wotton
kearney

Our ref: 10000251

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Health and Disability Commissioner

By email: review@hdc.org.nz

Dear Commissioner

Review of the Health and Disability Commissioner Act 1994 and Code of Health and Disability Services Consumers' Rights
Response to consultation document

Introduction

1. Wotton + Kearney is a firm of lawyers with a significant medicolegal practice. We engage regularly with the Health and Disability Commissioner's office. The Medical Protection Society (**MPS**) is one of Wotton + Kearney's clients. MPS is the professional indemnity provider for approximately 87% of the medical practitioners in New Zealand. Its members also include psychologists, physiotherapists, nurses, nurse practitioners, sonographers, radiographers, audiologists, podiatrists, anaesthetic technicians and dieticians.

2. This submission is made jointly on behalf of both Wotton + Kearney and MPS as stakeholders in the jurisdiction created by the Health and Disability Commissioner Act 1994 (**Act**).

Topic 1 — Supporting better and equitable complaint resolution

Legislative suggestions for change

<u>Amend the purpose statement of the Act</u>

3. The consultation document proposes broadening the principles for complaint resolution in the purpose statement of the Act (s 6) to include a focus on outcomes for people. It discusses incorporating the concept of upholding mana into the purpose statement and refers to s 3 of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

4. We do not wholeheartedly agree that the Act "does not focus the HDC on the outcomes the Act and the Code should deliver for people".[1] The heart of the existing purpose statement is to "promote and protect the rights of health consumers",[2] which are outcomes.

5. That said, we have no objection to introducing the concept of upholding mana. In our view the Commissioner's work should not however be focussed solely on consumers. It is inevitable that not all complaints will be meritorious. The Act recognises this by providing that promoting and protecting

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[1] Health and Disability Commissioner, Review of the Health and Disability Commissioner Act 1994 and Code of Health and Disability Services Consumers' Rights (April 2024) (**consultation document**) at 21.
[2] Health and Disability Commissioner Act 1994, s 6.

consumers' rights is to be achieved by the "fair, simple, speedy, and efficient resolution of complaints".[3] The concept of fairness, which is important for providers, should not become subordinated to upholding consumers' mana. Indeed, the mana of all people participating the in the Commissioner's processes should be upheld.

6. Over the years some of our clients have described their experiences of complaints under the Act as being highly negative and disempowering. Clients describe feelings of wanting to stop providing health care services in New Zealand or retire earlier than planned. This is undesirable at a personal level — but also has the potential to exacerbate health workforce shortages.

7. We also consider it would be desirable for the Act to explicitly refer to the rules of natural justice. We note the Health Practitioners Competence Assurance Act 2003 imposes the rules of natural justice on responsible authorities[4] and the Health Practitioners Disciplinary Tribunal.[5] Similarly, the Human Rights Review Tribunal must act in accordance with the principles of natural justice.[6]

Clarify cultural responsiveness

8. The consultation document proposes amending/clarifying Right 1(3) of the Code of Health and Disability Services Consumers' Rights (**Code**) to reflect a more modern understanding of cultural responsiveness.

9. We agree that Right 1(3) should be modernised and widened to include groups such as the LGBTIQA+ community.

10. We note however that the standard of 'taking into account' or something similar should be retained. An absolute expression (for example, something like 'every consumer has a right to have services provided in a way that is culturally safe for them') would be far too uncertain, onerous and likely impossible to achieve in every case. What is culturally safe can also be highly subjective to the individual and impossible to know in advance. Further, the public health service relies heavily on international graduates who understandably will take time to learn cultural norms and nuances.

Clarify the role of whānau

11. The consultation document proposes changes to Rights 3, 8 and 10 of the Code to clarify the role of whānau in the consumer-provider relationship and to help providers to enable whānau participation appropriately.

12. Right 3 — we agree it would be appropriate to replace the word 'independence' with 'autonomy'.

13. Right 8 — we agree that, where appropriate, consumers obtaining support remotely should be facilitated. Revised wording will however need to be considered carefully. For example, a blanket right to have whānau be 'present' by video may raise issues such as:

    13.1 Who is responsible for facilitating the video link (equipment/connection/cost etc)?

    13.2 What takes precedence where a support person wanting to make a recording clashes with the provider's terms of service and their own privacy rights?

