



Request for health practitioner's complaint history with HDC

Legislation	Official Information Act 1982, ss 4(a), 4(c), 9(1), 9(2)(a)
Requester	Otago Daily Times
Agency	Health and Disability Commissioner
Ombudsman	Professor Ron Paterson
Case number	355627
Date	June 2016

Contents

Summary	2
Background	2
Complaint	3
Investigation	3
HDC submissions	3
Analysis and findings	4
General discussion	4
Privacy interest	5
Public interest considerations	5
General principles	6
Opinion	7
Appendix 1. General principles	8
Privacy interest	8
Public interest	10
Application of general principles	13

Summary

The requester, a reporter at the Otago Daily Times (ODT), sought details of complaints made to the Health and Disability Commissioner (HDC) against a midwife. HDC refused the request under section 9(2)(a) of the Official Information Act 1982 (OIA), in order to protect the privacy of natural persons. Having reviewed the information at issue, I conclude that, on the facts of this case, HDC was entitled to rely on section 9(2)(a) of the OIA to refuse the request.

It is 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. As Ombudsman, I have developed general principles to guide HDC in responding to future requests for the complaint history of a health practitioner. The principles may also be a useful guide, by analogy, for District Health Boards (DHBs) responding to OIA requests for a health practitioner's complaint history. The general principles are attached as Appendix 1.

Background

1. On 18 February 2013, ODT journalist Tracey Roxburgh covered a Health Practitioners Disciplinary Tribunal hearing into the alleged professional misconduct of a midwife. The complaint that led to the charges of professional misconduct against the midwife was made by a maternity services consumer (consumer). At the end of a four day hearing the Tribunal found the charges against the midwife had not been proven and it lifted an order for interim name suppression.
2. The ODT published several articles by Ms Roxburgh, including a story about the consumer's reaction to the Tribunal's decision.
3. On 26 February 2013, Ms Roxburgh telephoned HDC to enquire about obtaining '*details of other complaints laid against [the midwife]*'. Ms Roxburgh spoke to the Director of Proceedings, who said he '*would get back to her*'. Ms Roxburgh understood this to mean that HDC would contact her and explain how to make a formal request for the information.
4. On 5 March 2013, Ms Roxburgh received an email from HDC's Chief Legal Advisor. The email was headed '*Enquiry: Your OIA request re [the midwife]*' and contained a decision on her request:

I write in response to your telephone call to [the] Director of Proceedings, on 26 February 2013 in which you requested under the Official Information Act 1982 (OIA) all complaints regarding [the midwife].

I have considered your request under the OIA and have decided to decline it under section 9(2)(a) of that Act. The decision is made on the basis that I consider that any public interest in making the requested information available to you is outweighed by the privacy interests concerned.

Complaint

5. On 22 March 2013, Ms Roxburgh complained to the Ombudsman about HDC's decision to refuse to provide details of other complaints laid against the midwife.

Investigation

6. In September 2013, HDC was notified that the Chief Ombudsman intended to investigate Ms Roxburgh's complaint.
7. That same month, HDC provided information to the Chief Ombudsman to assist her investigation. Further information was provided in March 2014.
8. In May 2014, the Privacy Commissioner provided advice on the privacy issues raised in this case in response to consultation by the Chief Ombudsman under section 29B of the OIA.
9. Further consultation with the Privacy Commissioner occurred in December 2014 and January 2015.
10. In March 2015, HDC was asked to comment on a provisional opinion. HDC responded to the provisional opinion in May 2015.
11. I assumed responsibility for this investigation in February 2016, and took the following steps.
 - a. In March 2016, the ODT was contacted to discuss the provisional opinion and proposed general principles developed during my investigation. The ODT accepted that it was an appropriate outcome in the circumstances.
 - b. In April 2016, HDC was asked to comment on a draft final opinion.
 - c. At the same time, I consulted with the Privacy Commissioner on the draft final opinion.
12. HDC responded to the draft final opinion in April 2016.
13. Further comments were received from the Privacy Commissioner in May 2016.

HDC submissions

14. HDC reiterated submissions it had made previously, in the context of another investigation and review by former Ombudsman David McGee (case number 282209):

[I do] not consider that disclosing a health practitioner's complaint history would play any significant role in ensuring public safety. Rather, that is primarily the domain of the relevant regulatory authority and, where applicable, the employer of the provider. I also do not consider that making

complaint history available will improve patient choice as, in many circumstances, patients do not have a choice of provider...

