Naming Policy under the Health Practitioners Competence Assurance Act

A discussion paper for the
Dental Council of New Zealand
and the
Pharmacy Council of New Zealand

31 July 2019

claro
NZ's Health Sector Lawyers

Table of contents

Introduction

Background and scope

1. The Dental Council of New Zealand (Dental Council) and the Pharmacy Council of New Zealand (Pharmacy Council) have asked Claro to assist with the development of a Naming Policy. Under the recently updated Health Practitioners Competence Assurance Act (the Act), all responsible authorities (RAs) are required to develop, consult on and implement a "Naming Policy" by 12 April 2020 (one year after the amended Act came into force).

2. The Naming Policy requirements are set out under new sections 157A to 157I, and apply to an RA's powers under section 157(1) of the Act to publish a notice naming a health practitioner about whom any order or direction is made under the Act.

3. This paper takes members of the Dental Council and the Pharmacy Council (the Councils) through the issues we have identified in relation to the development of a policy that addresses the requirements of the Act. It also draws the Councils' attention to matters where a decision is needed on the policy position each Council wishes to take.

4. Once the Councils have considered the issues and identified policy positions, where required, we will develop draft policy for consideration. Depending on how closely aligned the Councils' decisions are, it may be that two separate policies need to be developed.

5. The proposed timeline for key deliverables is set out as follows:

Task	Deadline
Claro considers issues and develops issues paper. May include initial work on policy framework, pending steer from Councils on content.	31 July 2019
Councils consider issues paper and set policy direction.	August 2019 Council meetings
Councils consider first draft policy and consultation paper, provide feedback for revisions.	September 2019 Council meetings
Councils approve final draft policy with any last amendments and consultation paper.	October 2019 Council meetings
Consultations open.	21 October 2019
Consultation closes.	20 December 2019
Consider submissions and provide direction on revisions to draft.	February 2020 Council meetings

Consider amendments and agree final changes to be made.	March 2020 Council meeting
Make any final amendments as per Council decisions.	9 April 2020
Councils post final policy to website	10 April 2020

Key contacts

6. Rachael Heslop, Policy Consultant, led the drafting of this report and consideration of the policy issues, with support from Megan Purves, Policy and Project Adviser.

7. Jonathan Coates, Partner, managed the legal issues, with support from Patrick Wynne, Solicitor.

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Executive summary

8. When considering the scope of a Naming Policy, the starting point is the RA's power set out in s 157(1) to publish a notice (including the name of the practitioner) setting out the effect of any order or direction the RA has made under the Act.

9. An RA cannot promulgate a policy that excludes the possibility of publishing the name of a practitioner when an order or direction has been made about the practitioner under the Act. To put it another way, an RA must leave open the possibility that a practitioner's name will be published when any order or direction has been made by the RA about a practitioner under the Act. To do otherwise would amount to the RA fettering its statutory power in s 157(1). That would be unlawful.

10. This means that the RA's Naming Policy must leave open the possibility that orders or directions about competence, health and other matters about a practitioner will result in the practitioner's name being published.

11. Whether the RA ought to name a practitioner who is subject to any specific order or direction will be something to be determined on a case by case basis. Key relevant considerations that will need to be considered, and which ought to be set out in the Naming Policy, will include:

    - The public interest in knowing the name of the practitioner. This will include (but will not be limited to):

        - Public safety. Would publication assist in ensuring the safety and quality of health services?

        - Public choice. If a reasonable patient would expect to know about the order or direction made by the RA so that the patient can make an informed choice about whether to receive health services from the practitioner, that will weigh in favour of publishing the name of the practitioner;

    - The private interest the practitioner has in not being named. This will include (but will not be limited to):

        - The nature of the information that would be published and the impact publication would have on the individual. For example, sensitive health information about the practitioner, the disclosure of which might lead to genuine harm to the practitioner, might be less likely to be disclosed than less sensitive information;

        - The context in which the order or direction is made. For example, an order or direction that involves historical information and relates to a

practitioner who is no longer practising might be less likely to need to be published.

12. Parliament has clearly signalled that its intention is to achieve greater transparency in RA decision-making. With our knowledge of how the Councils have previously applied s 157(1), we think the new Naming Policy will likely result in the naming of practitioners in circumstances where that has not previously occurred.

13. Applying the above, a good Naming Policy will:

    - ensure that the RA does not limit the statutory discretion given to the RA in s 157(1);

    - set out the principles that will be considered in each case – but will leave the RA with sufficient discretion to make each decision on the basis of all the particular circumstances;

    - reflect Parliament's intention that RAs move to act with greater transparency when making decisions about whether practitioners should be named.

14. Taking into account the matters referred to above, we think the particular areas for RAs to consider when developing a Naming Policy are:

    - As a matter of policy, a view on where the particular RA sees itself sitting on the spectrum of naming practitioners where there are formal orders or directions made. While no RA can be 'black and white' (and cannot therefore say 'we will never name' or 'we will always name' when a particular order is made), an established and stated policy position will help set the tone and direction of the Naming Policy.

    - Whether there are any generalisable principles that might be set out in relation to some or all of the specific orders or directions that the RA can make under the Act. A table setting out these orders/directions is set out on the following page. We think that the RA should work through this list carefully.

    - More specifically, whether there ought to be a rebuttable presumption either in favour of naming practitioners or not naming practitioners when an order or direction is made, and, in particular orders or directions about:
        - health issues
        - competence issues – including an order to undertake remedial action following a finding that the practitioner fails to meet the required standard of competence
        - interim orders made about a practitioner where the Council believes there is a risk of harm or risk of serious harm.

Orders and directions

Section 157(1)

15. Section 157(1) provides that the Councils may publish a notice setting out the effect of **any order or direction** *(our emphasis)* it makes. The Act includes around 30 situations in which an authority may make an order or direction. A complete list of the orders and directions that RAs may make is set out below.

Section	Order/Direction
31(4)	Cancel interim practising certificate
38(1)	Where the Authority has reason to believe the practitioner fails to meet the required standard of competence, it may order one or more of the following: • Competence programme • Conditions • Examination or assessment • Counselling or assistance
39	Interim suspension of practising certificate or conditions pending competence review, where there are reasonable grounds for believing the practitioner poses a risk of serious harm.
43	Where a practitioner does not satisfy the requirements of a competence or recertification programme, the authority may: • Change permitted health services s43(1)(a)(i) • Include conditions s43(1)(a)(ii) • Suspend registration s43(1)(b)
48(2)	Authority suspects practitioner is unable to perform required functions due to mental or physical condition: • Interim suspension s48(2)(a) • Changing permitted health services s48(2)(b)(i) • Conditions s48(2)(b)(ii)
48(3)	Extension of s48(2) order – 20 more days
50	Authority is satisfied that the practitioner is unable to perform required functions due to physical or mental condition Suspension – s50(3) Conditions –s50(4)
51	Revoking suspension imposed under 39, 48, 50, 67A – s51(1) Revoking conditions imposed under 39, 48, 50, 67A – s51(2) Order to vary conditions imposed under 39, 48, 50, 67A, 69A
67A(2)	Upon receipt of notice of conviction, Authority may order: • Medical examination or treatment ((2)(b)(i)) • Psychological or psychiatric examination ((2)(b)(ii)) • Course of treatment or therapy for alcohol or drug abuse ((2)(b)(iii))
67A(6)(b)	Following 67A orders, Authority may order conditions.
69	Interim action if appropriateness of practitioner's conduct is in doubt