14. Right 10 — again, this will require careful consideration. Possible scenarios where it may be appropriate for someone other than the consumer to make a complaint include:

    14.1 The consumer is competent, wants to make a complaint, and asks a support person to do so on their behalf. This should be acceptable.

    14.2 The consumer is not competent but there is another person able to make decisions on their behalf (for example the parent of a child or the person appointed under an enduring power of

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[3] Health and Disability Commissioner Act 1994, s 6 (emphasis added).
[4] Health Practitioners Competence Assurance Act 2003, schedule 3, cl 2 and s 72.
[5] Health Practitioners Competence Assurance Act 2003, schedule 1, cl 5.
[6] Human Rights Act 1993, s 105(2)(a).

attorney for personal care and welfare (**EPOA**)). It makes sense that the legally-empowered decision-maker should be able to make a complaint.

14.3 The consumer is a *Gillick* competent child who does not want to complain, but their parent does. It is submitted that the views of a *Gillick* competent child should be taken into account. Perhaps a parent's complaint should be accepted, but consideration given as to how much information is ultimately shared if the child wants their health information to remain private.

14.4 The consumer is not competent and there is no other person with legal authority to make decisions for them. It makes sense that an appropriate person ought to be able to complain on the consumer's behalf.

15. What we <u>strongly disagree with</u> is:

15.1 Permitting a third-party to complain on behalf of a competent consumer without that consumer's explicit request (or at least consent) that they do so.

15.2 Permitting a third-party to complain on behalf of an incompetent consumer where there is another person who is legally empowered to make decisions for them (such as an EPOA). With respect to this scenario, we have assisted clients with responding to a complaint made by the daughter of an incompetent consumer where that complaint was explicitly not supported by the EPOA, who was closely involved in the relevant healthcare decisions. This resulted in a highly respected and skilled consultant retiring sooner than planned because of how he experienced the compliant process. Our clients perceived the complaints process was being used to further a dispute between the EPOA and their sibling.

Ensure gender-inclusive language

16. The consultation document proposes updating the Code's language to be gender-inclusive. We agree.

Protect against retaliation

17. The consultation document proposes including a 'non-retaliation' clause as part of Right 10 and refers to s 22 of the Protected Disclosures (Protection of Whistleblowers) Act 2022 as an example.

18. We are concerned that a non-retaliation clause may do more harm than good. The materiality of the policy problem (i.e. how real and significant is the perceived barrier to making a complaint) is also unclear from the consultation document.

19. There are situations where a complainant has demonstrated a deep and persistent loss of trust in the provider where it may be appropriate for the provider to facilitate the consumer obtaining ongoing care elsewhere. We are aware of providers who have expressed that they would rather retire than be forced to continue providing care to a consumer who has made serial complaints and threatened to make more. In such a situation it is impossible to establish the trust that is required for a therapeutic relationship.

20. Retaliation is also already covered by the existing rights (and, for medical practitioners, professional standards). For example, a true, vindictive retaliation would breach Rights 4(2) and 1(1).

21. We are concerned that a non-retaliation clause will make it difficult or impossible for providers to take reasonable steps where the therapeutic relationship between them and the consumer has irrevocably broken-down.

22. If, despite these submissions, the Commissioner decides to proceed with a non-retaliation clause, it will need to be drafted in a way that distinguishes between true, vindictive retaliation and reasonable actions that are intended to keep the provider clinically safe, such as:

22.1 Refusing to see a consumer without a chaperone.

22.2 Setting 'ground rules' about how the consumer is expected to behave when engaging with the provider.

22.3 Ending the therapeutic relationship in a way that complies with professional standards (such as the Medical Council of New Zealand's statement "Ending a doctor patient relationship" (December 2020)).

Clarify provider complaint processes

23. The consultation document proposes amending Right 10 to simplify and set clearer expectations for provider complaint processes, including promoting the right to complain. We agree.

Strengthen the Advocacy Service / Improve the language of complaint pathways in the Act

24. In our view the entire complaints process (including how provider processes under the Code dovetail with the Advocacy Service and the Commissioner's processes under the Act) ought to be designed with an emphasis on conciliation. In many cases, the best way to uphold mana (for all involved) and "facilitate the fair, simple, speedy, and efficient resolution of complaints"[7] is to have an early face-to-face or video meeting between the consumer and provider. In cases where the consumer was open to it and conciliation could be done in a 'without prejudice' environment (if necessary guided by a skilled facilitator), this would in our view be far more empowering for the consumer than a drawn out process centred on exchanging correspondence.

