:30) he was re-assured and allowed her to take clear fluids. He noted that this would be an appropriate treatment for someone with a partial bowel obstruction, although he had not considered that diagnosis at that time.
29. With reference to his notes on 4 and 5 September Dr Haron said that he would only make a note in his findings of a change. He removed the IV on 5 September. He would not have done this if he considered that the patient was losing a significant amount of fluid.
30. Dr Haron said that if he had been made aware of the nursing entry of 6 September concerning "faecal and odorous" vomit he would have come to the Hospital to re-assess the patient. This was an indication of bowel obstruction and he would want to exclude this possibility.
31. However on 7 September he was not aware of this information. He arranged for an ultrasound to be booked for the patient on the first available day, which was the following week. She was then to see her usual GP who was away at that time.
32. Dr Haron was cross-examined by Ms Fackender. Dr Haron repeated that if he had seen the note of 6 September he would have acted differently. He would have ordered an abdominal x-ray and referred her to the surgeon. As for the biochemistry results of 6 September there was a reduction in sodium possibly due to the vomiting but nothing else that worried him. He said that he saw these results prior to discharge (note his initials on the form). With hindsight he conceded that the white cell count had changed significantly from 3 September. He could not now recall if he had considered that the patient may have had a bacterial infection.
33. Dr Haron said that it was rare for the nursing staff to be present when he saw his patients in the Hospital. His practice was to speak to the staff on duty and he assumes he did this on 7 September. It was his practice to do a physical examination each time but in the past only to document changes. Now he documents all of his findings. He cannot specifically recall if he examined this patient on 7 September prior to discharge but he "imagines that he did". "Without records he cannot be sure".

34. Dr Haron conceded that his conduct fell below the accepted standards in that he did not read the notes of 6 September prior to discharge. Now he makes sure that he reads all of the entries and he makes every effort to communicate his findings to the nursing staff. His record keeping is now more comprehensive.
35. Dr Haron discussed the material before the Committee relating to his continuing education.
36. The Committee questioned Dr Haron as to his present work arrangements. He discussed his practice as to when he decides to transfer patients out of the hospital or ask for advice from other specialists. He said that his recall of the patient at issue was sketchy. She was not known to him before 3 September. He discussed how he would have examined her. He said that he thought that after the pathology results of 6 September he was in two minds whether to keep her in Hospital or let her go home as she wished. He was influenced by her wishes, which was not a good idea.
37. Dr Haron could not explain why he had failed to read the notes of 6 September. Perhaps he was pushed for time but, as he said, "this was no excuse for it". As to why the nursing staff had not contacted him about their findings he said that the particular nurse on 6 September was a new graduate and perhaps she did not appreciate the significance of the faecal smelling vomit. There is also an observation of vomiting by a nurse after Dr Haron has seen the patient on 7 September. Dr Haron said that this nurse was experienced and he was surprised she had not contacted him. The Hospital had carried out a Root Cause Analysis subsequent to these incidents and as a result of this a new system was in place as a safety net. Nursing observations are scored and a sufficient score will trigger contact with the treating doctor.

SUBMISSIONS

38. Written submissions were received from the HCCC and from Dr Haron. The detail of these submissions is discussed below where relevant. Basically the HCCC argue that the Complaint is made out and protective orders should extend to a reprimand and ordering Dr Haron to undertake a course in geriatric medicine. Dr Haron's representatives submit that the evidence does not establish unsatisfactory professional conduct, either because the Particulars are not made out or errors made do not amount to significant departures from the expected standards. If the Complaint is proven, Dr Haron's representatives argue, no particular orders of any kind are required.

REASONS FOR THE DECISION

39. We first set out the legal framework in which we are to consider the material placed before us. For the Complaint to be proven, the Committee must be reasonably satisfied on balance that Dr Haron committed the conduct complained of and that this conduct satisfies the statutory definition of unsatisfactory professional conduct. In this sense the onus is on the HCCC to establish that Dr Haron has departed significantly from the appropriate standards. The standard of proof relevant to our fact-finding exercise is conventionally referred to as the *Briginshaw v Briginshaw* standard (discussed above). Basically, the standard of proof is proportionate to the gravity of the issue to be proved. These disciplinary

proceedings will have professional and personal consequences for Dr Haron and we have taken account of this in our deliberations.

40. In evaluating Dr Haron's conduct he is to be judged by the standards of a practitioner of an equivalent level of training and experience. The Committee is of the view that Dr Haron is to be judged according to the standards expected of a very experienced General Practitioner and Visiting Medical Officer.

