What about the doctor's privacy?

At the recent IPAC conference, I used anonymised case studies to illustrate my argument that we need a patient safety agenda for primary medical care. My speech generated an interesting email discussion with Dunedin GP Phil White, who wrote to me as follows.

A doctor's query

"I felt very uncomfortable being in an audience of GPs and practice nurses when hearing you use specific case studies as examples. New Zealand primary care is not a large institution and it is possible that the professionals involved or close associates of the professionals involved may have been present. I do not know the individuals involved so have no axe to grind on their behalf but I am aware that doctors and nurses that have been involved in any complaint process whether 'fault' is found on their behalf or not find it a very difficult process with feelings of worthlessness, self-blame and a feeling that they should be giving up their professions. They go through a process of personal crucifixion alongside the public crucifixion they will be going through in their own communities and in the media, and in any complaints process. I do not want to belittle the suffering of the patients involved but for both parties after a period of time healing and some form of reconciliation and restoration begins to take place. I feel that to use case studies such as you did to an audience that might include the practitioners involved or their close associates showed a lack of respect, possibly harassment and exploitation, a lack of dignity, and a lack of support for the 'other' side of the complaint.

I do not know whether you sought informed consent from the practitioners involved — you may be aware of the lengths that scientific journals and conferences expect to be taken to protect the privacy of any patient who is being talked about or whose photographs however unidentifiable are to be displayed. I feel that this did not happen in your talk.

While using case studies is good for education — in fact you may be reassured that as a practice we reviewed our systems for dealing with the records of new patients after reading your article in *NZ Doctor* about the most serious case you mentioned — I feel that in the forum to which you were talking it would be more appropriate to use hypothetical cases aggregated from specific cases that have come under your jurisdiction.

I would ask that for the maintenance of the profession and if you wish to retain the profession's ear and respect that you reconsider your use of specific case studies in talks that you give and articles that you write.

I feel that restorative justice will have been delivered by the various processes that the doctors and complainants have gone through and that there is no need in fact it is detrimental to keep sticking the spear into the side of the practitioners. With the process having fully come to an end it is more likely that the professionals who I imagine are fully repentant, will be able to be forgiven by the complainants and the process (although it is unlikely that they will ever forgive themselves) and that while never being able to forget may be able to learn and move on in the process of what they are usually very good at — caring and acting for their patients."

My response
I responded as follows:

“1) The case studies I use in *New Zealand Doctor* and in conference speeches like my IPAC speech are fully anonymised, so the practitioner will be recognised only by the parties involved in the incident.

2) I do not consider that I need the ‘consent’, informed or otherwise, of a practitioner to discuss a case in which they have been involved and their conduct scrutinised. In my view publicising anonymised case studies from complaints is my statutory duty under the HDC Act 1994.

3) It is good practice to obtain the consent of the patient to use their anonymised complaint for educational purposes, and I do so — and respect their wishes.

4) It is heartening that your practice acted on the lessons of the new asthmatic patient case, re transfer of records. But I am not confident that all practices would have so acted, and I felt that the lessons (especially about practice systems) merited raising at a national conference, particularly given IPAC’s focus on organised general practice.

5) I note your point about using aggregated case studies. But there is something very powerful about telling the individual story, and letting a patient describe her experience in her own words. The question for me is what is the most effective way of illustrating the educational points from a case.

6) I also note your point about retaining ‘the profession’s ear and respect’. However, you are the first practitioner to query my use of anonymised cases, something I have done in scores of speeches over the past 8 years (though concern has previously been raised with me about the risk of identification of the patient/complainant). That is not to say that your concern should be dismissed.

7) I think it is overstated to describe a confidential complaints process (ie, the vast majority of cases where the complainant has not identified herself and the practitioner in public) as ‘public crucifixion’. Nor do I think it fair to say that I ‘keep sticking the spear into the side of the practitioners’. I do not accept that ‘to use case studies such as [I] did to an audience that might include the practitioners involved or their close associates showed a lack of respect, a lack of dignity and a lack of support for the “other” side of the complaint’. As far as reasonably practicable, I ensure that the practitioner involved will not be in the audience for a speech. To ascribe to me possible motives of ‘harassment and exploitation’ is unwarranted.

You may have heard Susan Dovey, in her speech on Friday morning, accuse the complaints system of being overly focused on guilt. It is in fact medical professionals and researchers who have repeatedly highlighted the sense of shame and feelings of worthlessness and self-blame experienced by many doctors involved in an adverse event and a complaint. I have taken these concerns seriously, both in the way HDC handles complaints and in my advice to the profession about responding to a complaint. …

I will continue to think carefully about the general point your raise, about how to achieve restorative justice (ie, resolution of the individual complaint, ideally with healing and reconciliation, and the important need to allow the practitioner to 'move on' and continue 'caring and acting for their patients'). But I must also balance the need to share the lessons of cases with the profession and the public — bearing in mind that most patients who complain are seeking to prevent the same thing happening to someone else."

