Naming Providers in Public HDC Reports

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Introduction

1. The Health and Disability Commissioner (HDC) began naming providers in 2006, and extended the naming policy in 2008 following concerns that a lack of transparency was undermining public confidence in the health sector. Consumers were being denied information that could influence their choice of practitioner or facility, and there was a growing public desire for openness. In the intervening period, the desire for openness and transparency in the health sector has only grown.

2. It is important to note that the policy applies only to naming by HDC. Unlike a Court or Tribunal, the Commissioner has no legal power to order name suppression, so it is always possible for parties to an investigation to put names in the public arena.

HDC Policy on naming providers

3. The policy is set out in two parts. Part 1 explains when a naming decision will be made. Part 2 gives specific detail on how the policy applies to providers.

Part 1: Decision to name

4. The decision to name comes after the Commissioner has investigated a complaint and formed an opinion on whether or not the Code of Health and Disability Services Consumers' Rights (the Code) has been breached. Each decision is made on a case-by-case basis, applying the general principles listed in Part 2. The question is whether the public interest in naming outweighs the potential harm to the provider.

5. The Commissioner has a range of options for resolving complaints under the Health and Disability Commissioner Act 1994 (HDC Act), and investigation is usually only appropriate if the apparent breach of the Code is serious and/or there is a significant risk to the public. Around 4–5% of complaints are formally investigated and, of these, approximately 70–75% result in a breach finding. It is only to these cases that the naming policy applies.

6. Generally, naming will be considered only where the provider has breached the Code. Providers will not be named in "no breach" opinions unless the Commissioner considers that it is in the public interest to do so. There may be occasions, however, where it is appropriate for the Commissioner to name a district health board (DHB), for example case studies of complaints resolved without formal investigation or "no breach" opinions that may be educational for other DHBs.

7. For health professionals, naming will not occur until any Director of Proceedings and Health Practitioners Disciplinary Tribunal (HPDT) processes (including any appeals) arising from the particular breach report have been completed. The provider is entitled to ask that the Commissioner's opinion include details of the outcome of these proceedings.

8. When proposing to name, the Commissioner will consult the relevant provider, and will take the provider's views into account. The relevant complainant and/or consumer will also be

consulted if there is any risk that, by identifying the provider, the complainant and/or consumer may also be identified.

Part 2: Application of policy

9. This section sets out the general principles that will guide the Commissioner's naming decisions, regardless of which type of provider has breached the Code. In each case:

- The key question is whether the public interest in naming outweighs the potential harm to the provider; and
- The relevant parties (including the complainant and/or consumer if they may be identified) will be consulted.

Public interest

10. The definition of the "public interest" will depend on the circumstances of the particular case. However, in general terms, the following factors are relevant to identifying the public interest:

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

11. In the event that naming may identify an individual provider, the risk of identification and the privacy interests of that individual will be weighed against the public interest in disclosing the name of the organisation. In some cases, the public interest may still favour disclosure.

12. Withholding a practitioner's name may cast undue public suspicion on to his or her colleagues, or cause the public significant unease when using any practitioner at the same facility. These factors will be considered in weighing the public interest.

District health boards and public hospitals

Policy

The Commissioner will continue to 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.

Rest homes/residential care facilities/private hospitals

13. Rest homes and residential care facilities receive public funding and are required to meet strict certification criteria. The public has a clear interest in knowing that services are

provided to particularly vulnerable groups of consumers in a manner that meets their requirements and respects their rights.

14. Consumers often choose a private hospital when they require specialist treatment that cannot be accessed in the public system, where there may be delays in access, or where they wish to ensure treatment from a particular specialist. 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.

15. Consumers are primarily concerned about the safety and quality of a facility's systems. Accordingly, the public interest in naming will be stronger for systemic breaches. In considering the factors for and against naming, the Commissioner will also take account of any unfair prejudice to the provider's commercial interests.

16. Naming a group provider may identify an individual — such as a rest home or residential care facility's certified person, or a specialist working at a private hospital. 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 some cases, the public interest is likely to favour disclosure.

Policy

The Commissioner will name rest homes, residential facilities, and private hospitals where their systems are found to be 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.

Medical centres, pharmacies, and other group providers

17. Medical centres, pharmacies, and other group providers provide the front line 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 these primary care providers are offering a reliable and competent service.

18. Although medical centres and pharmacies are classified as group providers, often they are owned and/or managed by individual providers. Where naming may identify an individual, this needs to be weighed against the public interest. In some cases, the public interest is likely to favour disclosure.

19. As with rest homes, residential care facilities, and private hospitals, the public is primarily wants to know that medical centres and pharmacies are using safe systems. Similar considerations apply to other group providers.

Policy

The Commissioner will name medical centres, pharmacies, and other group providers where their systems are found to be 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.

Individual providers

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

21. When one or more of the following factors are present, the naming of an individual provider is likely :

Public safety concerns

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

23. 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.

