

# Consultation Document —

## Review of Policy on Naming Providers in Public HDC Reports

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### Introduction

On 1 July 2007, HDC introduced a new policy outlining the circumstances in which the Commissioner would consider naming providers found in breach of the Code of Health and Disability Services Consumers' Rights (the Code), in publicly released HDC reports.

The policy prompted a strong response from the sector, particularly in relation to HDC naming group providers such as rest homes, private hospitals, residential care facilities, medical centres and pharmacies. In light of these concerns, the Commissioner has decided to consult the sector and review the naming policy.

This document sets out the Commissioner's policy on naming providers in section 1 and the approach HDC intends to take to requests for providers' names under the Official Information Act (OIA) in section 2. The Commissioner's legal authority to name is discussed in section 3 and the public interest factors for and against naming are considered in section 4.

Your comments are sought as part of this review. Discussion is welcome on any aspect of the policy, regardless of whether the matter you wish to raise is specifically discussed as part of this consultation. However, to simplify the process of providing comments, this document has been structured into separate parts and questions have been presented at the end of key sections. You may wish to use these questions as a guide when providing your comments.

The consultation will take place between January and March 2008. The policy on naming group providers (other than DHBs) and individual providers will be placed on hold during this period.

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### How to have your say

Please submit your comments to HDC by 5pm on **Friday 29 February 2008**. Written submissions may be e-mailed to [hdc@hdc.org.nz](mailto:hdc@hdc.org.nz) or posted to:

Naming Policy Consultation  
Health and Disability Commissioner  
P O Box 12299  
WELLINGTON 6144

All submissions will be carefully considered. We aim to complete the review of the policy by 31 March 2008, and to publish and implement the new policy by 30 April 2008.

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## 1. HDC Policy on naming providers

This section sets out the general principles that will guide the Commissioner's naming decisions.

In deciding whether to name a provider in a publicly released HDC report, the Commissioner will weigh the public interest in making this information available against the impact that naming will have on the provider. This will require a case specific analysis of the factors arising in each case and the parties will be consulted as part of the decision-making process. The Commissioner will also have regard to the public interest factors that are discussed in section 4 of this document.

The policy does not cover the naming of providers not found in breach of the Code, in publicly released HDC reports. However, there may be cases where the public interest supports disclosure of such information.

1. Do you consider that providers not found in breach of the Code should also be named in publicly released HDC reports?

### *Public Hospitals/District Health Boards*

Since 2006, the Commissioner has adopted a practice of naming District Health Boards (DHBs). The rationale for this policy was that "healthcare organisations, particularly DHBs, should expect to be publicly accountable for the quality of care they fund or provide" (*NZ Doctor*, 3/5/06, 16).

HDC reports have also prompted quality improvement initiatives by other DHBs. For example:

- Palmerston North Hospital, MidCentral DHB (2005) — medication error
- North Shore Hospital, Waitemata DHB (2006) — maternity care; cervical cancer treatment
- Southland DHB (2006) — urology service prioritisation.

In each case, however, HDC will consider whether naming is appropriate. This will include consultation with the parties so that relevant factors for and against naming can be carefully considered. HDC will also consider whether naming is necessary in the public interest. Relevant public interest factors include:

- whether publication would detract from quality improvement efforts of the provider;
- the nature and circumstances of the breach;
- the passage of time since the events in question.

Consideration will be given to whether naming the District Health Board and the public hospital may also result in the identification of the consumer and any individual providers involved in the case. For example, if only one dietitian works at a hospital and the consumer received dietary services, releasing the name of the hospital will inevitably result in the identification of the dietitian. However, this individual privacy interest must still be weighed against the public interest in disclosing the name of the organisation. In many cases, the public interest is likely to favour disclosure.

**Policy:** The Commissioner will name DHBs and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer.

2. What are your comments, if any, on the criteria for naming DHBs in publicly released HDC reports?
3. Are there any other criteria that should be considered?

#### *Rest Homes/Private Hospitals/Residential Care Facilities*

Rest homes and residential care facilities receive public funding and are required to meet strict certification criteria. The public has a strong interest in knowing that services are provided to particularly vulnerable groups of consumers in a manner which meets their requirements and respects their rights.

Consumers often choose a private hospital when they require specialist treatment and cannot access the treatment in the public system. Consumers have a right to know whether private facilities are meeting their obligations under the Code, since this information may affect their choice of facility.

As with DHBs, HDC will consider whether naming rest homes, private hospitals and residential care facilities is appropriate on a case by case basis. This will include consultation with the parties so that relevant factors for and against naming can be carefully considered. HDC will also consider whether naming is necessary in the public interest (discussed above in relation to DHBs).