	Suspension – s 69(2)(a) Conditions – s 69(2)(b)
69(4)	Revocation of 'with notice' orders for suspension or conditions
69A	Without notice interim suspension where there is a conduct or criminal proceeding and Authority believes the practitioner poses a risk of serious harm to the public.
69A(5)	Revoking (without notice) suspension
69A(6)	Authority may include conditions when revoking without notice suspension.
142	Health Practitioner requests cancellation - Authority may direct Registrar to cancel registration.
143	Health Practitioner dies - Authority may direct Registrar to cancel registration.
144(5)	Authority may direct Registrar to cancel an entry in the Register.
146	Authority may direct Registrar to cancel registration if: • Practitioner gave false information - s146(1)(a) • Practitioner is not entitled to registration -s146(1)(b) Authority may direct Registrar to notify cancellation in any publications it so directs – s146(3)
147(5)	Authority may review the registration of a practitioner where their qualification is cancelled or suspended or an overseas authority removes, cancels or suspends the practitioner's registration. Authority may suspend or cancel the practitioner's registration s147(5)(b)

16. It is important to be clear that this is an exhaustive list of the orders and/or directions to which the Naming Policy will apply. Applying the conclusions we reach below about the scope of the legal power, we think that it must be *at least possible* that a practitioner's name (and other details) will be published in some situations where an order or direction is made under all the statutory powers described in the table above.

17. We can envisage any number of situations relating to competence or health where the relevant Council may decide that it is appropriate to publicly name the practitioner. Scenarios might include, for example:

    a) A dentist's husband has contacted the Dental Council to advise that the dentist is in the midst of a manic episode in relation to previously undiagnosed bipolar disorder. The dentist cannot be persuaded to cease practice and in fact believes that he is doing his best work ever. The Dental Council promptly considers the matter and decides upon interim suspension under section 48 of the Act. The dentist refuses to comply with the Dental Council's order and continues to treat patients.

    b) The Pharmacy Council has put in place a competence programme for a pharmacist in relation to poor record keeping and patient communication deficiencies identified during a competence review. Six months into the 12 month programme, the supervisor has reported that, while supervision started well, the pharmacist has missed nearly half of the required supervision meetings in the last four months, and has not started any of requirements to remediate her practice. The Pharmacy Council has written to the pharmacist twice reminding her of the obligation to

participate in the competence programme and to complete requirements within a specified timeframe. In a third letter, the Pharmacy Council included a warning that it may need to invoke section 43 (failure to satisfy the requirements of a competence or recertification programme). The pharmacist has still made no effort to comply with the competence programme. The Pharmacy Council has decided to make orders under section 43 that the pharmacist be suspended from practice pending satisfactory completion of her competence programme.

c) A dentist's employer has notified the Dental Council of serious concerns about the dentist's competence, and lack of insight. The employer has suspended the dentist on full pay pending a case audit. The employer is aware that the dentist also works part time in solo practice. The dentist advises that the notification is a result of an employment dispute and that there is no substance to it; however, the records and background that the employer provided to the Dental Council indicate real concerns about hygiene practices and two cases of excessive bleeding requiring hospitalisation, following what appeared to be standard, non-complex extractions. The dentist has been difficult to engage, and is in significant financial difficulty. The Dental Council has invoked section 39 (interim suspension pending a competence review) but has a reasonable degree of concern that she will continue to practise in her own practice in order to maintain a much-needed income stream.

18. These are hypothetical scenarios given for illustrative purposes. Clearly more information would likely be needed.

The scope of the legal power

19. It is important to emphasise that the recent amendments to the Act, and the introduction of the requirement to issuing a Naming Policy, did not change in any way at all the statutory power conferred on RAs to name practitioners in certain situations.

20. The power to name a practitioner has always been, and remains, as set out in s 157(1). Sub-section 157(1) provides:

> An authority may publish in any publication a notice setting out –
>
> (a) the effect of any order or direction it has made under this Act in respect of a health practitioner; and
>
> (b) a summary of any finding it has made under this Act in respect of the health practitioner; and
>
> (c) the name of the health practitioner.

21. It is clear that RAs have always had the discretionary power to name a practitioner when any order or direction has been made under the Act.

22. It would always have been permissible, prior to the amendments, for an RA to set a policy as to how to would exercise its s 157(1) power. The fact that there is now a statutory requirement on RAs to develop a policy does not change the underlying legal principles relevant to setting policy.

23. Fundamental principles that apply to policy development by administrative/statutory decision-makers (including RAs) include:

    a) A policy cannot fetter the statutory power. Using the language of the Court of Appeal:[1]

    > *The policy cannot deny the power which the law has conferred.*

    b) Any policy must be based on factors and purposes relevant to the power, and must not be unreasonable.[2]

    c) A policy which sets the exceptions so high as to be virtually impossible to meet is unlawful.[3]

24. Therefore the issue becomes whether the new statutory provisions in ss 157A – 157I permit a RA to 'read down' the s 157(1) power such that the RA, through policy, will never name a practitioner when particular 'orders or directions' are made.

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[1] *Westhaven Shellfish Ltd v Chief Executive, Ministry of Fisheries* [2002] 2 NZLR 158 (CA) at [48].
[2] *Green v Daniels* (1977) 13 ALR 1. See the discussion in Taylor (ed) Judicial Review: A New Zealand Perspective, 3rd ed, 2014, at 15.72.
[3] *Criminal Bar Assocation of New Zealand Inc v Attorney-General* [2013] NZCA 176.

25. For the brief reasons that follow, we think that it would be unlawful to promulgate a Naming Policy that excludes the possibility of ever naming a practitioner when particular orders or directions are made:

    a) First and foremost, Parliament has not amended the s 157(1) power – at a time when Parliament was closely considering the naming of practitioners. There is no suggestion anywhere that Parliament intended to amend the s 157(1) power;

    b) Secton 157A defines 'Naming Policy' to mean a policy issued by an RA relating to the naming of a practitioner published under s 157(1). That definition confirms that the s 157(1) power is the starting point;

    c) There is nothing in ss 157A – 157I that expressly limits the s 157(1) power;

    d) There is no basis to depart from the general administrative law principles described above.

26. We are aware that there has been some debate within RAs about s 157B in particular, and whether the language used in this section might be relied upon to read down the s 157(1) power. In our view, s 157B cannot be relied upon to read down the s 157(1) power, but we do note the following:

    a) We think the language used in s 157B(2) is somewhat unhelpful. For example, the reference to RAs *"and their disciplinary procedures"* does not accurately reflect the role of RAs. The 2003 Act largely removed any disciplinary function from the RAs. The provisions now applying to Naming Policies are quite separate from the Tribunal's (disciplinary) processes. In our view the reference to the RAs' "disciplinary procedures" is unhelpful – but it is not sufficient to justify a RA reading down the s 157(1) power;

    b) Section 157B(2)(b) refers to practitioners whose <u>conduct</u> has not met expected standards. By custom, many RAs use the term 'conduct' to refer to practitioners' actions that are considered under Part 4 of the Act. However, 'conduct' is not a term that is defined in the Act. We do not think the term 'conduct' in s 157B(2)(b) can be relied upon by a RA to justify reading down the s 157(1) power.