25. In cases where (a) conciliation cannot take place; (b) conciliation is unsuccessful; or (c) the Commissioner considers the nature of the complaint is such that they wish to preserve the option of a formal investigation, then the complaint should enter the 'preliminary assessment' phase. The key outcomes of a 'preliminary assessment' being either 'resolved without formal investigation' or 'formal investigation'.

26. The formal investigation pathway is well established. We disagree with any suggestion that the 'resolved without formal investigation' pathway should be expanded to include, for example, publishing decisions. This pathway already includes fewer procedural protections for providers, despite resulting in letters which can be critical and take a view on the facts. The reduced procedural protections would cut much deeper if such decisions took on a more formal status or were published.

27. To achieve the above, we suggest considering a model whereby:

27.1 All complaints (other than those that meet some high threshold of materiality (for example sexual exploitation or the death of a patient) must be dealt with by the Advocacy Service in the first instance. The Advocacy Service should be focussed on conciliation.

27.2 Only complaints that remain unresolved by the Advocacy Service undergo 'preliminary assessment' by the Commissioner.

28. Reducing the number of complaints reaching the Commissioner may free up resources to improve the timeliness of the complaints process. Very long delays doubtless have negative impacts on consumers. They also affect providers. For example:

28.1 Providers' faith in the process is shaken when, after many, many months of delay, they are given short deadlines within which to respond/provide further information.

28.2 Delays can (understandably) exacerbate the consumer's sense of grievance and impact ongoing therapeutic relationships.

29. We also encourage the Commissioner to adopt a system to ensure that providers have been given the opportunity to provide input to complaint responses. The Commissioner will often address initial complaint notifications to the service, rather than individuals. Some hospitals then use non-clinical staff or clinical leaders to respond to complaints and this can occur without input from the individual provider who was involved in the patients care. This means (a) the consumer may not receive an

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[7] Health and Disability Commissioner Act 1994, s 6 (emphasis added).

accurate picture of what occurred; and (b) the provider may not become aware of the complaint or have an opportunity to clarify what occurred.

30. While we do not oppose appropriate complaints which reach the 'preliminary assessment' stage then being accelerated/'fast-tracked' by the application of additional resources, fast-tracking should not be at the expense of fairness. For example, historically the complaints process involved:

    30.1 Notification of complaint and initial response.

    30.2 Notification of decision to undertake a formal investigation.

    30.3 Provision of clinical advice and response.

    30.4 Revised clinical advice.

    30.5 Provision of draft opinion and response.

    30.6 Final opinion.

31. It is becoming increasingly common for the process to be truncated to:

    31.1 Notification of complaint and initial response.

    31.2 Provision of draft opinion (based on clinical advice) and response.

    31.3 Final opinion.

32. Given how reliant many opinions are on clinical advice, removing the ability of providers to seek to challenge and persuade the Commissioner's adviser results in significant unfairness. In practice, it is near-impossible to persuade the Commissioner to depart from a provisional opinion already formulated without feedback from the provider. This is particularly so where the provider's comments on the provisional opinion are not fed-back to the clinical adviser to see whether this changes their opinion.

Topic 2 — Making the Act and the Code more effective for, and responsive to, the needs of Māori

33. We do not oppose any of the consultation document's proposals.

Topic 3 — Making the Act and the Code work better for tāngata whaikaha | disabled people

Legislative suggestions for change

Strengthen disability functions within the Act

34. We do not oppose this proposal.

Update definitions relating to disability

35. We do not oppose this proposal.

Strengthen references to accessibility

36. With respect to effective communication, Right 5(1) states that "Where necessary and reasonably practicable, this includes the right to a competent interpreter".

37. The consultation document proposes deleting the words "and reasonably practicable" and instead relying on clause 3 of the Code, which provides "A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code".