A rest home or residential care facility must nominate a “certified person” as part of the certification process. The list of certified persons is publicly available information. The naming of a rest home or residential care facility may therefore lead to negative publicity for the certified person. In the context of a private hospital, naming the hospital may result in the unintended identification of an individual provider, particularly if very few providers in that specialty practise there. These individual privacy interests will be given careful consideration but must still be weighed against the public interest in disclosing the name of the organisation. In many cases, the public interest is likely to favour disclosure.

**Policy:** The Commissioner will name rest homes, residential facilities and private hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer.

4. What are your comments, if any, on the criteria for naming rest homes, private hospitals and residential care facilities in publicly released HDC reports?<sup>1</sup>
5. Are there any other criteria that should be considered?

#### *Medical Centres/Pharmacies*

Medical centres and pharmacies provide the frontline of primary care for consumers in New Zealand. General practitioners not only act as an important first line of treatment, but provide an important referral service for secondary and tertiary care. Consumers have a significant interest in knowing that their medical centre and pharmacy is offering a reliable and competent service.

While medical centres and pharmacies are also classified as group providers, they are often owned and/or managed by individual providers. The naming of the medical centre or the pharmacy may therefore lead to the naming of the individual owner or manager. These individual privacy interests

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<sup>1</sup> Arguments that have been raised in opposition to naming rest homes, private hospitals and residential care facilities are also discussed in section 4 below.

will be given careful consideration but must still be weighed against the public interest in disclosing the name of the organisation. In many cases, the public interest is likely to favour disclosure. HDC will consult with the parties in each case so that relevant factors for and against naming can be carefully considered.

**Policy:** From 1 July 2007, the Commissioner will name medical centres and pharmacies found in breach of the Code unless it would not be in the public interest<sup>2</sup> or would unfairly compromise the privacy interests of an individual provider or a consumer.

6. What are your comments, if any, on the criteria for naming medical centres and pharmacies in publicly released HDC reports?
7. Are there any other criteria that should be considered?

### *Individual Providers*

Individual providers have the strongest individual privacy interest in protecting their professional reputation and livelihood. These interests must be weighed carefully against any relevant public interest considerations.

The public interest is only likely to favour naming if one or more of the three following criteria apply:

#### 1. *Public safety concerns*

If the conduct of the provider shows a flagrant disregard for the rights of the consumer or a severe departure from an acceptable standard of care, the Commissioner may decide that the public interest in naming the provider outweighs the individual privacy interests of the provider.

In determining whether a registered health practitioner should be named under this criterion, the Commissioner will have regard to other mechanisms available to protect the public, such as competence reviews and conditions on practice that can be imposed by registration authorities. In practice, registered health practitioners are only likely to be named for public safety reasons in rare cases.

In the case of unregistered providers who pose a risk of harm to the public, there may be few other options for limiting their practice. For example, in Opinion 06/07873, a natural therapist was named because he had habitually entered into sexual relationships with his clients and, despite investigation of three complaints, still did not appreciate the harm this had caused his clients.

#### 2. *Non-compliance with HDC recommendations*

Where a provider refuses to acknowledge or comply with the Commissioner's recommendations in the event of a breach finding, the Commissioner may decide that it is necessary, in the public interest, to warn the public that a provider is unwilling to remedy deficiencies in his or her practice. In practice, 98% of providers comply with HDC recommendations and, to date, the Commissioner has never taken the step of naming a provider for failing to comply with recommendations. However, there have been cases where it may have been appropriate. An alternative means of encouraging compliance with recommendations is to recommend to the relevant registration authority that the re-issuance of a practising certificate depend on compliance with the Commissioner's recommendations.

<sup>2</sup> As discussed above in relation to DHBs.

Each case must be considered on its own merits and the provider will be given an opportunity to respond or comply with the recommendation before a decision to name is made. If the provider has also been referred to the Director of Proceedings, the Commissioner will consult with the Director on the impact subsequent naming may have on further proceedings.

Providers have argued that naming for refusal to comply with minor recommendations, such as an apology, is not warranted. However, complainants and consumers do not consider an apology to be a “minor recommendation”. If a provider refuses to apologise, it is generally because he or she is unwilling to accept that the care he or she provided was substandard. Naming the non-compliant provider would not occur while the provider is exercising his or her legal options to challenge the Commissioner’s opinion (eg, by complaint to the Ombudsmen or judicial review proceedings in the High Court). However, where no legal challenge is ongoing,<sup>3</sup> the fact of non-compliance is a matter that HDC considers worthy of public notice.