27. What, then, will a lawful Naming Policy look like?

28. In summary form, we think the answer to that question is as follows:

    a) It will start with the s 157(1) power – and will ensure that the RA leaves open the possibility of publishing a practitioner's name when any of the orders or directions that may be made under the Act are made;

    b) It will set out general policy positions – but it will leave the RA discretion to make decisions on a case by case basis. It will not set the bar for exceptions as being so high as to make it virtually impossible to meet the exceptions;

c) It must be consistent with the law – and, in particular, consistent with the matters set out in s 157G (i.e, the Act; the Information Privacy Principles in the Privacy Act; and the general law (including natural justice rights). These matters are considered in more detail below;

d) It must strive to achieve the purposes set out in s 157B(2). That is –

   i. Enhance public confidence by providing transparency about RAs' decision-making processes;

   ii. Ensure that health practitioners whose conduct has not met expected standards may be named where it is in the public interest to do so; and

   iii. Improve the safety and quality of health care.

e) It must set out the matters referred to in s 157B(3).

Context

Parliament's intent to increase transparency in the public interest

29. Reports of Parliamentary debates and discussion (Hansard) clearly capture discussions over the introduction of the amendments, and, in particular, Parliament's drive to increase transparency of regulation in the interests of improving public confidence.

First reading

> *"Greater transparency about decision making will improve public confidence in the process. This approach is consistent with protocols followed by the Health and Disability Commissioner, the Health Practitioners Disciplinary Tribunal, and overseas regulatory authorities." (Hon. David Clark, Minister of Health)*

Second reading

> *"While it's important that we've discussed tonight around having reviews and having a greater process in place, the underlying benefit is for the public of New Zealand to have greater confidence in the health services that they're receiving. That can be delivered through this bill by having transparency and increased access to information about the services that they're receiving, and that gives us a health system that's more robust, and it gives us a public that's more likely to benefit from the health services that are on offer." (Ginny Andersen, MP)*
>
> **And**

In Committee

> *"So, overall, the bill's changes, including those in the SOPs, will improve information available, and it will give confidence to New Zealanders that when something goes wrong in health treatment, there is an authority besides the Health and Disability Commissioner that can look into the incident and take appropriate action, if possible. The changes will improve operation and will improve responsiveness to people's concerns about practitioners, improve public confidence in the operations as they do that, and improve integrated services through encouraging collaboration between different responsible authorities and the practitioners that sit under them." (Hon. David Clark)*

Third reading

"It was interesting, just in terms of reading around the bill, the fact that in other jurisdictions, like the United Kingdom, there is more oversight of these responsible authorities than there is in New Zealand. So the changes that the bill is making are ensuring, as Minister Clark noted, that the public can have confidence in our health system, because some of the changes are about ensuring greater transparency." (Hon. Eugenie Sage, Minister of Conservation)

And

"So what the bill requires is that responsible authorities develop policies that outline what their decision making is around releasing the names of practitioners that they have reviewed in terms of their ***competence*** *or* ***fitness to practice*** *[sic] (our emphasis). It's important that what they're doing there is balancing that need for, basically, the public interest—so naming a practitioner if they have failed to meet expected standards—against the rights of a practitioner to have privacy and natural justice, and getting that balance right. But there is greater transparency around that." (Dr Liz Craig, MP)*

And

"I think this new kind of responsiveness in the Act will improve the transparency of the process, but also the faith that the public can have in the quality and competence of their health practitioners." (Hon. Nicky Wagner, MP)

And

"So, in conclusion, the Act does already provide a sound framework for protecting the public but this bill updates it. It improves public safety by fine-tuning aspects of the Act, allowing more efficient operation and making sure that it achieves its purpose and is seen to achieve its purpose through those additional transparency measures that have been introduced. The public should have great confidence in the professions that serve them, and this is one way of ensuring not only that they are operating effectively but that that can be transparently seen." (Hon. David Clark)

Evolution of transparency in New Zealand health regulation

30. In 1996, the Medical Practitioners Act 1995 (MPA) replaced the Medical Practitioners Act 1968. With the introduction of the MPA came a number of changes that signalled a fundamental shift away from self-regulation, and the first seeds of transparency beginning to be sown with a view to reducing public perception that the Medical Council's role was to protect doctors from public scrutiny. Changes included:
    - Removing disciplinary functions from the Medical Council's direct control, with the establishment of independent Complaints Assessment Committees and the Medical Practitioners Disciplinary Tribunal.
    - The requirement for lay people to be appointed to the Medical Council and to certain committees appointed by the Council.

31. Eight years later, the Act – based largely on the MPA - was introduced, and saw these requirements implemented across all the regulated professions.

32. In the context of these incremental changes over the last 25 years, we think it is appropriate to view the recent changes to the Act as the next step in the evolution of regulation in favour of increased transparency and openness – with the objective of ensuring the public's confidence in the regulation of health practitioners.

International trends towards transparency to improve public confidence

United Kingdom (UK)

33. The push for greater transparency has largely been led by developments in the UK, through the Professional Standards Authority as the regulator of regulators.

34. The General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the General Dental Council (GDC) in the United Kingdom use their websites to publish everything from an 'undertaking' (similar to a condition) to 'warnings' (cases where there is no risk to the public but there has been a departure from expected standards). They also include information (including the name of the practitioner) for past and upcoming committee hearings (the names of the committees are different for each regulator but include: Fitness to Practise Committee, Conduct and Competence, Investigation Committee and Professional Conduct Committee). Remarkably, it appears that practitioners are being named even before any definitive decision about the conduct, competence or fitness has been made.

35. While the introduction of the Naming Policy requirements here may have been inspired by what is happening in the UK, the level of transparency applied there does go beyond what is possible within the Act, where RAs are limited to naming only where an order has been made.

Republic of Ireland

36. In Ireland, the Regulated Professions (Health and Social Care) (Amendment) Bill 2019 proposes that **all** sanctions [including competence and fitness-related sanctions, which are captured under a catch-all "disciplinary sanctions" definition] be published to ensure

the public has access to information.[4] This is understood to remove previous balancing protections for practitioners, and appears to be consistent with what is happening in the UK.

37. The Irish Minister of Health, Minister Harris, said of the changes:

> *"This is an important piece of legislation both for the public and for health professionals. It will offer patients reassurance knowing they have information about all sanctions imposed on health professionals they are seeing, while also giving health professionals the right to appeal minor sanctions. I look forward to progressing this important piece of legislation to ensure the regulation of our health care professions is as robust as possible. This is good for the profession and for the patient."*

38. Clearly, both the UK and Ireland are beginning to place much stronger weight on the public's right to know about any issues their health practitioner is facing. We will discuss the arguments for moving towards this approach later in this paper, including under discussion of the meaning of Right 6 of the Code of Health and Disability Services Consumers' Rights.

Australia

39. In contrast, AHPRA's website indicates that, in accordance with the National Law, **practitioners' names are not published**, even where there has been a disciplinary finding against them.[5] The site further notes that a case summary is provided where there are clinical learnings; however it appears from the table provided that the last summary was published in 2013 – six years ago, and two years after the National Law came into force. It is difficult to see how either the public interest or improved public safety are being achieved through this closed-door approach to disciplinary matters.