24. 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 06HDC07873, a natural therapist was named because he had habitually entered into sexual relationships with his clients, and, despite investigation of three complaints, he still did not appreciate the harm this had caused his clients.

Non-compliance with HDC recommendations

25. Where a provider refuses to 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.

26. An alternative means of encouraging compliance with recommendations is to recommend to the relevant registration authority that it withhold re-issue of a practising certificate until the provider has complied with the Commissioner's recommendations.

27. 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, generally it is because he or she is unwilling to accept that the care provided was substandard. Such behaviour is itself evidence of a lack of professionalism. Naming of a 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,[1] the fact of non-compliance is a matter that HDC considers worthy of public notice.

Frequent breaches

28. When a provider has been found in breach of the Code in relation to three separate episodes of care within the past five years, the Commissioner may decide that the public interest in naming the provider outweighs his or her privacy interests.

29. In 2010, a surgeon was named publicly after a trio of cases led to breach findings within an 18-month period, resulting from the surgeon's inadequate disclosure (Opinion 09HDC01870).

Policy

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 serious 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 the past five years.

HDC practice in responding to Official Information Act requests

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

31. One of the underlying principles of the OIA is that official information should be made available unless there is good reason for withholding it (s 5). Good reasons for withholding information are listed in the Act, and include protecting "the privacy of natural persons" (s 9(2)(a)) and protecting information where it "would likely unreasonably prejudice the

[1] 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.

commercial position of [the legal or natural person who provided it]" (s 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 that render it desirable, in the public interest, to make that information available.

32. Each request for information under the OIA prompts a case-specific evaluation of these competing considerations.

33. The legal processes for deciding whether to release names in response to an OIA request, and deciding whether to name a provider under the naming policy, are different. When an OIA request is received, the Commissioner *must* comply with his statutory obligations under the OIA. However, a decision to name a provider in an opinion is discretionary, and involves consideration of a broader range of factors.

34. HDC processes requests for names under the OIA by weighing the public interest in making that information available against any withholding grounds set out in the OIA. If the public interest in disclosing the information outweighs the withholding grounds in the OIA, the Commissioner is required to release the name of the provider to the requester.

35. In June 2016, the Office of the Ombudsman released an opinion on an OIA request for a practitioner's complaint history held by HDC. The opinion refers to "the growing recognition for more transparency in the health sector", and arguably signals a move away from the traditional view that the public interest in disclosure does not outweigh the individual privacy interest.

36. The opinion provides useful guidance on the factors to be considered when weighing the practitioner's privacy interest against public interest in disclosure. For example, the public interest in disclosure may be lower if the issues raised are historical and have minimal relevance.

Legal context for naming providers

37. Although the 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

38. The purpose of the HDC Act is "to promote and protect the rights of consumers" (s 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.

39. Under s 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.

40. The HDC Act gives the Commissioner a broad discretion to determine his or her procedures under the Act (s 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.

41. 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)(b)(iii) gives the Commissioner power to report his opinion, with reasons, to "any other person that the Commissioner considers appropriate".

42. 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 of the Code. In *Culverden Group Ltd v Health and Disability Commissioner* (HC Auckland, M1143-SD00, 25/6/01), Glazebrook J stated at [102]:

> "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."

Health Practitioners Competence Assurance Act 2003 (HPCAA)

43. 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 HPDT when it is considering whether to order name suppression in disciplinary proceedings.[3] 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.)

44. To date, s 95(2) has been applied by the HPDT in accordance with the following statements of Panckhurst J in *T v Director of Proceedings* (HC Christchurch, CIV 2005-409-002244, 21/2/06):

> "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." (at [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." ([62].)

45. It should be noted that name suppression orders by the HPDT do not apply to "communications" made by the Commissioner. 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 …"

46. 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 of the Code (and referred to the Director) where facts subsequent to the issuing of an 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. However, the current HDC policy is not to name health practitioners until any Director of Proceedings or HPDT processes (arising from the particular breach report) have been completed. Nor has the Commissioner ever named a practitioner who has been granted name suppression by a disciplinary tribunal.

47. Amendments to the HPCAA now require regulatory authorities to have a naming policy that outlines their decision-making process on when they will name providers, and what they will take into account when making that decision. This change came about in large part because of a desire for greater transparency in health regulation, with the intent that it will improve public confidence in health services.

New Zealand Bill of Rights Act 1990

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

> "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."

49. Section 14 of the Bill of Rights 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."

50. The criminal courts have considered these provisions in light of the power to prohibit the publication of names in s 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).)

51. Section 27 of the Bill of Rights 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, and that the decision-maker be disinterested and unbiased. A range of legally recognised interests are protected, including interests in preserving one's livelihood or reputation.

Official Information Act

52. 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, responds 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). HDC's practice in responding to OIA requests and the Ombudsman's opinion on the matter is discussed at paragraphs 30 to 36 above.

Privacy Act 1993

53. The Privacy Act applies to "personal information", the definition of which is wide enough to cover all the information gathered about a provider. Only natural persons can rely on the protections granted by the Privacy Act — it is not relevant when naming group providers or other corporate bodies.