38. This proposal is opposed. Requiring providers to take (and carry the onus of proving) 'reasonable actions in the circumstances' is a different test from making an objective assessment of what is reasonably practicable. In other words, the proposal will amount to a substantive change. The reality is that interpreter services are often not available at all; not available when needed; and/or not funded. The proposal risks putting GPs in the position of needing to halt a precious 15 minute consultation to take steps that will enable them to later prove they 'took reasonable actions in the circumstances' to obtain an interpreter. Reverting to clause 3 would also make it unclear whether a GP would be expected to hire an interpreter even if not funded to do so.

39. Finally, we have no confidence that clause 3 will be applied. From surveying the Commissioner's published opinions, it is extremely rare for them to include any explicit reference to and consideration of clause 3.

Strengthen and clarify the right to support to make decisions

40. We do not oppose the spirit of enabling decision-making, including by providing support for consumers to understand information. With respect to how any amendments to Rights 5 and 7 are framed however, we repeat the concerns expressed above with respect to interpreters. There is a risk of imposing an impossible standard given the extremely constrained resource environment of the public health service. Tangata whaikaha may be disadvantaged if providers are required to only provide care in a way that is practically impossible to achieve.

41. We agree with the proposal to update the language in Right 7(4) from consumers' "views" to "will and preferences".

42. We are unsure of what the final bullet-point of the list on page 40 of the consultation document is driving at. This concern seems to already be covered by Right 7 as it stands.

Progress consideration of HDC's draft recommendations relating to unconsented research

43. No comment.

Topic 4 — Considering options for a right to appeal HDC decisions

Legislative suggestions for change

Introduce a statutory requirement for review of HDC decisions

44. We agree with this proposal, provided the right to request an internal review applies equally to consumers and providers. We see no principled basis for excluding providers. We note similar jurisdictions do not limit review rights to the consumer — see for example s 194(2) of the Lawyers and Conveyancers Act 2006 and s 111 of the Real Estate Agents Act 2008.

45. If a formal right to internal review is adopted, then the process should be transparent (e.g. published relevant considerations/criteria etc) and, if new information or submissions are received from one party, then other interested parties should be given an opportunity to see and respond to the new material.

46. We agree that a general right of appeal to an existing or newly established judicial body is unnecessary and impractical from a resourcing perspective.

Lower the threshold for access to the HRRT

47. At present consumers only have access to the HRRT via the Director of Proceedings or in cases where the Commissioner has undertaken a formal investigation and concluded the Code was breached.

48. We agree the threshold should not be lowered to provide access whenever a complaint to the Commissioner has been made. This would result in serious resourcing implications for not only the HRRT, but providers as well. The cost of indemnity cover would likely increase materially, thus raising

the cost of providing healthcare. Providers would also be taken away from clinical work to prepare for and participate in HRRT proceedings. The result would be a very significant drag on the health system dealing with complaints that are minor, frivolous or vexatious.

49. We do not oppose expanding access to cases where the Commissioner has undertaken a formal investigation but not concluded that the Code was breached. As explained in the consultation document, this would capture a relatively modest number of additional cases and it is unlikely all of those would result in HRRT proceedings.

50. (We note that we disagree with the observation that lowering the threshold for access to the HRRT "would allow greater challenge of HDC decisions for both complainants <u>and providers</u>".[8] The Act does not empower providers to challenge the Commissioner's decisions in the HRRT.)

Topic 5 — Minor and technical improvements

Identification of issues

51. We consider s 72 (vicarious liability) should be identified as an issue for reform as part of any other package of amendments to the Act.

<u>Amending the definition of 'vicarious liability'</u>

52. Any review of the Act ought to resolve the issues regarding s 72 that were highlighted in the recent decision of the Supreme Court.[9]

53. This provision was the subject of an appeal brought by a GP (Dr Ryan) who was found in breach of the Code for the prescription error of another GP who practised at the same medical centre. The Supreme Court (with one dissenting opinion) upheld the decisions of the High Court and the Court of Appeal in favour of the Commissioner's application of s 72 and the imposition of vicarious liability on Dr Ryan.