### *3. Frequent breaches*

When a provider has been found in breach of the Code in relation to three separate episodes of care within a five year period, and each breach involved an (at least) moderate departure from appropriate standards, the public interest may warrant naming of the provider in the third HDC opinion.

If the decisions are historic, they may not reach the threshold for naming under this criteria. Between 1996-2000, HDC resolved a greater proportion of complaints through investigation, resulting in a higher number of breach findings. Some of the complaints that resulted in providers being found in breach of the Code during that era would not meet the threshold for investigation under current criteria. Far fewer breach findings have been made in recent years. In the year ended 30 June 2007, only 63 individual providers were found in breach of the Code. Of those, only two (a natural therapist and a dentist) were found to have breached the Code for the third time in five years. Thus the possibility of naming a “frequent flyer” is seldom likely to arise in practice.

### *Public interest*

As with the other criteria for naming, individual providers will be consulted and the Commissioner will consider the public interest and privacy issues that arise in each case. There may well be occasions where similar practitioners will fall under suspicion if there is a reference to, for example, a Hawkes Bay surgeon or a Matamata therapist. The impact on other practitioners and the level of unease felt by the public in having contact with other practitioners of the same specialty will also be taken into account.

**Policy:** In summary, the Commissioner may decide to name individual providers found in breach of the Code if:

- the conduct of the provider demonstrates a flagrant disregard for the rights of the consumer or a severe departure from an acceptable standard of care, such that the provider poses a risk of harm to the public; or
- the provider has refused to comply with the Commissioner’s recommendations; or
- the provider has been found in breach of the Code in relation to three episodes of care within a five year period.

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<sup>3</sup> Note that defending disciplinary or Human Rights Review Proceedings, subsequent to the Commissioner’s Opinion, is not regarded as a legal challenge to that decision.

8. What are your comments, if any, on the criteria for naming individual providers in publicly released HDC reports?<sup>4</sup>
9. Are there any other criteria that should be considered?

## 2. HDC practice in responding to OIA requests

Information that is collected by HDC, including the names of the providers who have been found in breach of the Code, is information that is covered by the Official Information Act<sup>5</sup> (the OIA). Any written or oral request for information from HDC is covered by the OIA (whether or not the OIA is specifically mentioned by the request) and is referred to hereafter as an OIA request.

Historically, HDC has not released the names of providers in response to OIA requests, citing privacy interests. However, this practice may have been inconsistent with the principle of availability in section 5 of the OIA and the withholding grounds set out in sections 6, 7 and 9 of the OIA. Each request for information under the OIA should prompt a case specific evaluation of these competing considerations. It is conceivable that in certain cases, such as where a provider has repeatedly been found in breach of the Code, the public interest in informing the public about a provider may reach the threshold where it outweighs the provider's individual right to privacy or any likely prejudice to commercial interests. In such cases, it is arguable that HDC would not be justified in withholding the provider's name.

On 1 July 2007, HDC's approach to responding to OIA requests changed. Now, each time HDC receives a request for a provider's name, or complaint statistics about a provider, HDC evaluates the request in accordance with the withholding grounds set out in the OIA<sup>6</sup> (rather than invariably treating privacy interests as a decisive factor against disclosure). HDC considers that this approach is consistent with its legal obligations under the OIA.

10. What are your comments, if any, on the Commissioner's practice in releasing names in response to an OIA request?

## 3. Legal context for naming providers

Although the Health and Disability Commissioner Act (HDC Act) does not specifically address the issue of whether the Commissioner can name providers in reports, a number of provisions in the HDC Act and other statutes suggest that this option is available to the Commissioner.

### *Health and Disability Commissioner Act (HDC Act)*

The purpose of the HDC Act is "to promote and protect the rights of consumers" (section 6). The facilitation of "the fair, simple, speedy, and efficient resolution of complaints" is a subsidiary purpose, expressed in the statute as being "to that end". The Commissioner's primary responsibility, therefore, is to consider whether actions taken under the Act are achieving the broader purpose of promoting and protecting consumer rights.

<sup>4</sup> Arguments that have been raised in opposition of naming individual providers are also discussed in section 4 below.

<sup>5</sup> The Official Information Act applies to the organisations named in Part 2 of Schedule 1 to the Ombudsmen Act 1975, including HDC.

<sup>6</sup> The withholding grounds under the OIA are discussed on pp 9-10 below.

Under section 14(1) of the HDC Act, the Commissioner's functions include promoting "by publicity, respect for and observance of the rights of health consumers and disability services consumers" and making public statements and publishing reports "in relation to any matter affecting the rights of health consumers or disability services consumers". The Act therefore anticipates that the Commissioner will make public statements and reports to the public and does not include any restrictions on the information that can be disclosed in this context.