40. On the other hand, AHPRA has established a consumer reference group, with whom it regularly consults. The group has a stated purpose of:

    a) providing information and advice on strategies for building community knowledge and understanding of the role of AHPRA and National Boards in protecting the community and managing professional standards;

    b) providing information and advice to AHPRA and National Boards on strategies for consulting the community about issues relevant to their work;

    c) providing feedback and advice from a consumer and community perspective on National Board standards, codes, guidelines, policies, publications and other specific issues, as requested by National Boards, and

[4] https://health.gov.ie/blog/press-release/minister-for-health-publishes-regulated-professions-health-and-social-care-amendment-bill-2019/
[5] https://www.ahpra.gov.au/Publications/Panel-Decisions.aspx

d) providing consumer and community perspectives and advice to the National Boards and AHPRA about issues relevant to the National Scheme.[6]

41. While not directly relevant to the immediate question of whether to publicly name an individual practitioner, AHPRA's initiative demonstrates the increased involvement of the public as part of regulation, and it is likely that a consumer reference group would have strong views about issues relating to transparency.

[6] https://www.ahpra.gov.au/About-AHPRA/Advisory-groups/Community-Reference-Group.aspx

Legal principles

Legal principles as the framework for the policy

42. Section 157G provides that a Naming Policy must be consistent with:

    a) The Act;
    b) The information privacy principles in the Privacy Act; and
    c) The general law (including natural justice rights).

43. There is considerable cross-over between the legal principles that can be drawn from the above sources. Reference to "the general law" is particularly broad. For immediate purposes, we will refer to the following here:

    - Consistency with the Act itself;
    - Principles drawn from the disciplinary jurisdiction, including open justice;
    - Right 6 of the Code of Health and Disability Consumers' Rights;
    - Principles drawn from the general law, including natural justice;
    - Transparency;
    - Privacy principles

Consistency with the Act

Principal purpose

44. The principal purpose of the Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions – section 3(1).

45. This means that all decisions made by the Councils, as statutory authorities established under the Act, must be in line with the Act's principal purpose. Often, this will mean that a Council's decisions must go directly against the interests or wishes of health practitioners regulated by the Council – whether individually in the context of case management, or collectively, in terms of policy requirements.

The function of the Naming Policy is consistent with the function of the Councils

46. Section 118 of the Act lists the functions of each authority in respect of the health profession(s) it regulates. Section 118(f) requires the Councils to receive information from any person about the practice, conduct, or competence of health practitioners and, if it is appropriate to do so, act on that information.

47. A Naming Policy that provides for the publication of the name of a practitioner where it is "appropriate to do so" would be consistent with the Councils' s 118(f) function.

Principles drawn from the disciplinary jurisdiction

48. The disciplinary jurisdiction is a source of well-developed case law that provides guidance on the task of balancing the practitioner's privacy interest against the public interest. We think that the underlying principles that can be drawn from the disciplinary jurisdiction are relevant and useful for immediate purposes.

49. However, we do sound a note of caution. The hearing of a professional disciplinary charge is substantively different from the orders and directions that will form part of the Naming Policy. We refer here to the disciplinary jurisdiction as a source of relevant principles – rather than suggesting that the approach taken by the Tribunal is directly applicable.

50. In the disciplinary jurisdiction, there is a statutory presumption that proceedings will be heard in public (s 95(1)). This includes a presumption that the relevant practitioner will be named.

51. There is no statutory presumption that practitioners who are subject to an order or direction made by the RA (and therefore those matters covered by the Naming Policy) will be named. However, it is one of the express purposes of a Naming Policy (s 157B(2)(b)) to:

> ensure that health practitioners whose conduct has not met expected standards may be named where it is in the public interest to do so.

52. While it falls short of the s 95 presumption, this express purpose does provide a strong legislative direction towards naming a practitioner whose conduct does not met expected standards.

53. With these preliminary comments in mind, we turn to consider some of the key principles that arise out of the professional disciplinary jurisprudence.

Case law supports weight of public interest

54. The factors supporting disclosure of a practitioner's name will be balanced against the adverse impact of publicity on the practitioner, his or her professional reputation and standing in the community, interest in personal privacy, practice and ability to earn a livelihood, the prospects for and impact of publicity on rehabilitation and the impact and stress on third parties, such as his or her family, business partners and colleagues. *Kewene v Professional Conduct Committee* [2013] NZHC 933.

55. The following factors are generally part of the Tribunal's consideration of whether name suppression orders are appropriate:

    a) The importance in a democracy of freedom of speech, open disciplinary proceedings and the right of the media to report the latter fairly and accurately as "surrogates of the public". *R v Liddell* [1995] 1 NZLR 538 (CA) at 547.

b) The freedom of expression guarantee in section 14 of the Bill of Rights Act (BORA) 1990. The purpose of the requirement that justice is administered in public is to maintain public confidence in the integrity of the disciplinary system and accountability for the exercise of disciplinary power, through the ability of the public to access and consider information about disciplinary proceedings and the workings of the disciplinary process. The public interest also includes the public knowing the identity of a health practitioner **charged with**, or found liable for, a disciplinary offence. *Hart v Standards Committee (No 1) of the New Zealand Law Society [2011[NZCA 676 at [9]*

c) Regard for the legislative intention of section 95 to dispel public suspicion that professional self-regulation creates a lack of impartiality in the process.

d) Publicity may be needed to avoid suspicion falling unfairly on other practitioners, to minimise the risk of further offending, or to encourage other victims to come forward, leading to the discovery of evidence or other offences". *Dr N v Professional Conduct Committee of Medical Council of New Zealand* [2013] NZHC 3405.

e) The public interest in educating the community by alerting it to risks to their health and safety is also a relevant factor. *Director of Proceedings v Nursing Council of New Zealand* [1999] 3 NZLR 360 (HC) at 379.

f) Given the protective purpose of the Act, an important consideration is whether publicity is necessary for the protection of the public and patients. *Guy v Medical Council of New Zealand* [1995] NZAR 67 (HC).

g) Something out of the ordinary in the nature of serious adverse consequence or a real likelihood of harm is generally required to outweigh the public interest in open justice. *Dental Board (QLD) v B* [2003] QCA 294.

56. In this context, the public interest and open justice principles generally favour the publication of the name of practitioner facing charges and in particular, in respect of whom charges are proven, so that existing and prospective patients and other practitioners contemplating referrals may make informed choices about whether to consult the practitioner or remain in his or her care. *Singh v Director of Proceedings* [2014] NZHC 2848 at [99].

57. A high level summary is delivered by Pankhurst J in T v Director of Proceedings (HC) Christchurch, CIV 2005-409-002244, 21 February 2006:

> *"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])*
>
> ***AND***
>
> "*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]).

The patient's right to be fully informed about a health practitioner

58. We think that a patient's right to be fully informed about the health practitioner who may provide services to the patient is a matter of considerable importance when developing the Naming Policy. In terms of s 157G, we would include this under the "general law" heading – but we deal with it separately here.

59. All health consumers have a right to all information that a reasonable consumer, in that consumer's circumstances, would expect to receive (Right 6(1) Code of Health and Disability Services Consumers' Rights).

60. For immediate purposes, the relevance of right 6(1) relates to the policy debate as to whether a reasonable patient would expect to be informed about the order or direction made by a RA so that the patient can make an informed choice about whether to use the practitioner.