54. However, in both the majority and dissenting judgments reference was made to the anomaly created by s 72 in its present form. At paragraph [28] the majority, when addressing s 72 with reference to similar statutory provisions and its legislative history, observed that:

> *… The Department [of Justice] also noted that imposing liability for the acts of employees even if not authorised, but with a reasonable steps defence, was stricter (i.e. more likely to hold employers liable) than the without authority proviso. This may explain why Parliament introduced a reasonable steps defence in s 72(5) for employing authorities in relation to the acts of employees but not in relation to the acts of agents or members. The availability of this defence in relation to acts of employees but not agents (or members) has also been said to be an anomaly.*

55. In a footnote, the majority also referred to a United Kingdom authority which identified the same feature in the Equality Act 2010 (UK) as an anomaly. The England and Wales Court of Appeal found it "rather surprising" that the reasonable steps defence was available to employers but not to principals.[10] The Supreme Court found it notable that equivalent provisions in some Australian statutes provide for a reasonable steps defence as well as a type of 'without authority' proviso for both employers and principals. The footnote concluded that:[11]

> *In the present case, if the prescription error had been made by an employee of the Medical Centre, it seems likely from the findings of fact made by the Commissioner that the reasonable steps defence would have been available to the Medical Centre.*

56. When choosing between the interpretation put forward on behalf of the Commissioner as against that by Dr Ryan, the Supreme Court concluded:[12]

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[8] Consultation document at 46.

[9] *Christopher Ryan v Health and Disability Commissioner* [2023] NZSC 42.

[10] *Christopher Ryan v Health and Disability Commissioner* [2023] NZSC 42, see footnote 26.

[11] *Christopher Ryan v Health and Disability Commissioner* [2023] NZSC 42, see footnote 26.

[12] *Christopher Ryan v Health and Disability Commissioner* [2023] NZSC 42 at [91].

> *Ms Casey argued that to require the employing authority to have authorised the very breach of the Code that that is in issue would make s 72 ineffective in holding employing authorities responsible for the acts of agents and members. We agree. On the other hand, we also accept Mr Waalkens' point that interpreting the without authority proviso to require only that the agent or member be acting in the course of carrying out the functions they are authorised to do makes the without authority proviso of very limited scope. Neither interpretation is particularly attractive, but we consider that the interpretation advocated by Ms Casey is the interpretation that better reflects the purpose of the section and the consumer protection objectives of the HDC Act.*

57. In the dissenting judgement of Young J, the following reasons were provided for preferring the interpretation advanced on behalf of Dr Ryan:[13]

> *If the effect of the proviso is to exclude liability unless the agent has the authority of the employing agency to do the wrongful act alleged, the practical scope of liability under s 72(3) will be extremely narrow. This is a weighty factor against the interpretation offered on behalf of Dr Ryan, particularly as its effect would, in some circumstances, limit the relief that could practically be obtained by a complainant. It is, however, to my way of thinking, outweighed by three considerations that go the other way:*
>
> *(a) On the majority's approach the words I have italicised in s 72(3) may as well not be there;*
>
> *(b) I see that approach as inconsistent with the understanding of Parliament as to what s 72 would achieve; and*
>
> *(c) That approach will produce anomalous outcomes.*
>
> *The second and third of these factors are interconnected.*

58. Young J's judgement concluded with the following remarks:[14]

> *I consider that s 72 warrants reconsideration by Parliament.*
>
> *The structure of s 72 does not coincide closely with recognised legal notions of business structure involving sole traders, partnerships and corporations and, for this reason, is not particularly well-tailored to the way people conduct business.*

59. As s 72 is currently worded, the principal of an agent or member is held to a stricter liability for those persons' breach than an employer for an employee's breach. As the courts have identified in New Zealand and elsewhere, this is an illogical anomaly. This outcome is also likely inconsistent with Parliament's original intention when the legislation was enacted.

60. There is an obvious and readily available remedy to this anomaly. The positive defence available to employers provided by s 72(5) should be available to principals of agents and members. The drafting of this could be refined, however the amendment of subsection (5) as follows is, in our view, all that is required (the words in bold and underlined to be added):

> *(5) In any proceedings under this act against any employing authority in respect of anything alleged to have been done or omitted by an employee, **<u>agent or member</u>** of that employing authority, it shall be a defence for that employing authority to prove that he or she or it took such steps as were reasonably practicable to prevent the employee, **<u>agent or member</u>** from doing or omitting to do that's thing, or from doing or admitting to do is an employee, **<u>agent or member</u>** of the employing authority things of that description.*

61. The Supreme Court's decision in *Ryan v Health and Disability Commissioner* has caused much angst and disquiet within the medical profession. There was significant media coverage of this both within the profession and outside of it. The concept of a principal of an agent being held to a higher standard than an employer in similar circumstances is not justifiable. The current review of the Act is an opportunity to correct what seems to be widely acknowledged as an illogical anomaly.