Discussion of the Particulars

41. We now discuss each of the Particulars in turn. *Particular 1. Failed to review his provisional diagnosis of gastroenteritis, hiatus hernia or gastro – oesophageal reflux disease, in view of Patient A's persistent symptoms of nausea, vomiting and abdominal pain.*
42. The allegation that Dr Haron failed to review his provisional diagnosis extends to the period of the patient's hospitalization, 3 September to 7 September.
43. The criticism of the peer reviewer is not directed at Dr Haron's failure to initially diagnose bowel obstruction, as this can be difficult to detect. Her criticism is that he failed to see that the patient was still unwell and needed ongoing medical treatment. An aspect of this criticism is that he failed to review his initial diagnosis in the light of her persistent symptoms.
44. Dr Haron concedes that "he did not reconsider with sufficient attention" his provisional diagnosis. And he accepts the criticism of the peer reviewer that the diagnosis of bowel obstruction was missed.
45. The failure to read the notes of 6 September on its own establishes this failure. And possibly there was other material before Dr Haron that should have alerted him to other possibilities. As Dr Duncan noted in her evidence:

It was significant that the patient's symptoms persisted from 3 September to 6 September. She had persistent pain and continued to vomit. This showed that the condition had not settled and that caution should be exercised. This was additionally worrying as the patient was in her eighties.

46. It was the view of Dr Duncan that in these matters Dr Haron had significantly departed from the accepted standards. We agree. The proven facts of this Particular amount to a significant departure from the expected standards; and thus a breach of s 36(1)(a) of the Act
47. *Particular 2: Failed to read the nursing entries in the medical record for 6 and 7 September 2007, prior to authorising Patient A's discharge from hospital on 7 September 2007.*
48. Dr Haron agrees that he did not read the nursing notes of 6 September 2007. He was not aware that she had vomited on the night of 6 September. He states that he did read the notes on 7 September prior to his seeing her on that date. We note that the HCCC in its submissions "does not press the Particular" in relation to 7 September. And we are not satisfied that Dr Haron failed to read the nursing entries for that day.

49. However, the central allegation of this Particular relates to the nursing entries of 6 November at 19.30 where it is noted that the patient vomited which "appeared faecal and odorous" and that there were gurgle sounds in her stomach which was bloated and tender. Clearly Dr Haron did not read this entry prior to discharge. Perhaps he was let down by the nursing staff who should have alerted him to these significant facts. In his oral evidence Dr Haron rightly conceded that it was his responsibility to read these notes and that in not doing so his conduct fell below the accepted standards.
50. It was Dr Duncan's evidence that this failure amounted to a significant departure from the accepted standards and we agree with this view.
51. In our judgment the proven facts of this Particular amount to a significant departure from the expected standards; and thus a breach of s 36(1) (a) of the Act.
52. *Particular 3: Failed to review the results of Patient A's biochemistry tests prior to authorising her discharge from hospital on 7 September 2007.*
53. Dr Haron claims that he did review these results but concedes that in view of the patient's symptoms he may not have given these results "as much attention as (he) could have". However the Particular, as drawn, alleges a particular factual omission, a failure to read, rather than a failure to *properly* or *critically* review the results. The HCCC argue that Particular 3 should be understood so as to take on this extended meaning. We do not agree with this approach. The point of the Particulars is to put Dr Haron on notice as to the factual matters alleged against him. Particulars should not be significantly re-understood at the conclusion of the proceedings, as is suggested in the HCCC submission.
54. In oral evidence Dr Haron said that he did read these results and pointed to his initials on the result form. We accept this evidence and find this Particular not proven.
55. *Particular 4: On 7 September 2007 failed to :*
 - (a) *Conduct a further physical examination, of Patient A and/or*
 - (b) *Document the findings of a further physical examination, of Patient A, in the medical record prior to Patient A's discharge from hospital on 7 September 2007.*
56. Dr Haron claims that he did conduct a physical examination on 7 September, as this was his usual practice, but concedes that he did not document this examination.
57. His evidence at the hearing about this matter was less than convincing but on balance we are not satisfied that he failed to examine her on 7 September. However, he clearly failed to document his findings and we find Particular 4(b) proven. It was Dr Duncan's evidence that this amounted to a significant departure from the accepted standards and we agree with this view.

58. In our view, the proven facts of this Particular amount to a significant departure from the expected standards; and thus a breach of s 36(1) (a) of the Act.

The appropriate Orders

59. Our findings above can be summarised as follows. Particulars 1, 2 (in so far as it relates to the entries of 6 September) and 4(b), are in our view proven and amount to unsatisfactory professional conduct as significant departures from the expected standards. Particulars 3 and 4(a) are not proven as we are not satisfied on balance that the facts alleged are made out.
60. With regard to the appropriate Orders in this matter the Committee notes its jurisdiction in these disciplinary proceedings is both to protect the public and to assist in maintaining the appropriate ethical and clinical standards of the profession. With the object of protecting the public in mind we must take account both of the likelihood of Dr Haron repeating the conduct we have found to be unsatisfactory professional conduct in these proceedings and also the need to deter others from falling short of the expected standards. It is not our role to punish Dr Haron.
61. As discussed above we are comfortably satisfied that the Complaint of unsatisfactory professional conduct is made out with regard to Particulars 1, 2, and 4 (b). We must now consider the relevant protective orders to be made. We note that the powers available to us in this regard are set out in s 61(1) of the Act.