15. HDC further submitted that whether it is appropriate to publicly release a provider's complaint history will depend entirely on the circumstances. Any decision needs to consider all of the relevant circumstances, including that:
- a. certain providers attract more complaints due to the nature of their practice, and therefore the number of complaints does not properly represent concerns about that provider's competence (for example, ACC assessments and plastic surgery);
 - b. some consumers complain frequently and there may be little substance to their complaints;
 - c. advising the Medical Council of a pattern of complaints is different from putting a complaint history in the public arena—the Medical Council has the ability to judge the seriousness of complaints and whether concerns about competence are valid in light of other information that it holds, whereas the public are generally not in a position to do so;
 - d. the release of information without context, for example comparative provider complaint histories, '*[a]t best ... runs the risk of being meaningless; at worst, it may cause undue concern and alarm for patients*'; and
 - e. Australian data regarding complaint histories does not necessarily translate to the New Zealand context:

HDC's close working relationship with the regulatory authorities and other relevant agencies means that we are able to, and do, raise concerns about particular providers through the appropriate channels.

16. HDC submitted that public safety is primarily the domain of the regulatory authorities and that their oversight role means that there is no over-riding public interest in disclosing the complaint history of a health practitioner. HDC relied on a statement made by former Ombudsman David McGee (in case number 282209), that it is the role of HDC and the Medical Council to assess the '*competency of medical practitioners*', and that the oversight provided by these agencies is sufficient to meet the public interest in the availability of information about the adequacy of care provided by, and competence of, a health practitioner.

Analysis and findings

General discussion

17. The Ombudsman periodically receives complaints about decisions made by HDC and DHBs to refuse a request for the complaint history of a health practitioner. Such requests are usually made by an unhappy patient or family, or by the media. They may follow publicity surrounding a Coroner's inquest or a Health Practitioners Disciplinary Tribunal

hearing, or when a patient or family has given the media details of an adverse event or complaint, and raised concerns about the competence or conduct of a practitioner.

18. Both HDC and DHBs generally refuse such requests, invoking the privacy interest of the health practitioner as a good reason to withhold the information under section 9(2)(a) of the OIA.
19. Where the requester complains to the Ombudsman about the agency's refusal, absent special considerations, the traditional approach 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.
20. These cases go to the heart of one of the purposes of the OIA, *'to protect official information to the extent consistent with the public interest and the preservation of personal privacy'* (section 4(c)).
21. It is 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, and having regard to another of the purposes of the OIA, *'to increase progressively the availability of official information to the people of New Zealand'* (section 4(a)).
22. The Chief Ombudsman has recently issued a guide to the public interest test ([Public interest—A guide to the public interest test in section 9\(1\) of the OIA and section 7\(1\) of the LGOIMA](#)), which I have taken into account when forming this opinion and developing the general principles set out in Appendix 1.

Privacy interest

23. From the perspective of the individual health practitioner, there will always be a high privacy interest in internal records of complaints and concerns held by HDC or an employer about that practitioner.
24. Depending on the situation at the time of the request, it may no longer be **necessary** to withhold the information to protect privacy. Examples include where the requester knows about the prior complaints or where their existence is already in the public domain.

Public interest considerations

25. There is no single public interest consideration in relation to OIA requests about the complaint history of a health practitioner. A range of public interests need to be taken into account, including:
 - a. transparency about complaints and concerns about health practitioners;
 - b. the safety and quality of health care and the competence of health practitioners;

- c. fairness to practitioners who may suffer reputational damage where complaints are made public (especially where the complaint has not been investigated and may not even have been notified to the practitioner); and
 - d. accountability for the performance of HDC (as the public watchdog agency responsible for assessing and investigating complaints about health practitioners) and DHBs (in monitoring the quality of health and disability services).
26. I note HDC's concerns about the ability of the public to contextualise information about a health practitioner's complaint history. The likelihood that information will be taken out of context is often raised as a concern by agencies subject to the OIA. However, in many cases such harm can be mitigated by disclosure of additional information that gives appropriate context.
27. I do not accept that the co-regulatory roles of HDC and the relevant responsible authority (such as the Midwifery Council in this case) mean that the public interest in public safety can effectively be discounted and thus complaint history information should not be disclosed under the OIA. There is a significant public interest in the public being able to access information about:
- a. complaints made to a statutory agency such as HDC, given its high profile and statutory role in assessing and investigating complaints against health practitioners; and
 - b. the outcome of HDC's handling of a complaint.
28. I acknowledge HDC's concern that certain providers attract more complaints due to the nature of their practice and that the number of complaints may not of itself raise legitimate concerns about a provider's competence. I appreciate that some complainants make frequent complaints, often with little substance. However, the release of contextual information about the nature of the relevant practice can help address the former concern. Likewise, release of information about the source (eg, from the same complainant) or minor nature of the relevant complaints can satisfactorily address the latter concern.