61. There are some HDC opinions which are relevant:

    - A general surgeon was found to be in breach of right 6(1) for failing to disclose to a patient that the surgeon had restrictions on his practice. The surgeon was undergoing an audit by the Medical Council and his operating privileges were restricted due to competence concerns. The HDC held that the failure to inform the patient meant that the patient could not make an informed choice as to whether to proceed with surgery performed by the surgeon (03HDC19128);

    - In a similar case involving a general surgeon, in 2015 the HDC found a surgeon in breach of the right 6(1) for not disclosing voluntary restrictions on his practice. The HDC found that that the information about the restrictions *"may have influenced the man's decision to undergo the surgery at that time and place, and to have had it performed by that surgeon"* (12HDC01488);

    - A midwife who failed to inform the patient that she did not have an access agreement with the hospital was found in breach of right 6(1) (HDC08628);

    - A surgeon was found in breach of right 6(1) for failing to tell a patient about the surgeon's lack of experience in an innovative procedure (08HDC20258).

62. The Councils will need to think about what factors a reasonable patient might take into account when deciding on which health professional to attend. Would, say, a reasonable patient expect to know if the oral health practitioner or pharmacist he or she is considering consulting has recently had remedial orders imposed because of a finding that the practitioner failed to meet the required standard of competence?

63. The HDC clearly seems to be indicating that patients want – and are entitled – to know about restrictions on practice and other relevant matters, so that they can make an informed decision. This view might be seen as being supported by the proliferation of on-

line rating systems – including websites like ratemydoctor.com, indicating the public's interest in gathering information about health professionals to help them choose where to seek advice. Information on such sites might lack the reliability that the public desires – but, the trend towards such sites might well be a relevant factor for RAs when deciding whether the statutory power to name ought to be exercised.

The general law

Natural justice

64. The two key principles of natural justice are:
    a) Parties be given adequate notice and an opportunity to be heard; and
    b) The decision maker be disinterested and unbiased.

65. In addition, natural justice requires that both the substantive decision and the procedure followed in reaching the decision are ***fair***. Procedural fairness can be achieved by ensuring the above principles are followed. Substantive fairness means ensuring that the decision made is reasonable and appropriate in the circumstances. Achieving fairness might be achieved by – among other things – applying relevant "right touch" principles:
    a) the response is ***proportionate*** to the risk presented;
    b) the response is ***consistent*** with decisions made in similar situations, with the law, and with guiding policy.

66. The Act provides step-by-step guidance on good procedure where an RA's decision may impact adversely on the practitioner involved. For example, sections 27(4), 37(3), 43(2), and 51(4) (among others) each require the authority to give the practitioner notice of its proposed action, a copy of the information upon which it has relied in forming its provisional view, and a reasonable opportunity to respond to the proposed action.

67. Even when there is no mandatory requirement, there is a statutory obligation on the RA to observe natural justice (Cl 2, Sch 3).

Freedom of speech and open justice

68. The task of balancing competing public and private interests when a judicial decision-maker is considering naming or suppressing the identity of an individual inevitably involves the application of foundational principles relating to freedom of speech and open justice. The role played by an RA when making an 'order or direction' under the Act is different to the role of the courts – but, nonetheless, many of the same principles apply. The RAs are acting in a quasi-judicial capacity. Further, the rights affirmed by the New Zealand Bill of Rights Act must be observed by RAs.[7]

69. Freedom of expression, and the freedom to impart information, are affirmed by s 14 NZ Bill of Rights Act. Similarly, 'open justice' is fundamental to our system of law.[8]

[7] Section 3 NZ Bill of Rights Act.
[8] *Broadcasting Corp of NZ v AG* [1982] 1 NZLR 120 at 123. See also *Gravatt v The Coroners Court* [2014] NZHC 390 at [38].

70. In the coronial jurisdiction, the High Court has set a high threshold for granting name suppression to health practitioners who give evidence before a coroner. While there is a specific statutory test that is applied in the Coroners Act, the High Court has placed much emphasis on principles of open justice and freedom to impart information when setting a high threshold for name suppression.[9]

Other general law considerations

The practitioner's privacy interest balanced against public interest

71. This issue is, in our view, the key issue that the Councils will need to manage when setting out the principles they will apply in deciding whether to name a practitioner. The two interests to balance when considering naming are:
    a) The practitioner's privacy interest; and
    b) The strength of public interest in disclosure.

Ombudsman's report

72. In June 2016, the Office of the Ombudsman released an opinion on an Official Information Act (OIA) request for a health practitioner's complaint history held by the HDC.[10] The Ombudsman (Ron Paterson, former Health and Disability Commissioner) noted that the traditional response has been to accept that the practitioner has a privacy interest in their own complaint history; that withholding is necessary to protect the practitioner from reputational or other harm from disclosure; and that the public interest in disclosure does not outweigh the individual privacy interest. He considered it was timely to "*reconsider the approach taken by Ombudsmen to requests for a health practitioner's complaint history, in light of the growing recognition of the need for more transparency in the health sector*."

73. That opinion included useful guidance on factors to consider and, in the table below, we have adapted relevant parts of the guidance to provide a useful start point for development of policy considerations for Council when balancing interests.

Practitioner's privacy interest

Extent to which information is already known to the requester, or in the public domain	• The privacy interest may be diminished by prior knowledge or public availability of the information.
Age and relevance of complaint information	• The privacy interest may be higher if the matter is historical and of no current relevance. In this context, the disclosure of personal information about the health practitioner may be unfair.

[9] See *Gravatt,* above.
[10] http://www.ombudsman.parliament.nz/resources-and-publications/documents/request-for-health-practitioner-s-complaint-history-with-hdc

Whether the matter is substantiated	• The privacy interest is higher where the matter is unsubstantiated— the allegation made has not been formally upheld (i.e., at initial receipt of the notification, and while inquiries are being made or an investigation is being undertaken). • A health practitioner's legitimate expectation of privacy will be diminished where the matter has been substantiated (e.g., results of competence review, Tribunal decision).
Whether the investigation is ongoing	• Health practitioners are likely to have a higher privacy interest while the investigation of a matter is ongoing. Disclosing the existence of a matter during an ongoing investigation may unfairly suggest that there is substance to the matter.
Likelihood of harm arising from disclosure	• There may be factors that heighten the risk of personal or professional harm arising from disclosure of information, for example the physical or mental health of the health practitioner, or the size of the community in which they practise.
Minimising harm by placing information in context	• It is important to consider whether any potential harm from disclosure can be mitigated by releasing summary information with appropriate context.

Public interest in disclosure

Public safety	• Ensuring the safety and quality of health care and the competence of health practitioners. Non-disclosure in a particular case may run the risk of harm to future patients. Disclosure may elicit other complaints or concerns about a practitioner's competence.
Accountability of health practitioners and providers of health services	• Health practitioners are accustomed to being held to account for the standard of care or service they provide. They should expect that some information about their practice needs to be disclosed if serious accountability or health and safety concerns are raised.
Accountability of agency	• An agency receiving notifications about health practitioners is accountable for the proper discharge of its responsibilities in the assessment and investigation of those matters and in taking any necessary remedial action.
Public choice	• The right of the public and potential patients to know the relevant history of a particular practitioner to be able to make an informed choice whether to engage their services in the future.