The HDC Act gives the Commissioner a broad discretion to determine his or her procedures under the Act (section 59(5)). Section 59(1) states that "[e]very investigation ... by the Commissioner may be conducted in public or in private". The fact that the Act envisages hearings that are accessible by the public supports the argument that the Commissioner has an inherent ability to name providers, or any other party involved in a complaint, if he or she considers it appropriate.

Once the Commissioner forms an opinion and issues a report, there is no restriction on how widely the report can be distributed. Section 45(2) of the HDC Act states that:

- "[Following breach finding] the Commissioner may ...
- (b) Report the Commissioner's opinion with reasons ... to ...
  - (iii) Any other person that the Commissioner considers appropriate."

There is only one High Court decision on the power of the Health and Disability Commissioner to publish the names of providers found in breach. In *Culverden Group Ltd v Health and Disability Commissioner* (HC Auckland, M1143-SD00, 25/6/01) Glazebrook J stated:

"I understand too that a copy of the report with all details of names and any other identifying factors [removed] will be posted on the Commissioner's website. Given the educative functions of the Commissioner this appears to be a totally reasonable action. While the Commissioner has the power to publish a report with names, it is my understanding that the Commissioner does not intend to do that in these circumstances. This again appears reasonable." (para 102)

#### *Health Practitioners Competence Assurance Act 2003 (HPCAA)*

In deciding whether to name providers, the Commissioner must weigh the public interest in making this information available against the impact that naming will have on the provider. A similar assessment is made by the Health Practitioners Disciplinary Tribunal (HPDT) when it is considering whether to order name suppression in disciplinary proceedings. Section 95(2)(d) of the HPCAA states:

"If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is *desirable* to do so, it may ... make ... an order prohibiting the publication of the name, or any particulars of the affairs, of any person." (emphasis added)

The case law on the predecessor provision to s 95(2), HPCAA (s 106(2), Medical Practitioners Act 1995) was mixed. Some judges favoured open reporting — for example, Doogue DCJ in *Harman v MPDT* (DC Auckland, NP No 4275/00, 3/5/00) stated:

“[T]he objectives of the Act to protect the public will also be served by openness of reporting of proceedings. The public interest requires identification of those practitioners who fall below the required standards.” (para 13)

Laurenson J in *F v MPDT* (HC Auckland, AP21-SW01, 5/12/01) stressed the right of the public and potential patients to know the identity of the practitioner so as to be able to make an informed choice whether they wish to engage his or her services in the future (paras 66, 75).

Other judges have been much more sympathetic to the doctor’s personal interests. The highwater mark of such an approach (albeit in the context of interim name suppression) is the judgment of Frater J in *Director of Proceedings v I* (HC Auckland, Civ-2003-485-2180, 20/2/04), an approach described by Manning as “a more lenient view taken in favour of those who are educated, professional, affluent, or in possession of a position of status” (“Health Care Law — Part 1: Common Law Developments” [2004] NZLRev 181, 206).

The approach of the courts to s 95(2), HPCAA is not yet settled. The most authoritative statement to date is that of Panckhurst J in *T v Director of Proceedings* (HC Christchurch, CIV 2005-409-002244, 21/2/06):<sup>7</sup>

“Once an adverse finding has been made, the probability must be that public interest considerations will require that the name of the practitioner be published in the preponderance of cases.” (para 42)

“Openness and transparency in relation to the hearing and outcome of a medical disciplinary process are in themselves important values. But more than that, the right of the public to know of failings on the part of a general surgeon is to my mind a most pressing public value consideration in the circumstances of this case.” (para 62)

While it is helpful to consider the factors the HPDT considers in deciding whether to grant name suppression, it is clear that name suppression orders by the HPDT do not apply to “communications” made by HDC. Section 96(3) of the HPCAA states:

“[An order] cannot be made under section 95(2)(d) in respect of —  
any communication by or on behalf of the Health and Disability Commissioner under the Health and Disability Commissioner Act ...”

What this means in practice is that if the Commissioner decides to name an individual health practitioner in an HDC opinion, the HPDT cannot subsequently order name suppression in relation to that opinion. Section 96(3) would also appear to permit the Commissioner to name a provider found in breach (and referred to the Director) where facts subsequent to the issuance of the opinion lead the Commissioner to form the view that name publication is in the public interest. The HPCAA implicitly accepts that the Commissioner has the discretion to name health practitioners and that such decisions are outside the scope of HPDT name suppression orders.

#### *New Zealand Bill of Rights Act 1990*

The New Zealand Bill of Rights Act 1990 (NZBORA) also forms part of the legislative context in considering the Commissioner’s ability to name providers. Section 6 of the NZBORA states:

<sup>7</sup> The judgment is currently under appeal to the Court of Appeal.

“Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning.”

Section 14 of the NZBORA states:

“Everyone has the right to freedom of expression, including the freedom to seek, receive, and impart information and opinions of any kind in any form.”

The criminal courts have considered these provisions in light of the power to prohibit the publication of names in section 140(1) of the Criminal Justice Act 1985:

“[T]he starting point must always be the importance in a democracy of freedom of speech, open judicial proceedings, and the right of the media to report on the latter fairly and as “surrogates of the public” ... the prima facie presumption as to reporting is always in favour of openness.”

*R v Liddell* [1995] 1 NZLR 538, 546–547, per Cooke P (CA)

“[T]he best protection against speculation is the freedom to receive and impart information recognised by s 14 of the New Zealand Bill of Rights Act 1990.”

*Lewis v Wilson & Horton* [2000] 3 NZLR 546, 564–565, per Elias CJ (CA)

Section 27 of the NZBORA affirms a person’s right to natural justice whenever a public authority has power to make a determination in respect of that person’s rights, obligations, or interests protected or recognised by law. The two key principles of natural justice are that the parties be given adequate notice and an opportunity to be heard (*audi alteram partem*) and that the decision-maker be disinterested and unbiased (*nemo debet esse iudex in sua causa*). A range of legally recognised interests are protected, including interests in preserving one’s livelihood or reputation.<sup>8</sup>

#### *Official Information Act*

The OIA does not specifically address the issue of whether the Commissioner can name providers in reports. It does, however, set out the factors that must be taken into account when HDC, as an organisation subject to the OIA, in responding to a request for information (such as the name of an unidentified provider in an HDC report, or the complaint history of a specific provider).

One of the underlying principles of the OIA is that official information should be made available unless there is good reason for withholding it (section 5). Good reasons for withholding information are listed in the Act and include protecting “the privacy of natural persons” (section 9(2)(a)) and protecting information where it “would be likely to unreasonably prejudice the commercial interests of the provider” (section 9(2)(b)(ii)). However, even where a good reason for withholding information does exist, an organisation is required to weigh these reasons against any other considerations which render it desirable, in the public interest, to make that information available.

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<sup>8</sup> In *Ainsworth v Criminal Justice Commission* (1992) 175 CLR 564, the High Court of Australia held that a report was susceptible to review, even though it did not affect rights and carried no legal consequences. It was enough that the report affected personal and business reputation (even if there was not a “decision” that may trigger the prerogative remedies of certiorari, mandamus, prohibition).

The OIA does not specifically require HDC to consult with providers before releasing information. However, in its Practice Guidelines<sup>9</sup> on section 9(2)(a), the Office of the Ombudsmen recommends that government agencies consult with the person to whom the information relates as part of assessing the privacy interests at stake:<sup>10</sup>

“While the person concerned does not have a right to veto the release of personal information, his or her views about whether its release would infringe privacy are likely to be relevant”.

Similar considerations arise under section 9(2)(b)(ii) when an organisation (such as HDC) is assessing whether the information is likely unreasonably to prejudice the commercial position of the person<sup>11</sup> who supplied or who is the subject of the information. The Practice Guidelines state:<sup>12</sup>

“The likelihood and nature of prejudice to a third party’s commercial position cannot be established by a simple assertion made by the holder of the information that such prejudice would be likely to arise. Direct consultation with the third party or parties may be necessary in order to establish the basis for this concern. However, although the views of the third party may be relevant to any consideration of the prejudice that would be likely to result if the information were released, it is not open to an agency to refuse a request simply because the third party does not consent to disclosure”.

Accordingly, there may be situations where the public interest favours the Commissioner releasing identifying information about a provider to the requestor. The Commissioner’s practice in responding to OIA requests is discussed on page 6 above.

11. What are your comments, if any, on the legal context for the Commissioner’s naming decisions?

#### 4. Public interest in naming providers

As discussed in section 3, the provisions of the HDC Act and other statutes establish the Commissioner’s discretion to name providers in appropriate cases. As with any statutory discretion, the Commissioner is required to exercise the discretion to name providers fairly and reasonably. Under the rules of administrative law, the Commissioner:

- must not exercise a power for an improper purpose;
- must consider each case on its own merits and not be bound by rigid policy; and
- must only take into account relevant considerations.

This will require a case specific analysis of the factors arising in each case. Affected parties will be consulted on the proposed decision to name. There are, however, a number of broader public interest factors, both for and against naming, that need to be taken into account. These are discussed below.

<sup>9</sup> [www.ombudsmen.govt.nz](http://www.ombudsmen.govt.nz) For government agencies – Practice Guidelines.