General principles

29. The general principles attached as Appendix 1 have been developed as a guide for future cases where requests are made under the OIA to HDC for a health practitioner's complaint history. The principles may also be a useful guide, by analogy, for DHBs responding to OIA requests for a health practitioner's complaint history.

Opinion

30. Having reviewed the information at issue in this case against the general principles, I consider that the public interest in disclosure did not, at the time of HDC's decision on Ms Roxburgh's request, outweigh the need to withhold details of any complaint history of the midwife, in order to protect her privacy. I conclude that the HDC was entitled to refuse the ODT's request under section 9(2)(a) of the OIA.

Appendix 1. General principles

1. These general principles have been developed to clarify the application of the Official Information Act 1982 (OIA) to requests made to the Health and Disability Commissioner (HDC) for a health practitioner's complaint history with HDC.¹
2. The principles may also be a useful guide, by analogy, for District Health Boards (DHBs) responding to OIA requests for a health practitioner's complaint history.

Privacy interest

Patient confidentiality and privacy of complainants

3. When a person (other than the complainant) requests information from HDC about a health practitioner's complaint history, a paramount consideration is the need to protect patient confidentiality and the privacy of complainants. Specific consideration should be given to the extent to which providing the requested complaint history of a health practitioner may affect the privacy of an individual patient or complainant.

Privacy of health practitioners

4. The need to protect the privacy of health practitioners is an important factor, as affirmed in section 9(2)(a) of the OIA, which recognises that there may be good reason to withhold information in order to protect the privacy of natural persons.

General comment

5. It is well established in previous Ombudsman opinions and in advice from the Privacy Commissioner that:
 - a. the complaint history of a health practitioner is personal information about that person; and
 - b. subject to consideration of the specific factors set out below, it will often be necessary to withhold that information in order to protect their privacy.
6. The Privacy Commissioner has noted that a strong professional reputation is invaluable in the health industry, and the privacy interest in such information will often be very high. The High Court, in *Director of Proceedings v I*, commented that '*the consequences of publicity for a professional ... can be particularity acute*'.²

¹ These principles will also apply to individual health care providers who are not health practitioners (ie, unregistered practitioners), subject to the important qualification that in such cases there is no '*responsible authority*' (under section 5(1) of the Health Practitioners Competence Assurance Act 2003) or regulator to ensure the competence of such practitioners and protect the health and safety of members of the public.

² [2004] NZAR 635 at 653.

Specific factors to consider

7. A number of specific factors are relevant considerations when assessing the strength of the privacy interest in a particular case.

<p>Extent to which information is already known to the requester, or in the public domain</p>	<ul style="list-style-type: none"> The privacy interest may be diminished by prior knowledge or public availability of the information.
<p>Age and relevance of complaint information</p>	<ul style="list-style-type: none"> The privacy interest may be higher if the complaints against the health practitioner are historical and of no current relevance. In this context, the disclosure of personal information about the health practitioner may be unfair.
<p>Whether the complaint was substantiated</p>	<ul style="list-style-type: none"> The privacy interest is higher where the complaint against a health practitioner is unsubstantiated—ie, the allegation made against the practitioner in the complaint has not been formally upheld.³ Conversely, a health practitioner’s legitimate expectation of privacy will be diminished where complaints made about them have been substantiated.
<p>Whether the investigation is ongoing</p>	<ul style="list-style-type: none"> Health practitioners are likely to have a higher privacy interest while the investigation of a complaint against them is ongoing. Disclosing the existence of a complaint during an ongoing investigation may unfairly suggest that there is substance to that complaint.
<p>Likelihood of harm arising from disclosure</p>	<ul style="list-style-type: none"> There may be factors that heighten the risk of personal or professional harm arising from disclosure of a health practitioner’s complaint information, for example the physical or mental health of the health practitioner, or the size of the community in which they practise. In some situations, there may be no risk of harm from disclosure, for example where there have been no complaints made against a health practitioner. Confirmation that no complaints have been received may be to a health practitioner’s benefit rather than detriment. However, routine confirmation of the fact that no complaints have been received may give rise to a suspicion, in other cases where information has been withheld, that complaints have been received.