Dr White responds
Dr White continued our discussion.

"While not wishing to protract this dialogue overmuch I would just like to make a few comments in response to your letter.

1) One of the points I was trying to raise in my original letter was that in New Zealand and in the NZ general practice community it is not possible to 'anonymise' your case studies. There is likely to be someone in each Primary Care audience you address who knows the practitioner in some way.

2&3) Do practitioners not deserve the same level of rights to informed consent as complainants/patients?

4) That is fair comment — it is important to be able to see when things have gone wrong and try to address the problems that have contributed to its cause.

7) Sorry my comments about public crucifixion were intended to be linked with local media and community rather than the complaints process."

Further thoughts from HDC
I wrote back to Dr White.

"I have enjoyed our discussion. Thank you for clarifying what you meant about public crucifixion.

I note your point about the practical difficulty of some cases not being able to be truly anonymised in a small country, since someone in a practitioner audience may recognise the case and know who the practitioner is. This is actually far more likely to be the case in small subspecialties. My own view is that one aspect of professionalism is being willing to have one's case discussed before one's peers. This of course happens in peer review meetings and in mortality and morbidity meetings (often without the consent of the unidentified patient — though in a hospital setting many staff will know who the 'case' was). I think it could be argued that when I, as Commissioner, use a case for educational purposes before a practitioner audience (even if it also includes some managers) this is another form of professional discussion. In both settings, it is important that the person presenting the case does so in a respectful way, and I do try to ensure this.

No, I do not think that practitioners have the same right to give informed consent to the use of a case they were involved in, in anonymised form, for teaching purposes. In both cases privacy legislation permits the case to be used in this way. But practitioners (usually), researchers and ethics committees have recognised the importance of seeking the patient's permission before their health information (albeit anonymised) is used for teaching purposes as an individual case study. (In your original email you noted that this is your own practice.) It is seen as ethically appropriate, even if not legally required. It is, in a sense, an extension of informed consent. If I am your patient and you are my doctor, you need my informed consent before you treat me, ie do things to my body. By extension, you need my informed consent (or 'authorisation', in the language of privacy law) before you use information gained from me/ my body.

The practitioner's privacy interest in anonymised information about the way they handled a case cannot, in my view, be seen in the same category. After all, as a patient I am free to leave the consultation room and tell other people about the way you treated me, and even to name you. No one suggests that is a breach of the doctor's confidentiality.

In some ways, our present discussion is rather artificial. It simply wouldn't arise in the vast majority of countries. The cases I used in my IPAC talk (causing harm by the negligent injection of the wrong medicine, Depo Provera, and causing the patient's death by the negligent prescription of a contraindicated betablocker) would lead to a civil claim for negligence which, if it proceeded to trial and judgment, would be reported publicly as *P v Dr Jones*, etc. The Court would suppress publication of the patient's name, but not of the doctor's name. Teachers could then teach the *P v Jones* case to generations of law and medical students. And if the doctor's indemnity insurer settled the case, they might well publish it (in anonymised form) in a casebook for practitioners, like the *MPS Casebook*, for educational purposes.

Although I do not think the doctor's consent is required, my practice is to advise the doctor, in any provisional 'opinion' in which I am critical of the doctor's conduct, that I propose to place a copy of the anonymised report on the HDC website for educational purposes. So the doctor has the opportunity to comment on the proposed publication (as well as on the proposed adverse comment or breach finding), in response to my provisional opinion. This is not the same as consent, and I would not regard the doctor's objection to publication as a veto over my doing so (whereas I do treat the patient's objection as a conclusive reason for non-publication), but I would think carefully about the arguments made by the doctor in favour of non-publication. I cannot recall a case where a doctor has raised an objection.

In 2001 a rest home tried to stop HDC from publishing an anonymised report on our website, about a case in which the rest home was ultimately found in breach of the Code for failing to obtain the consent of an elderly man to his admission (which had been arranged by family members). Publication of an anonymised report was described by the judge as 'totally reasonable' given HDC's educative function (*Culverden v HDC*, HC Auckland, 25 June 2001, para 102).

Please be assured that I am sensitive to the concerns you raise, and will keep them in mind when giving talks in future.

Finally, it occurs to me that our correspondence would be of interest to a wider audience. Would you be happy for me to use it for one of my *New Zealand Doctor* columns? And would you be happy to be named, or would you prefer to be referred to as 'a concerned doctor'?"

A happy ending
Dr White ended our enjoyable discussion with the following note:

"Thank you for clarifying your position further and answering my points. I would be happy for you to use our correspondence in one of your *NZ Doctor* columns — it will be interesting to see whether it raises further debate. In this instance I have no problem with you using my name!"

Ron Paterson
Health and Disability Commissioner

NZ Doctor, 18 June 2008