<sup>10</sup> Practice Guidelines, Part B, Chapter 4.1, page 4.

<sup>11</sup> Section 2 of the OIA defines “person” as including a corporation sole, and also a body of persons, whether corporate or unincorporate.

<sup>12</sup> Practice Guidelines, Part B, Chapter 4.2, page 8.

*Public interest factors in support of name disclosure*

The following arguments (in no particular order of significance) have been raised in support of name disclosure by HDC:

1. The secrecy of complaints and discipline in the New Zealand medico-legal system is increasingly out of step with the approach taken in comparable jurisdictions overseas. For example:
  - In Ontario, the College of Physicians and Surgeons of Ontario is the professional regulator for complaints and discipline in relation to doctors. The College publishes the names of doctors with charges pending, together with a brief description of the conduct charged. The College website ([www.cpsso.on.ca](http://www.cpsso.on.ca)) also publishes an alphabetical list of doctors who have been found guilty of a disciplinary offence, including a summary of the nature of the offence.
  - In the United Kingdom, the General Medical Council publishes a schedule of all upcoming hearings with the name of the doctor and a summary of the case ([www.gmcpressoffice.org.uk/apps/home/](http://www.gmcpressoffice.org.uk/apps/home/)). The outcomes of disciplinary hearings are also published.
  - In the United States, consumers have access to a wide range of physician databases on official websites. Most states have some form of publicly accessible database. The type of information and mandatory “disclaimer provisions” vary, but information about the results of malpractice claims and disciplinary proceedings is usually accessible.
2. The media and some New Zealand consumer groups have begun to pressure for similar information to be made available in this country — particularly given the dearth of publicly available comparative information about the quality of health care. Women’s health consumer groups have been calling for a similar approach in New Zealand for two decades.
3. Despite being one of the first countries to move to a system of co-regulation (ie, by professional registration authorities and an independent Commissioner), New Zealand has adopted a more secretive approach to complaints and discipline than other countries using systems of traditional professional self-regulation. The veil of secrecy is all the more remarkable given the absence in New Zealand of the major alternative forum for public hearings about the quality of health care — the civil courts (as a result of the statutory accident compensation regime).

Legal academic Joanna Manning makes the case for much greater openness and transparency of health professional discipline:

“Indeed, there is a strong argument that the principles of open justice and reporting weigh even more heavily in respect of professional disciplinary tribunals in the health field than for criminal courts. The reason is that there are so few avenues in New Zealand for the public airing of health and disability complaints, given the absence of medical malpractice actions and the existence of confidential compensation and complaints systems.”

(“Health Care Law — Part 1: Common Law Developments” [2004] NZLRev 181, 206)

4. Secrecy is undermining public confidence in the health professions and disciplinary procedures. The public is currently being “kept in the dark” about information that may influence a person’s choice of practitioner or facility and there is an increasing public desire for openness. More than a decade after the public disquiet that led to the overhaul of the complaints and medical disciplinary system, it is still common to read headlines like “Outrage at ‘old boys’ network that protects medics” (*Herald on Sunday*, 30/7/06). The principle of informed consent and the public’s right to know was at the heart of the Cartwright Inquiry Report. Judge Cartwright stated:

“I believe that most patients would not want to return to the days when doctors could be sued for negligence. Not one patient told me she wanted financial redress. The vast majority want information, a chance to take part in a treatment decision, the opportunity to decline inclusion in a trial, and the right to ensure that a negligent, rude or incompetent doctor’s reputation is known so that other patients can choose alternative health care.”  
(The Report of the Cervical Cancer Inquiry, 1988, p 172)

5. HDC is in danger of not practising what it preaches. Right 6(1) of the Code requires providers to volunteer the information that a reasonable patient, in that patient’s circumstances, would expect to receive. By analogy, it may be argued that HDC should, as a provider of public complaints adjudication services, volunteer names of providers found in breach, since the “reasonable public” would expect to be told. It is also relevant to note the position HDC has taken in promoting open disclosure by providers. HDC has a responsibility to set a good example of openness and transparency.
6. If providers’ names are not published in HDC reports, unsuspecting consumers may seek care from a practitioner whom others familiar with their background would not contemplate. There is something inherently unethical about such a situation.
7. The publicity that arises from naming may “flush out” other complainants. The Cartwright Inquiry itself was triggered by a journalistic exposé of “An Unfortunate Experiment at National Women’s Hospital” (*Metro*, June 1987). The media has played a key role in informing consumers in other cases, after initial suppression of information by the courts, HDC, and MPDT.
8. HDC’s current practice risks harm to future patients. As legal researcher Saul Holt notes:<sup>13</sup>