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[13] *Christopher Ryan v Health and Disability Commissioner* [2023] NZSC 42 at [110].

[14] *Christopher Ryan v Health and Disability Commissioner* [2023] NZSC 42 at [115] and [116].

Legislative suggestions for change

Revise the requirements for reviews of the Act and the Code

62. We agree with the consultation document's proposal that reviews only be required every 10 years, with earlier reviews permitted to occur where necessary.

Increase the maximum fine for an offence under the Act

63. We do not oppose the proposal to update the maximum fine for offences against the Act from $3,000 to $10,000.

Give the Director of Proceedings the power to require information

64. The consultation document suggests an amendment to enable the Director of Proceedings to require information to be provided. This is opposed.

65. The scheme of the Act is that complaints may be investigated by the Commissioner. The Director's functions (s 49) are restricted to deciding whether to institute proceedings; deciding whether to take any of the actions contemplated by s 47; and then carrying out the course of action decided upon. The Act does not contemplate that the Director will reopen the investigation themselves. At the point of referral to the Director, the investigation phase is complete. This is analogous to the Professional Conduct Committee (**PCC**) process under the Health Practitioners Competence Assurance Act 2003. While a PCC is investigating, it is empowered to require information (s 77). Once the investigation is ended, the PCC must decide under s 80 whether to bring a charge. If a charge is brought, then the PCC may ask the Tribunal to require further information on its behalf (schedule 1, cl 7).

66. There is a real concern that providing the contemplated power to the Director may:

    66.1 Allow the Director to undertake further investigations directed to liability rather than whether proceedings should be initiated — further delaying an already lengthy process.

    66.2 Allow the Director to investigate for the purpose of formulating a charge, rather than performing the functions contemplated by 49. This could be seen as making the Director's prosecutorial discretion under s 49 adversarial rather than an even-handed decision based on the Commissioner's investigation about what further action the case merits.

    66.3 Put the Director in a different position from PCCs, cutting across Parliament's seeming intention that, after the investigation phase is complete, any compelling of evidence should be controlled by the Tribunal. It is the Tribunal, as a neutral judicial body, that is best placed to decide whether the provider should be compelled to provide further information for the purposes of a charge against them.

Introduce a definition for 'aggrieved person'

67. We think this issue should be approached with caution. We are already opposed to situations where complaints are entertained from people other than the (competent) consumer, where it is unclear whether the consumer considers themselves aggrieved or supports the complaint (see [14] and [15] above). In our view the Act rightly focusses on the consumer. It is the consumer who is potentially aggrieved. In our view access to the HRRT should be limited to:

    67.1 The consumer.

    67.2 Where the consumer is not competent, their representative.

    67.3 Where the consumer is deceased, their personal representative.

68. If amendments are necessary to achieve this they would not be opposed, but we disagree with the proposed solution of extending the concept of 'aggrieved person' to people other than the consumer whose Rights under the Code were breached.

69. As addressed by the Court in *Marks v Director of Health and Disability Proceedings*:[15]

> *… we consider that there would be difficulties in defining which secondary victims can be aggrieved persons. Ms McDonald was not able to be more precise in her definition than proposing that it would be a question of fact in each case but that such victims must have a connection to the primary victim greater than the public at large … . We suspect this test would encompass too large a group and would also risk not being interpreted in the same manner by differently constituted tribunals. We also consider that there would be issues in determining what causal link is required between the breach of the Code and the situation of the secondary victim and then in deciding on when that causal link is proved. Ensuring an appropriately close causal link between the breach of the Code and any damage suffered by secondary victims could risk narrowing the ambit of the HDC Act remedies for primary victims, contrary to the purpose of the Act … . Moreover … there may also be conflicts between primary and secondary victims that are not resolved by the HDC Act.*

70. Changing the definition of 'aggrieved person' could trigger a very significant expansion of complex litigation and have various unforeseen consequences. The focus of the Act and the Code is consumers, and that is where it should remain.

