Public watchdog

People often speak of the need for the Health and Disability Commissioner to be a "public watchdog", speaking up to protect patients. Similarly, the "watchdog" theme featured in recent *New Zealand Herald* critiques of the Commerce Commission and the Securities Commission. We take our public protective role seriously, and readers may have noticed HDC being more visible in the media over recent months. I have increasingly been using investigation reports (on our website, www.hdc.org.nz) to highlight patient safety concerns – medication safety in hospital (the Palmerston North case (03HDC14692); credentialling of independent practitioners with access agreements at DHB maternity facilities (04HDC04652); and emergency departments at Dunedin Hospital (04HDC12081) and Gisborne Hospital (04HDC04456).

Naming provider organisations

A key change, which has made it more likely that media will cover our reports, has been my decision to name DHBs and public hospitals in cases where the local community would be interested in the findings, and there are lessons for the health sector nationally. In my view, health care organisations, particularly DHBs, should expect to be publicly accountable for the quality of care they fund or provide. But we continue to refer to practitioners simply as Dr A and Nurse B, etc, in our public reports, since we do not think naming individuals is justified outside of disciplinary process or court proceedings (eg, Coroners' inquests).

There are risks in this new approach. As the Gisborne ED case showed, even when we anonymise the rest of our investigation report, it can be relatively easy for a journalist to track down an individual complainant or provider. It was troubling to see TV One ("Close Up") name the individual junior doctor and midwife found in breach of the Code. The doctor had to endure a TV crew outside his house trying to film him. Is such exposure of an individual practitioner helpful? Does it benefit the quality of health care or promote public safety?

Culture of openness

I do not believe that naming individuals will benefit the community; it is more likely to hinder our investigation process and make providers unwilling to openly disclose mistakes. HDC seeks to create a culture of openness where adverse events are freely discussed and used to improve the quality of health care. Rather than assist with identifying possible causes of an adverse event, providers who are afraid of being named, blamed and shamed if found in breach of the Code will be unwilling to accept responsibility or provide an explanation for what went wrong. The potential to improve services will be lost.

Some politicians have begun to call for public naming of providers found in breach of the Code, and journalists have accused HDC of secrecy and protecting providers' reputations. Recent TV coverage of the complaints against an Auckland independent midwife implicitly criticised HDC for not making the complaints themselves public. My approach is to promptly alert registration authorities if a complaint raises serious concerns (in addition to routine notification if we commence a formal investigation). The relevant council can then take immediate steps to review a practitioner's competence or place limits on his or her practice. This, in my view, is far more effective in addressing public safety concerns than naming individuals in the media.

Serving the public interest

A key point is that HDC's finding is usually in respect of a single instance of care or communication. Being found guilty of a breach of the Code does not necessarily mean that a practitioner was bad at their job. Publicity may blow the misdeed out of all proportion, damage a hard-earned reputation or destroy the confidence of a fledgling practitioner. Consideration of the ways in which practice and systems can be improved is more likely to promote the public good of safe, high quality health care.

But what about the public interest? Does the public have a right to know if a practitioner has been found in breach of the Code? The Commissioner is subject to the Official Information Act and must balance a provider's privacy interest against the public interest in availability of information. The greater the degree of public interest in a case, the harder it is for individual privacy to justify non-disclosure. If there are multiple complaints against one provider, as in the recent midwifery case, the media will inevitably test with the Ombudsmen the limits of legitimate non-disclosure by HDC.

Name suppression

Where the public interest (in accountability and setting standards) requires it, I refer a provider found in breach to the Director of Proceedings (DP). Last year, 14 of the 71 providers found in breach were so referred. The DP decides whether to issue proceedings before the Health Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal. Name suppression for individuals charged with a disciplinary offence is at the discretion of those tribunals. Current rulings tend to support interim name suppression, but lifting of name suppression after a guilty finding. In the past four years, three GPs have appeared before the disciplinary tribunal on charges filed by the DP; one was granted permanent name suppression.

In a recent hearing before the High Court, a surgeon who had been found guilty of professional misconduct (whose identity is already well known in the surgical community and in his former local community) appealed the Health Practitioners Disciplinary Tribunal's decision to decline permanent name suppression. In *T v Director of Proceedings* (21/2/06) Panckhurst J ruled: "The scheme of the section means … that the publication of names of persons involved in the hearing is the norm, unless the Tribunal decides it is desirable to order otherwise … [T]he starting point is one of openness and transparency, which might equally be termed a *presumption in favour of publication*" (emphasis added). The statutory test of what is "desirable" is flexible – the balance "may incline in favour of the private interests of the practitioner" before the substantive hearing ("interim suppression"). Once an adverse finding has been made, "the probability must be that the name of the practitioner will be published in the preponderance of cases" (ie, "permanent suppression" is unlikely). The High Court declined the appeal (in effect authorising the lifting of name suppression), but the surgeon has now appealed to the Court of Appeal.

Keeping watch

So, what lessons can we draw from recent media coverage? First, as HDC's profile is raised, we expect to receive more complaints – as our Assessment Team is already finding. Secondly, while some patients and families will choose to release the full HDC report to the media, as is their right, we must always be careful to ensure that our office is a "safe haven" for complainants, most of whom do not wish to be named.

Thirdly, we must always be on the lookout for the single complaint, or the series of complaints, that should prompt us to "raise the red flag". The public rightly looks to the Commissioner as a public watchdog, and we need to carefully assess the whole picture of a provider's practice (including previous complaints) and to promptly notify registration bodies, employers and funders, of concerns that may require immediate action. Good watchdogs bark!

Ron Paterson
Health and Disability Commissioner
New Zealand Doctor, 4 May 2006