54. The Information Privacy Principles (IPPs) contained in the Privacy Act apply variously to information that is "collected", "held", or "obtained". Those terms are broad enough to include all information received during the course of an investigation, including the Commissioner's opinion.

55. The Privacy Act allows the Commissioner to disclose personal information if this is a purpose for which the information was obtained, or a related purpose. IPP 11 provides:

> "An agency that holds personal information shall not disclose the information to a person or body or agency unless the agency believes, on reasonable grounds,—
>
> (a) That the disclosure of the information is one of the purposes in connection with which the information was obtained or is directly related to the purposes in connection with which the information was obtained;"

56. In obtaining information, the Commissioner's purposes include:

- The conduct of an investigation;
- The promotion, by education and publicity, of respect for and observance of consumers' rights and of awareness of those rights and how they may be enforced; and

- The making of public statements and publication of reports in relation to any matter affecting the rights of consumers, including reports that promote understanding or compliance with the Code.

57. As a consequence, the Commissioner falls within the IPP 11(a) exception when publicly releasing the name of an individual provider found in breach of the Code.

Public interest in naming providers

58. A number of factors are relevant to the context in which HDC's naming policy operates. Many of these factors will be relevant when weighing the public interest in individual cases. This section outlines those factors.

Public interest factors in support of name disclosure

59. The following arguments (in no particular order of significance) support name disclosure by HDC:

1. Internationally the trend has been for increased transparency and openness in health care. It is recognised that secrecy undermines public confidence in the health professions and disciplinary procedures.
    - The NSW Health Care Complaints Commission names individual providers when issuing its public statements and statement of decision at the conclusion of its investigations. It also publishes the names of individuals and the outcome of disciplinary proceedings against them.
    - Queensland's Office of the Health Ombudsman publishes names of individuals when it has taken immediate action to suspend, or impose conditions on, registered health practitioners. It also publishes the names of individuals and the outcome of disciplinary proceedings against them.
    - In the United Kingdom, the General Medical Council (GMC) has a statutory duty to publish a range of decisions by disciplinary and investigation tribunals, and undertakings agreed by doctors. Information is published on both the GMC website and, where relevant, the Medical Practitioners Tribunal Service.
    - 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 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 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.

60. While the Commissioner accepts that breach opinions and medical disciplinary proceedings are different in kind, there is a general trend towards making medico-legal regulation processes more transparent and accessible by the public.

61. 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 who are found in breach of the Code, since the "reasonable public" would expect to be told. The Commissioner is of the view that consumers are entitled to know about restrictions on practice and other relevant matters so that they can make an informed decision. For example, in Opinion 12HDC01488 a surgeon was found in breach of Right 6(1) of the Code for not disclosing voluntary restrictions on his practice. Similarly, in Opinion 08HDC20258, a surgeon was found in breach of Right 6(1) for failing to tell a patient about his (the surgeon's) lack of experience in an innovative procedure.

62. Publication of the name of a provider gives existing and prospective patients, and other providers who are contemplating referrals, an informed choice about whether to consult the practitioner or to remain in the practitioner's care — see *Singh v Director of Proceedings* [2014] NZHC 2848 at 99.

63. 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). In other cases, the media has played a key role in informing consumers, after initial suppression of information by the courts, HDC, and HPDT. Conversely, non-disclosure in a particular case may run the risk of harm to future patients.

64. 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 on prompting the organisation to improve its service, and putting the focus on similar problems in other DHBs.

65. 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 an error of law." ([1999] 3 NZLR 360, 381–382.)

66. HDC is accountable for the proper discharge of its responsibilities in the assessment and investigation of complaints made to it.

67. The free flow of information is particularly important given the centrality of HDC in the New Zealand medico-legal system, the 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.

68. 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.

69. 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 could actually lead to less sensationalism. Where inquiry findings are published, with names, by official sources, the media and the public are able to see the full picture, including the nature of the breach and any remedial steps taken by the provider(s). If details of a breach of the Code are already in the public domain, it is artificial for the Commissioner to withhold them.

70. There may be a compelling case for disclosing the name of a practitioner where all other similar practitioners come under suspicion and public confidence is adversely affected. Publicity may be needed to avoid suspicion falling unfairly on other practitioners (see *Dr N v Professional Conduct Committee of Medical Council of New Zealand* [2013] NZHC 3405).

71. 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.

Public interest factors against name disclosure

72. The following points (in no particular order of significance) argue against 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 have an impact on an individual's career and standing in his or her profession. In a small country and 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.
2. In some cases, an individual provider is found in breach of the Code and referred to the Director of Proceedings but later found not guilty of a disciplinary offence. The media are likely to report on the Code breach, but may not report 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 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. 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 s 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 have an impact on individual careers.
6. 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 mistakes and still protect their reputation, without negative publicity blowing their misdeed out of proportion.
7. 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 be judged only by their peers (eg, in the HPDT).