Policy Document —
Naming Providers in Public HDC Reports

Introduction

For the first decade after the Code of Consumers' Rights came into force (on 1 July 1996), HDC published investigation reports without naming the health and disability providers involved. The focus was on educating the sector, and a policy of blanket name suppression ensured maximum provider co-operation with those processes.

By 2006, however, the Commissioner was concerned that this level of secrecy was undermining public confidence in the health professions and complaint handling procedures. Consumers were being denied information that could influence their choice of practitioner or facility, and there was a growing public desire for openness.

The Commissioner decided to name district health boards in Code breach opinions on the basis that they should be publicly accountable for the quality of care they fund or provide. In 2007, the policy was extended to include other group providers and individual providers (in limited circumstances).

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 put the policy on hold (no providers having been named in the interim), consulted the sector and reviewed the naming policy in 2008.

This document sets out the new naming policy developed as a result of that consultation. It explains:
- the operation of the naming policy (section 1);
- the interaction between the Official Information Act 1982 (the OIA) and the policy (section 2);
- the legislative basis allowing the Commissioner to name (section 3); and
- the factors taken into account by the Commissioner when deciding to introduce this policy (section 4).

The separate 'Consultation Review' document summarises concerns raised during the consultation process and HDC's response on those issues.

It is important to note that the new 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.

Commencement and Review

This revised policy will apply to all breach opinions issued from 1 July 2008. The policy will be reviewed at three-yearly intervals.

1. HDC Policy on naming providers

The policy is 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

The decision to name comes after the Commissioner has investigated a complaint and formed an opinion on whether or not 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.

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 10% of complaints are formally investigated and, of these, approximately 60% result in a breach finding. It is only to these cases that the naming policy applies.

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

For health professionals, naming will not happen 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.

When proposing to name, the Commissioner will consult the relevant provider and will take their 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

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 might be identified) will be consulted.

Public interest
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.

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.

Withholding a practitioner's name might 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
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.

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.

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.

Naming the group provider might 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
Medical centres, pharmacies and other group providers 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 these primary care providers are 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. 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.

As with rest homes, residential care facilities and private hospitals, the public is primarily concerned with knowing 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
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. The policy set out below means that in practice individual providers found in breach of the Code will rarely be named by the Commissioner.

The public interest is only likely to support 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 his or her privacy interests.

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 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.

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. Such behaviour is itself evidence of a lack of professionalism. 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,[1] 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 the past five years 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 criterion. 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 the past five years. Thus naming under this criterion is seldom likely to arise in practice.

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 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 the past five years where each breach involved an (at least) moderate departure from appropriate standards.**

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 covered by 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".

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

[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.

information where it "would likely unreasonably prejudice the 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.

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 s 5 of the OIA and the withholding grounds set out in ss 6, 7 and 9 of the OIA. Each request for information under the OIA should prompt a case-specific evaluation of these competing considerations.

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 quite 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.

From 1 July 2008, the Commissioner will process 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.

However, where an OIA request is made, the Commissioner will consult with the relevant provider and take their views into account, as suggested by the Practice Guidelines issued by the Office of the Ombudsmen.[2] Where the OIA request is from the media, the Commissioner will consider whether publishing the full report will help reduce media sensationalism.

3. Legal context for naming providers

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
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.

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.

[2] www.ombudsmen.parliament.nz Practice Guidelines, Part B, Chapter 4.1, page 4 and Chapter 4.2, page 8.

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.

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".

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 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)

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)

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." (at [62])

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:

[3] The Commissioner has no equivalent power to suppress names under the HDC Act.

> "[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. 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 (see Part 1, page 2, above). Nor has the Commissioner ever named a practitioner granted name suppression by a disciplinary tribunal.

New Zealand Bill of Rights Act 1990

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."

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."

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)

> "[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 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
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 is discussed at pages 5–6 above.

Privacy Act 1993
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.

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.

The Privacy Act allows the Commissioner to disclose personal information if this is a purpose that the information was obtained for, 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;"

In obtaining information, the Commissioner's purposes include:[4]
- 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.

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.

4. Public interest in naming providers

The Commissioner took a number of factors into account when deciding to introduce this policy. Many of these factors will be relevant when weighing the public interest in individual cases. This section outlines those factors.[5]

[4] See the HDC Act, section 14(1)(e), (c) and (d).
[5] See also Holt & Paterson, "Medico-legal secrecy in New Zealand" (2008) 15 *Journal of Law and Medicine* 602.

Public interest factors in support of name disclosure
The following arguments (in no particular order of significance) support 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, both the General Medical Council and the General Dental Council in the United Kingdom publish on their registers warnings of practitioners who have committed conduct that, although serious, is not serious enough to warrant disciplinary sanctions. Warnings can be issued in relation to any conduct that represents a departure from expected standards. In both cases warnings are imposed at the end of an investigation.

2. The results of disciplinary hearings are made publicly available in many overseas jurisdictions:

- 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.cpso.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/). 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.

  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.

3. The media and some New Zealand consumer groups have begun to press 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.

4. 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)

5. 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)

6. 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.

7. If providers' names are not published in HDC reports, unsuspecting consumers may seek care from a practitioner whom others familiar with his or her background would not contemplate.

   In *F v MPDT* (HC Auckland, AP21-SW01, 5/12/01), Laurenson J 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 (at [66] and [75]).

8. 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 HPDT.

9. Not naming risks harm to future patients. As legal researcher Saul Holt notes:[6]

> "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

[6] Unpublished LLM research paper, University of Auckland, 2006.

to reform its policy in the same way as the General Medical Council" (following the Bristol and Shipman inquiries).

10. 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. 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.

11. 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.

12. 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.

13. 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,[7] 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.

14. 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 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.

15. 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.

[7] A right of appeal is not a condition precedent of natural justice.

16. It is increasingly bizarre that litigation in the health sector is subject to intense scrutiny, yet complaints and discipline are not. Examples include employment disputes, judicial review of contracting arrangements (such as for laboratory services), and appeals of ACC cover decisions. These are all civil claims and the names of the parties are invariably published.[8]

17. 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.

18. 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.

Public interest factors against name disclosure
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 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. 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.

[8] For example, in *X v Auckland DHB* (AC 10/07, ARC 52/05, 23/2/07) the Court of Appeal refused to grant permanent name suppression to a doctor in an employment dispute.

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 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 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 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 be judged only 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.