Nature of information	• Does the information raise serious safety or competence concerns? Does non-disclosure raise a risk of harm to future patients? Complaints and concerns of a serious, as opposed to trivial or inconsequential nature, will raise stronger public interest considerations in favour of disclosure.
Number of notifications	• A high frequency of notifications, or notifications raising recurrent themes may be indicative of wider competence issues, and justify disclosure of additional information in the public interest.
Role of practitioner and seniority, degree of responsibility, and ability to impact on members of the public	• In relation to a DHB psychiatrist, former Ombudsman David McGee noted *'the competing public interest is also high, particularly where the employee in question held a position of responsibility in respect of particularly vulnerable members of society'*.
Action taken in respect of the matter	• The public interest in disclosure may be higher where a complaint has been investigated and found to be substantiated.
Extent to which information about the matter is already in public domain	• If information about the matter is already in the public domain, this may increase the public interest in disclosure of a summary about the outcome of the matter. The purpose of such disclosure would be to demonstrate that appropriate action has been taken to investigate and institute any protective measures or remedial action.
Age of complaint information	• The public interest in disclosure may be lower if the issues raised are historical and have minimal relevance.
Risk of harm or risk of serious harm	• Where the Council has formed a view that a practitioner poses a risk of harm or a risk of serious harm (under the relevant sections of the Act), that might weigh in favour of naming the practitioner.

Public interest against publication / risk of unintended policy consequences

74. The Act - combined with other leaps forward in the management of adverse events (such as the ACC framework for treatment injury, and the concept of open disclosure) - has gone a long way to reducing "defensive practice" in New Zealand.

75. In January 2019, the Professional Standards Authority (UK) published an update on progress with regard to (among other things) barriers to open disclosure. It noted that –

> "*…it is striking that the word 'fear' was mentioned when discussing barriers to being candid by 37 of the 60 organisations/individuals*

that responded to the questionnaire and calls for information. This could be fear of litigation, fear of the regulator striking a professional off their register, or fear of public and media perceptions and the ensuing impact on a professional's livelihood."[11]

76. The risk of being publicly named may incentivise providers to aim for an early resolution of the issue. While this may assist the individual complainant to find resolution, a drive to resolve the matter early may mean that the underlying issues are not properly unpacked and addressed – which may result in a repeat event further down the track. This has the potential to ultimately result in a failure to properly ensure that the public is protected.

Risk that practitioners will not make a notification about a colleague for fear of damage

77. In the context of the Act, health practitioners have discretion to refer concerns about competence to the relevant RA, and may also bring questions of conduct to an RA's attention. Many practitioners are already hesitant to use their discretion in relation to competence and conduct concerns – and may become more so if they believe it will lead to adverse publicity and impact on a colleague's career and wellbeing. It is likely that the professions will view with concern and scepticism any indication that naming will become "standard practice."

78. All of the above fears and concerns are relevant to the practitioners involved, and are understandable. But, it might be argued that they work against public protection. With that in mind, it is critical that the policy – and indeed the consultation around it - assures practitioners, as much as possible, that a decision to name a practitioner will be made judiciously, and in accordance with an appropriate decision framework that genuinely factors in the practitioner's privacy interests and risk of reputational damage.

[11] https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf?sfvrsn=100f7520_6

HDC Naming Policy

79. The HDC issued a Naming Policy in July 2008.[12] While relevant to consideration of the question of balancing a practitioner's privacy interests against public interest, it is worth noting that the policy is now over 10 years' old.

80. The HDC recognises that individual health providers have a greater privacy interest than organisations, and has indicated that naming may only be in the public interest if one or more of the following applies:

    - *Public safety concerns*
      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.

    - *Non-compliance with HDC recommendations in the event of a breach finding*
      In practice, 98% of practitioners comply with HDC recommendations. At the time of writing, the HDC had never named a practitioner for non-compliance, but noted that there have been occasions when this may have been appropriate.

    - *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.

81. Relevantly, the HDC's Naming Policy was promulgated at a time when Professor Paterson was the Commissioner. Professor Paterson was then the Ombudsman who ruled on the matter referred to above. Certainly the Ombudman's ruling goes much further than the HDC Naming Policy. It will be interesting to see what the current position is of the present Commissioner when his office is consulted on the Naming Policy (as is required by s 157C).

Privacy Act principles

82. The Councils are obliged to comply with their obligations under the Privacy Act 1993 in all of their activities. Specific mention is given, under section 157G, to the requirement to ensure that the Naming Policy has regard to the information privacy principles in section 6 of the Privacy Act.

83. For completeness, we will set out below the information privacy principles. However, the key point for immediate purposes is that the privacy principles reflect an individual's **private interest** in privacy – and that an individual's personal information should not be 'made public' without the individual's authorisation, or in accordance with one of the established exceptions.

84. Therefore the consideration by an RA of the information privacy principles will, in the main, be a recognition of the legitimate private interests an individual practitioner has in wanting to protect his or her reputation.

[12] https://www.hdc.org.nz/decisions/naming-policy/

85. The complete information privacy principles are (in brief, and in plain English):

Principle 1: Personal information shall not be collected by Council unless connected with a function of Council and necessary for a lawful purpose.

Principle 2: Where possible, Council will collect personal information from the individual concerned (noting that there are grounds to collect from elsewhere).

Principle 3: Council must ensure, that the individual concerned is aware of the reasons for collection, intended purpose, intended audience and other relevant circumstances.

Principle 4: Information must be collected lawfully and fairly, without unreasonable intrusion.

Principle 5: Information must be securely stored.

Principle 6: The individual concerned is entitled to their personal information where the information can be readily retrieved.

Principle 7: The individual concerned may request that information held be corrected.

Principle 8: The accuracy of the information must take reasonable steps to ensure the information is accurate before using it.

Principle 9: Council must not hold the information for longer than necessary

Principle 10: There are limits on the use of personal information held by Council unless certain grounds apply.

Principle 11: There are limits on the disclosure of personal information unless certain grounds apply.

Principle 12: Council shall not assign a unique identifier to an individual unless that is necessary to assist Council in carrying out its functions.

86. For immediate purposes, principles 10 and 11 are probably the most relevant. They recognise that the starting point is that the information should only be used or disclosed with the authorisation of the individual – unless one of the exceptions applies.

87. One of the key grounds on which information can be used without authorisation is where the information is being used for a purpose directly related to a reason why the information was collected (Rule 10(1)(e), and Rule 11(1)(a)). RAs collect information to ensure practitioners are competent and safe to practise – thereby protecting the public. Therefore use or disclosure that is consistent with the purpose for which the information was collected would be consistent with the information privacy principles.

88. Another justification for using or disclosing information without authorisation is whether such use or disclosure is necessary to prevent or lessen a serious threat to public health or public safety (Rule 10(d) and Rule 11(f)). For the purposes of principle 10(d) or 11(f), "serious threat" means a threat that Council reasonably believes to be a serious threat having regard to all of the following:
    (a) the likelihood of the threat being realised; and
    (b) the severity of the consequences if the threat is realised; and
    (c) the time at which the threat may be realised. (section 2(1) Privacy Act).

Office of the Privacy Commissioner – preliminary views

89. In a meeting with RAs about the Naming Policy, the Office of the Privacy Commissioner (OPC) gave some preliminary and informal views. It noted that the powers under section 157 to name a practitioner was an override of the Privacy Act and made it clear that practitioners could be named.

Good regulatory practice

Right touch regulation

90. As with the legal principles identified above, principles of good regulatory practice can and should apply to the Naming Policy where they support or complement the legal obligations set out above. Council has already identified that it subscribes to the principles of Right Touch and risk-based regulation. The principles of Right Touch Regulation are (in order of relevance to this issue):
    (a) Transparency
    (b) Accountability
    (c) Proportionality
    (d) Consistency
    (e) Targeting
    (f) Agility.