“It would be regrettable if it took a case of repeated serious public harm, concerning which the Commissioner had earlier found a breach of the Code and not published it, for the HDC to reform its policy in the same way as the General Medical Council” (following the Bristol and Shipman inquiries).
9. Where HDC has published the names of public hospitals and DHBs, there is anecdotal evidence that the resulting media publicity has had a significant impact in prompting the organisation to improve its service and putting the focus on similar problems in other DHBs. Thus, following the publicity surrounding the Palmerston North medication safety case highlighted by HDC in 2005, Auckland DHB wrote to HDC: “This DHB has taken the key messages from your review

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<sup>13</sup> Unpublished LLM research paper, University of Auckland, 2006.

very seriously indeed. ... The measures we have put in place since receiving your report include: redesigning the drug chart so that the patient's name is handwritten; assigning a common area for patient records and drug charts in all wards; keeping the patient labels with the drug charts; and deploying a '10 rules of safe prescribing' document to all medical officers and senior nurses." This suggests that by failing to identify poor practice, HDC may be missing an important opportunity to improve the safety and quality of health care in New Zealand.

10. There is a public interest in the workings of public institutions being open to view. As stated by Baragwanath J in *Director of Proceedings v Nursing Council of New Zealand*: "[I]t can in my view be said that in today's conditions the value of public accountability is so important that a failure to consider it in the exercise of a discretion would entail error of law" [1999] 3 NZLR 360, 381–382. (Interestingly the statute in that case was also silent on the issue of open hearings, yet the Judge concluded that the public interest supported openness.) More recent legislation, such as the Coroners Act 2006, emphasises the need for public accountability in decision making.
11. The free flow of information is particularly important given the centrality of HDC in the New Zealand medico-legal system, the dramatic decline in medical disciplinary proceedings (due to HDC's gatekeeper function and the competence review powers of the Medical Council), and the unavailability of other avenues such as civil claims for negligence.
12. After a decade in existence, there appears to be professional and public confidence in the fairness and robustness of HDC's breach findings. Providers have a full opportunity to challenge adverse comments before they are published. Although there is no right of appeal, HDC opinions may be challenged (for procedural unfairness or substantive unreasonableness) by a complaint to the Ombudsmen or (at much greater cost and with a narrower ambit of review) in judicial review proceedings.
13. Publicity about a case often turns on whether an individual complainant tells his or her story to the media. Routine publication by HDC of breach findings identifying the provider would normalise the process and may actually lead to less sensationalism. Where inquiry findings are published, with names, by official sources, the media is able to provide balance to a story.
14. There may be a compelling case for disclosing the name of a practitioner in high profile cases where all other similar practitioners come under suspicion and public confidence is adversely affected. For example, a media report of an obstetrician in a regional centre being implicated in the preventable death of a baby was very unsettling for all the women receiving obstetric care in the region. In small towns and provincial areas, secrecy about official inquiries generates rumour, fear and uncertainty. Naming can be a benefit for other practitioners as well as the public.
15. Part of HDC's education function is to place anonymised versions of its decisions on the HDC website. However, the "anonymising" of opinions sometimes renders them virtually unintelligible. For example, in Opinion 04HDC00031 (24/2/05) re *Orthopaedic Surgeon Dr B* one finds the following passage:

"Dr B further advised me that while he was awaiting Dr D's opinion, he discussed with Mr A the possibility of having Dr E in [the second Public Hospital] give an opinion on the

management. Information received from the first Public Hospital suggests that Dr B met with Mr A on 26 March for the purpose of discussing treatment/management options. Mr A advised me that the meeting with Dr B occurred on 31 March.”

Publication of the names of providers would render HDC findings much more intelligible to the public.

16. It is increasingly bizarre that so many other parts of the health sector are subject to intense scrutiny, yet complaints and discipline are not. Thus, we can read in the *Sunday Star Times* (25/3/07) precisely “How they scored”, ie, which members of the DHBs’ evaluation panel rated the Diagnostic MedLab tender zero out of 10, and in the recent Employment Court judgment finding that Auckland DHB acted unlawfully in dismissing an unnamed “porn doctor”, all the key managers are named and their conduct criticized (*X v Auckland DHB*, AC 10/07, ARC 52/05, 23/2/07).<sup>14</sup> Tellingly, the examples given relate to civil claims in the courts.
17. It has now become quite easy to find out details about a particular practitioner who has had proceedings against them by putting their name into internet search engines such as Google. The Dental Council, for example, has all the proceedings and decisions on its website for practitioners who have a disciplinary decision and order made against them, for whom name suppression has not been granted. When this information is already in the public forum via registration authorities, it is somewhat artificial for HDC to withhold it.
18. The risk of being publicly named if a complaint to HDC is investigated and results in a breach finding may incentivise providers to co-operate and achieve an early resolution of the complaint, rather than risk adverse downstream consequences.
19. Even if providers are named in HDC opinions, the public will be reassured by the Commissioner’s recommendations and the steps taken to address problems with a practitioner’s practice. The public is discerning and understanding of human error and systems problems, if lessons are learned and steps taken to reduce the likelihood of the event occurring again.