<u>Allow for substituted service</u>

71. This proposal is supported.

<u>Provide HDC with grounds to withhold information where appropriate</u>

72. The proposal to provide the Commissioner with a discretion to withhold information is <u>strongly opposed</u>.

73. We disagree with the comparison between the Commissioner's investigations and those of the Privacy Commissioner. The context is quite different. Further, the Privacy Commissioner's powers are more limited. There is no prospect that the subject of a privacy complaint will be immediately named and shamed should the Privacy Commissioner determine that the complaint has substance. Rather, serious cases will be referred to the Director. If the Director initiates proceedings, a fair judicial process will unfold before the defendant becomes subject to consequences. In contrast, the Health and Disability Commissioner can make decisions that will have immediate serious implications for providers. It is therefore essential for the investigative process to be fair.

74. We also disagree with the comment that "Releasing information during the early stages of an investigation tends to favour providers (and their lawyers) who … may seek tactical advantages". This suggests the Commissioner's office sees providers as adversaries, which is unfortunate. We also do not understand how transparency provides any 'advantage' or opportunity for 'tactics'. In our experience the Commissioner reflexively withholds information even where there is no obvious reason to do so. We suggest the complaints process would be best served by far greater transparency of information. A provider may be far more willing to accept blame if they have confidence that they have seen all the available information and can assess their own actions in the full context of what happened. Healthcare does not happen in isolated silos and, in our respectful view, the complaints process should not be run in a way that creates artificial walls between different providers so they can only see part of the overall picture.

75. We endorse the principle of availability under the Official Information Act 1982. In our view the Commissioner should only be withholding information where doing so is <u>necessary</u> to protect the privacy of natural persons. As an example, in one case we were refused access to one person's account of a conversation that took place between that person and the provider. How is that <u>necessary</u> to protect privacy?

76. If the proposal is carried forward, our fear is that healthcare providers will lose faith in the complaints process; more decisions will become subject to judicial review; and providers will be asked to account for their actions based on limited and piecemeal information. This would not accord with the principles of natural justice. The better solution to perceived problems around the 'complexity' of providing

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[15] *Marks v Director of Health and Disability Proceedings* [2009] NZCA 151 at [61].

information and consumers who feel at a disadvantage is to provide far more proactive transparency from the outset, not expanded powers to keep stakeholders in the dark.

Expand the requirement for written consent for sedation that is equivalent to anaesthetic

77. We agree with the spirit of the proposal, but care will be required to distinguish between, say, IM midazolam (for which written consent should be obtained) and a GP being asked in a telephone consultation to prescribe some lorazepam to facilitate an anxious patient being able to present for an MRI scan. Were the latter captured, this would present a barrier to care in an environment where many people struggle to obtain timely face-to-face access to primary care doctors.

Clarify when written consent is required

78. We agree that Right 7(6)(d) should be amended to read “there is a significant risk of serious adverse effects on the consumer”.

Clarify the Code’s definitions of teaching, and of research

79. We do not oppose clarifying the definitions of teaching and research.

80. With respect to Right 6(1)(d), we note that providers would be assisted by clarity over what amounts to “participation in teaching”. In our view the definition should not be so broad as to capture every instance where a junior doctor is involved in providing care. The reality is that hospitals are teaching environments — both formally and informally. A registrar on a training programme may be very familiar with an examination, perform it unsupervised, but then discuss the exam and findings in a teaching environment later. In such a case is the registrar required to notify the consumer? What about where a registrar has performed many caesarean sections but the consultant remains in the room and provides suggestions/feedback on technique?

81. We also note that even if consumers need to be notified of participation in teaching merely because junior doctors will be involved in their care, this will not allow the consumer to demand care only from consultants. The public health system would cease to function.

Respond to advancing technology

82. We consider the Commissioner should proceed cautiously, as the environment is rapidly changing and the impact of new rules will be difficult to predict. We also recommend that all privacy issues be left to the Privacy Commissioner and the Health Information Privacy Code, so that there remains a single, coherent source of obligations in relation to that topic.

Conclusion

83. We and MPS are grateful for the opportunity to provide feedback on the consultation document. We are happy to remain involved in the process and will consider any specific amendments to the Act or Code ultimately formulated. We are also happy to meet with the Commissioner and provide further information if this would be helpful.

Yours sincerely

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