Transparency

91. As set out above, Parliament has given a clear steer that health regulation should be more transparent, in order to build public confidence. This principle supports the obligation on Council to be transparent and open where it is satisfied that public interest outweighs the practitioner's privacy interest with regard to publication of the practitioner's name.

Accountability

92. In the context of the Naming Policy, accountability and transparency go hand in hand. As a statutory authority, Council is accountable to the public, and needs to consider the extent to which publicly naming practitioners serves the ultimate purpose of improving public health and safety. Where there are significant public interest factors against naming, Council will need to take these into account, and consider whether there are alternative measures that it can take.

Proportionality

93. Again, the principle of proportionality supports the balancing exercise Council must undertake when determining whether to name a practitioner. A proportionate response includes consideration of the impact of publication of the practitioner's name on and his/her career and personal well-being, and determination that this is necessary in the circumstances.

Consistency

94. When considering application of the Naming Policy to any particular circumstance, Council will need to have regard to other decisions made. There is always some complexity in ensuring that each matter is considered on its individual facts, while also

ensuring that the practitioner in question is not being treated more or less harshly than Council has treated any other practitioner in a similar situation. A robust policy with strong decision-making guidelines will assist in the consistent application of Council's discretion to name practitioners in accordance with the Act.

Agility

95. Agility requires the regulator to anticipate, rather than looking back to prevent the last crisis from happening again. We suggest that giving consideration to naming a practitioner at every point when an order is made in relation to that practitioner is an appropriately agile response – including pre-empting risk of non-compliance by naming.

Targeting

96. Targeting requires the regulator to focus on the problem and minimise side-effects. It is the principle of targeting that has led to increased focus on risk-based regulation. In the context of the Naming Policy, Council is most likely to be considering naming an individual practitioner based on the circumstances of their case. That said, Council should ensure that its policy is appropriately targeted in the interests of the public.

97. This might mean, for example, that in some cases where there is significant media interest, and particular details (such as the practitioner's gender and general location) are available to the public, it may be appropriate to name the practitioner involved to protect other practitioners who meet the same criteria from suspicion.

Section 157B

Content

98. This section discusses the purpose and the required content of the Naming Policy. For ease of reference, we have included the full wording of the section below.

157B Authorities to issue naming policies

(1) Each authority must issue a Naming Policy not later than 12 months after this section comes into force.

(2) The purpose of the Naming Policy is to—

(a) enhance public confidence in the health professions for which the authority is responsible and their disciplinary procedures by providing transparency about their decision-making processes; and

(b) ensure that health practitioners whose conduct has not met expected standards may be named where it is in the public interest to do so; and

(c) improve the safety and quality of health care.

(3) A Naming Policy must set out—

(a) the class or classes of health practitioners in respect of whom the Naming Policy applies; and

(b) the circumstances in which a health practitioner may be named; and

(c) the general principles that will guide the authority's naming decisions; and

(d) the criteria that the authority must apply when making a naming decision; and

(e) the requirement to have regard to the consequences for the health practitioner of being named, including the likely harm to the health practitioner's reputation; and

(f) the procedures that the authority must follow when making a naming decision; and

(g) the information the authority may disclose when naming a health practitioner; and

(h) the means by which a health practitioner may be named.

The purpose of the Naming Policy - Subsection (2)

99. Subsection (2) sets out the three purposes of the Naming Policy. There is much cross-over here with what has already been considered. But, these three purposes are critical and we mention each here.

Enhancing public confidence by providing transparency – S 157B(2)(a)

100. It is important to recognise the connection that Parliament has made in s 157B(2)(a) between transparent decision-making and enhancing public confidence. We think a Naming Policy that is heavily weighed against naming practitioners where orders/directions are made would be inconsistent with the statutory direction given by Parliament in this subsection.

Naming practitioners whose conduct has not met expected standards – s 157B(2)(b)

101. The second statutory purpose of the Naming Policy is to ensure that practitioners *"whose conduct has not met expected standards"* may be named where it is in the public interest to do so.

102. We think this subsection allows for a principled distinction to be drawn between orders or directions that relate to a situation where a practitioner has not met expected standards on the one hand and, on the other hand, orders or directions that do not relate to a failure to meet expected standards.

103. So, for example, there is a material difference between the appropriateness of naming a practitioner where the practitioner has died and the RA directs cancellation on the one hand; and, on the other hand, an order that a practitioner undertake remedial action following a finding that the practitioner fails to meet the required standard of competence. We think that the latter scenario would be captured by the phrase *"whose conduct has not met expected standards".*

104. Subsection 157B(2)(b) directs matters to a consideration of the public interest. As noted in the legal analysis above, it is not sufficient to determine that there is public interest - the public's interest must outweigh the relevant practitioner's privacy interest.

105. In our view, inclusion in the policy of decision-making guidelines that assist Council to balance all the relevant considerations before arriving at a view will support good decision-making in this regard.

Improving safety and quality of health care – s 157B(2)(c)

106. The third statutory purpose of the Naming Policy is *"to improve the safety and quality of health care"*.

107. The implication from s 157B(2)(c) is that a reasonable and appropriate Naming Policy will assist in improving the safety and quality of health care. Presumably, the thinking is that the naming of practitioners in appropriate circumstances will either prompt health practitioners to improve their services (to avoid being named) and/or allow consumers to make a more informed choice about who to consult – and, directly and indirectly, the safety and quality of health care will be improved as a consequence.

108. When the 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 focus on similar problems at other hospitals.

109. 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* [1993] 3 NZLR 360, 381-382:

"It 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."

110. 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.

111. As noted above, the counter-argument is that the fear of being named might discourage otherwise well-meaning practitioners from raising concerns about themselves or colleagues. Certainly over recent decades there has been a strong school of thought that the best way to improve the quality of health service is by providing a safe and protected mechanism in which practitioners can raise concerns without fear of reprisal – with the Protected Quality Assurance Activity mechanism in part 3 of the Act being one example. Similarly, the Health Quality and Safety Commission de-identifies individual practitioners when reporting on adverse events. Such arguments have attracted widespread and mainstream support over the last 20 years – and may well be relevant to an RA seeking to find the right balance in setting the policy direction for its Naming Policy.

Punishment of the practitioner is not part of the Naming Policy's purpose

112. We think it is important to record that that punishment of the practitioner is not part of the policy's intended purpose, and we recommend that the Councils' policies explicitly provide that any punitive considerations will not form part of their deliberations on whether to publicly name a practitioner.

Summary of recommendations

Key issues

1. In our view, the key principle that the Councils need to provide for is a requirement to balance an individual practitioner's privacy interest against that of the public interest. Every case will be different as to the weight given to each of these two interests, and so the Naming Policy will need to provide the Councils with robust guidance on finding the appropriate balance in the particular circumstances.

Recommendations for policy direction decisions

We recommend that:

2. The Councils' policy positions embrace and respond appropriately to Parliament's direction to improve transparency for the public. This includes ensuring that internal processes support **consideration** of naming whenever an order is made. It may also be appropriate to use the statutory requirement for consultation to consider introducing a communications plan directed towards the public, with a view to building confidence that the Councils take a considered approach to naming, with public interest at the heart of their decisions.