12. What other relevant public interest factors support name disclosure?

*Public interest factors against name disclosure*

The following arguments (in no particular order of significance) have been raised in opposition to name disclosure by HDC:

1. Individual providers have a strong interest in protecting their professional reputations and livelihoods. Publication of a provider’s name in an HDC opinion may lead to negative media coverage that could impact on an individual’s career and standing in their profession. In an environment where New Zealand is struggling to fill clinical jobs in the health and disability sectors, this could further dissuade providers from working in health and disability services.

<sup>14</sup> The Court of Appeal refused to grant permanent name suppression to the doctor, noting that “it is not appropriate for the Court to be the arbiter of what information those who deal with Dr X have access to, particularly information which they might consider important”: *Dr X v Auckland DHB* [2007] 193 at [16].

2. In some cases, an individual provider is found in breach of the Code and referred to the Director of Proceedings but later found to be not guilty of a disciplinary offence. The media are likely to report on the Code breach but may not follow up on the later HPDT finding. Providers are concerned that this will leave the public with an unbalanced and incomplete account of the provider's conduct.
3. Individual providers should not be named in an HDC opinion if they are being referred to the Director of Proceedings as HPDT or HRRT processes may be prejudiced if the provider has already been named.
4. HDC seeks to create a culture of openness where adverse events are freely disclosed and used to improve the quality of health care. HDC has been commended for "a world-leading focus on addressing aspects of the system, which contribute to patient harm rather than seeking to identify individual scapegoats when things go wrong" (*NZMJ*, 21/7/06). There is a risk that routinely naming individual providers would undermine that approach. Providers may be unwilling to participate in open disclosure processes and accept responsibility if they are afraid of being named, blamed and shamed. The potential to improve services may then be lost.
5. Some DHBs have argued that naming DHBs will lead to the identification of individual Board members and management, and that these individuals deserve the same level of protection as other individual providers.
6. Group providers, such as private hospitals and rest homes, maintain that there should be no distinction between naming individual and group providers, as both risk loss of professional reputations and livelihoods as a result of being named.
7. Private hospitals argue that they should not be named as part of an investigation into the care provided by independent specialists, since they do not have the same amount of control over the doctors who use their premises as DHBs do in the public sector.
8. Small group providers, such as medical centres and pharmacies, may employ only two or three health practitioners. There is a risk that if a medical centre or pharmacy is named, this may lead to the unwarranted identification of an individual provider or to other providers being under suspicion.
9. Some providers argue that naming individual providers for non-compliance with HDC recommendations is inappropriate as it forces compliance with recommendations that the provider may oppose.
10. Currently there is no mandatory requirement for health practitioners to report colleagues who are practising below the required standard of competence. The ability to report is discretionary under section 34(1) of the HPCAA. There is a risk that health practitioners may be more reluctant to report substandard practice under the HPCAA if they believe it will lead to adverse publicity and impact on individual careers.
11. Research shows that medical errors are more often attributable to oversight or systems issues than to incompetence, carelessness or recklessness. Providers should be able to learn from

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mistakes and still protect their reputation, without negative publicity blowing their misdeed out of proportion.

12. Notwithstanding the robustness of HDC processes, it is arguable that a Commissioner's opinion that is not subject to appeal may be an insufficient basis on which to jeopardise the professional reputation of an individual practitioner. Some providers believe they should only be judged by their peers (eg, in the HPDT).
  13. As the naming of providers becomes established practice, those providers who oppose the policy, or fear they will themselves be named, may be less co-operative with HDC processes. Thus the early resolution of complaints to HDC may be hindered.
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| <ol style="list-style-type: none"><li>13. Should HDC ever name a provider (group or individual) if the provider has been referred to the Director of Proceedings (and further proceedings are possible)?</li><li>14. Should the reputation/commercial interests of group providers be given the same protection as the privacy interests of individual providers?</li><li>15. Should HDC apply different criteria if an organisation employs only a small number of practitioners and there is a risk that they will all fall under suspicion if the organisation is named? How should this be weighed against the public interest?</li><li>16. What other relevant public interest factors oppose name disclosure?</li></ol> |
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