A Committee may do one or more of the following:

- a) caution or reprimand the person,
 - b) order that the person seek and undergo medical or psychiatric treatment or counselling,
 - c) direct that such conditions, relating to the person's practicing medicine, as it considers appropriate be imposed on the person's registration,
 - d) order that the person complete such educational courses as are specified by the Committee,
 - e) order that the person report on his or her practice at the times, in the manner and to the persons specified by the Committee,
 - f) order that the person seek and take advice, in relation to the management of his or her medical practice, from such persons as are specified by the Committee
62. The HCCC submit that Dr Haron should be reprimanded. Dr Haron argues that there should be no reprimand or caution, as the mere finding of unsatisfactory professional conduct and the impact of the investigations and PSC proceedings is sufficient. On the basis of the findings we have made we consider that a caution is appropriate in this matter, as an indication of the Committee's view of the seriousness of the conduct found against Dr Haron.

63. In addition, it is an aspect of our responsibility to consider the health and safety of the public. In its submission the HCCC argued that it would be appropriate in this case to order Dr Haron to undertake a course in geriatric medicine. However, we do not consider that the material before us could justify such an Order. Dr Haron has put before the Committee positive references from a number of doctors who have worked with him over an extended period of time. We have no reason to discount these references. On the basis of these references and the material put before us at the hearing in our view Dr Haron has sufficient experience in the care of elderly patients and is himself an educator in the care of acutely unwell patients.
64. As to particular circumstances that led to this Complaint; at the hearing Dr Haron accepted full responsibility for his role in the poor care received by the patient at Glen Innes Hospital. He discussed in some detail the ways in which he has altered his practice as a result of this case. In our view he has clearly learnt all that can be learnt from this sorry experience.

DETERMINATION

65. Accordingly the Committee finds Dr Haron guilty of unsatisfactory professional conduct within the meaning of section 36(1) (a) and (b) of the *Medical Practice Act*. He has demonstrated that his knowledge, skill, judgment possessed or care exercised in his practice of medicine has been significantly below the standard reasonably expected of his level of training or experience.

ORDERS

66. In accordance with section 61(1) (a) of the Act the Committee orders that Dr Haron be cautioned.

PUBLICATION OF DECISION

67. Pursuant to section 180(1) of the Act the Committee provides copy of this written statement of decision to Dr Haron, the Health Care Complaints Commission and the Board.
68. Pursuant to section 180(3) of the Act the Committee provides a copy of this written statement of decision to Dr Haron's advisor and representative, the HCCC's peer reviewer, Dr G Duncan and Mrs X the original complainant.
69. The Committee provides a copy of this Decision to the Australian College of Rural and Remote Medicine for educational purposes.

NON-PUBLICATION DIRECTION

70. The power to make non-publication directions is granted to the Chairperson by Clause 6 of Schedule 2 of the Act in general terms – "if the person presiding thinks it appropriate in the particular circumstances of the case". And, in as much as there is a structure to the Chairperson's exercise of this power (as a result of the linkage between this power and the statutory context of s 176), the relevant matters to be considered by the Chairperson at this stage of the proceedings

concerns matters of public interest connected to the subject matter of the proceedings.


At the end of the Inquiry the Chairperson asked the HCCC and the Respondent to make submissions on the issue of possible non-publication directions. The HCCC argued that there would be no public interest in publishing the names of the complainants or witnesses to the Inquiry however it would be in the public interest to publish the name of the Respondent.

The Chairperson is of the view that there are clearly no public interest reasons at work in this matter that require the publication of the names and addresses of the original complainants, or any part of the subject matter that would lead to the identification of these persons. There is no reason to extend this direction to the name of the peer reviewer.

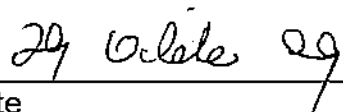
With regard to the Respondent, Dr Haron has a legitimate interest in protecting his privacy and in maintaining his reputation and it is clear from the references before us that he is held in high regard by his colleagues. However, it is now an aspect of his professional reputation that the Committee has made adverse findings against him with regard to this particular case. This Complaint deals with a failure in the workings of our public hospitals. The Committee has made observations about this aspect of the case. Clearly the public has a legitimate interest in being informed of matters that go to the proper workings of these institutions. And the details of what occurred including the identity of the doctor involved are aspects of this information that should not lightly be suppressed. On balance the Chairperson is of the view that the non-publication direction should not extend to the name and address of the Respondent.

APPEAL

71. An appeal against this decision is available under section 87 of the Act, or section 88 if the appeal is with respect to a point of law. Such an appeal is to be made within 28 days of the handing down of the decision (or such longer period as the Registrar may allow in any particular case).



Dr Arthur Glass, PhD
Chairperson



Date