3. The Councils agree that their Naming Policies will:
    - ensure that the Council does not limit the statutory discretion given to it in s 157(1);
    - set out the principles that will be considered in each case – but will leave the Council with sufficient discretion to make each decision on the basis of all the particular circumstances;

4. The Councils carefully work through the exhaustive list of orders and directions, and consider whether there are any generalisable principles that might be set out in relation to some or all of these. More specifically, consideration should be given to whether there ought to be a rebuttable presumption either in favour of naming practitioners or not naming practitioners when an order or direction is made in relation to any of the orders or directions that can be made under the Act – and, in particular orders or directions about:
    - health issues;
    - competence issues – including an order to undertake remedial action following a finding that the practitioner fails to meet the required standard of competence;
    - conduct issues; and
    - interim orders made about a practitioner where the Council believes there is a risk of harm or risk of serious harm.

5. Each Council adopts a policy position that it will turn its mind to the question of naming a practitioner in accordance with its Naming Policy when an order or direction is made.

6. Each Council agrees that one of the policy's main roles is to assist it in ensuring each practitioner's privacy interest is balanced appropriately against the public interest. Where the balance is even, we recommend that the policy provides that the Councils decide in favour of public interest.

7. Each Council needs to consider how minded it is likely to be to err on the side of naming, in terms of the spectrum from rare naming to frequent naming. While no RA can say 'we will never name' or 'we will always name' when a particular order is made, an established and stated policy position will help set the tone and direction of the Naming Policy.

8. Each Council agrees that punishment of the practitioner will not form part of its consideration when deciding whether to publicly name the practitioner, and that its Naming Policy will expressly state this.

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Appendix 1

History of relevant cases

Dr A (Dental Council)

1. Following a competence review in 2014, the Dental Council identified significant concerns about Dr A's practice and made orders under section 39 of the Act for interim suspension of his practising certificate pending completion of the requirements of his competence programme.

2. Dr A continued to practise after his suspension had taken effect. This was brought to the Dental Council's attention by ACC and, at its meeting in July 2015, the Dental Council resolved (among other things) to:
    a) Publish a notice in the local newspapers *[redacted],* under section 157(1) of the Act, to inform the public Dr A was suspended from practising dentistry; and
    b) Notify the New Zealand Dental Association, the *[redacted]* Dental Association, and the local general medical practices of Dr A's suspended practising status; and
    c) Notify Dr A of the Dental Council's intention to publish a notice of his suspension in the local newspapers, prior to publication.

3. This was an entirely appropriate use of section 157(1) in the circumstances. With the benefit of hindsight, it may have been appropriate to consider naming Dr A when orders were made for the interim suspension of his practising certificate. However, it was also reasonable at the time for the Dental Council to assume that, as a professional, Dr A would abide by his regulator's orders.

Mr B (Pharmacy Council)

4. In mid-August 2015, the Pharmacy Council wrote to Mr B in relation to criminal charges against him that related directly to his practice as a pharmacist. The circumstances giving rise to the charges included:
    - Criminal nuisance relating to alleged supply of excessive amounts of Nurofen Plus® to patients without recording the sale in the practice system. Excessive consumption of the medicine led to one patient's admission to hospital with life-threatening conditions;
    - Alleged supply of excessive quantities of the prescription medicine zopiclone to a restricted person formally identified as being dependent to prescription medicine, particularly zopiclone. The transaction for this supply was 8400% in excess of a reasonable commercial transaction, and was made to his personal bank account. The patient consumed the zopiclone and was later found in a serious medical condition. He was placed on life support, which was subsequently removed, and the patient died.
    - Alleged compliance with requests to conceal the supply of zopiclone to the above patient.
    - Alleged supply of excessive quantities of zopiclone to unknown persons over the course of 10 months, with 1250 tablets unaccounted for.

- Alleged supply of Relieve® (paracetamol 500 mg and codeine 8 mg) to a patient without a legal prescription and in excessive quantities, and at a transaction around 1900% in excess of what would be considered a reasonable commercial transaction.
- Alleged supply of Relieve® to unknown persons over a 10-month period, with more than 3500 tablets unaccounted for.
- Alleged attempt to pervert the course of justice by modifying a previous prescription, forging the doctor's signature, and attempting to present it as a legitimate prescription.

5. The Pharmacy Council proposed making interim orders under section 69 of the Act, and to publish a notice regarding Mr B under section 157(1) of the Act. Having invited submissions from Mr B, the Pharmacy Council considered the matter in late April and resolved to order the interim suspension of his practicing certificate, and to publish a notice to that effect under section 157(1) of the Act. The notice was published in Pharmacy Today, in the New Zealand Herald, and on the Pharmacy Council's website, as follows:

> ***Public Notice of Interim Suspension of Annual Practising Certificate – Mr [B] of [redacted]***
>
> *The Pharmacy Council brings to the public's attention that effective 3 September 2015, an order has been made under the Health Practitioners Competence Assurance Act to interim suspend Mr [B's] Annual Practising Certificate. Mr [B's] ability to practice as a pharmacist has been suspended until a further order is made by Council.*
> *Andrew Bary*
> *Chair*

6. In the circumstances, the Pharmacy Council's actions were entirely appropriate. There was evidence before it that Mr B had caused serious harm (and in one case, death) to at least two patients, and had also demonstrated behaviours indicating a disregard for his legal and professional obligations, including "under the table" transactions that were clearly putting vulnerable patients at risk. This behaviour would indicate and increased likelihood of non-compliance with any Council orders.

Mr C (Pharmacy Council)

7. Mr C's employment was terminated after he admitted taking a packet of LA Morph 10mg home from the pharmacy for his own use, and that this had occurred once or twice before.

8. Upon receipt of the notification, the Pharmacy Council's health committee ordered the interim suspension of Mr C's practising certificate under section 48 of the Act, and ordered him to undergo a medical examination under section 49 of the Act.

9. Mr C's medical assessor indicated that Mr C's history and behaviours were consistent with Opiate Use Disorder, but also suggested a possible underlying Somatic Symptom Disorder. He considered that Mr C was not fit to practise as he was in the very early stage of opiate substitution treatment, and there was a significant risk of relapse without a coordinated treatment plan.

10. The Pharmacy Council ordered the suspension of Mr C's registration under section 50(3) of the Act, pending evidence of three months' abstinence.

11. Were this situation to arise after the introduction of the Naming Policy, it would be appropriate for the Pharmacy Council – having made an order - to turn its mind to naming Mr C. However; given the weight of his privacy interest in terms of his personal health information, and the lack of evidence indicating any immediate or apparent risk to public safety, we would expect that this matter would be unlikely to reach the threshold for a section 157(1) publication.

Mr D (Pharmacy Council)

12. Mr D faced serious criminal charges, including alleged use of controlled drugs in committing sexual offences. It was alleged that due to his occupation as a pharmacist Mr D had access to a wide range of controlled drugs. An audit of Mr D's practice showed a number of controlled drugs unaccounted for which coincided with the dates of his alleged offending; more recently, a search of his home had located a variety of controlled drugs at that address. Mr D was on bail, with conditions relating to where he must reside (with an overnight curfew) and not to consume drugs (among other things).

13. The Pharmacy Council made orders under section 69 for the interim suspension of Mr D's practising certificate. It also considered publishing his name under section 157(1) of the Act, but ultimately decided that, due to Mr D having been granted name suppression in the criminal jurisdiction, there was a risk that naming him may breach those suppression orders.

14. We think that on the facts of the matter this was an entirely reasonable conclusion to draw, but we would not go so far as to say that a practitioner must never be named under section 157(1) where name suppression orders are in place in another jurisdiction. That is a complex question and will require careful consideration based on the relevant facts of the case. We would recommend legal advice is sought in such situations.