³ Complaints to HDC may only formally be ‘upheld’ by a breach finding following a formal investigation.

Minimising harm by placing information in context	<ul style="list-style-type: none"> It is important to consider whether any potential harm from disclosure can be mitigated by releasing summary information with appropriate context. For instance, where a complaint does not warrant investigation, or is not substantiated following investigation, the release of contextual information may reduce the harm of disclosure.
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Public interest

8. Section 9(1) of the OIA requires consideration to be given to whether the withholding of the information is outweighed by other considerations which render it desirable, in the public interest, to make the information available.

General public interest considerations

9. The following factors may heighten the strength of the public interest in disclosure.

Public safety	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 complaints may need to be disclosed if serious accountability or health and safety concerns are raised.
Accountability of complaint-handling agency	<ul style="list-style-type: none"> An agency receiving complaints about health practitioners is accountable for the proper discharge of its responsibilities in the assessment and investigation of complaints and in taking any necessary remedial action. This factor has particular strength in the context of complaints received by the HDC, given its role as a national public 'watchdog' in relation to complaints against health practitioners.
Public choice	<ul style="list-style-type: none"> The right of the public and potential patients to know the complaint history of a particular practitioner so as to be able to make an informed choice whether to engage their services in the future.

Specific factors to consider

10. A number of specific factors may heighten the strength of the public interest in disclosure in a particular case.

<p>Nature of complaints</p>	<ul style="list-style-type: none"> Does the complaint raise serious safety or competence concerns? Does non-disclosure raise a risk of harm to future patients? Complaints of a serious, as opposed to trivial or inconsequential nature, will raise stronger public interest considerations in favour of disclosure.
<p>Number of complaints</p>	<ul style="list-style-type: none"> A high frequency of complaints or complaints raising recurrent themes may be indicative of wider competence issues, and justify disclosure of additional information in the public interest.⁴ As I have noted in academic commentary on the ‘<i>frequent flier</i>’ issue:⁵ <p><i>[A]bove a certain threshold (eg, three or more complaints within three years) commissions and medical boards should make the number and nature of multiple complaints against an individual doctor a matter of public record – a move consistent with public expectations of greater transparency of health information, and with freedom of information laws. Avoiding public naming on an official agency’s list of complaint-prone doctors would undoubtedly be a powerful incentive to settling complaints and addressing the underlying problem behaviour. The current veil of secrecy over most complaints (which avoid publicity by never reaching the stage of disciplinary proceedings) allows repeat offenders to continue unheeded.</i></p> Under HDC’s protocol with the Medical Council (2009), HDC agrees to notify the Council ‘when HDC is aware of three or more similar “low level” matters relating to a registered medical practitioner within the past five years, which may indicate a pattern of conduct indicative of wider competence concerns’. It is arguable that, if HDC accepts that a pattern of low level complaints (three in five years) may indicate wider competence concerns and give rise to an obligation to proactively notify the registration body, there may be a public interest in providing some complaint-related information in response to a request under the OIA.

⁴ Research found that 3 per cent of doctors accounted for 49 per cent of complaints to Australian healthcare complaint commissions, and that a doctor’s complaint history predicts their risk of attracting future complaints. By the time of a third complaint, there is a 57 per cent probability of that doctor facing another complaint within two years. Bismark MM, Spittal MJ, Gurrin LC, et al. ‘*Identification of doctors at risk of*

<p>Role of practitioner and seniority, degree of responsibility, and ability to impact on members of the public</p>	<ul style="list-style-type: none"> In the context of an OIA complaint against a DHB about the withholding of complaint information pertaining to a psychiatrist, former Ombudsman David McGee noted <i>‘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’</i>.⁶ In that case, Dr McGee concluded: <ul style="list-style-type: none"> <i>... the public interest would be met by release of information in summary form including the number and nature of complaints, a description of steps taken to investigate those complaints, and the outcome of the investigation.</i>
<p>Action taken in respect of complaint/outcome of complaint</p>	<ul style="list-style-type: none"> The public interest in disclosure may be higher where a complaint has been investigated and found to be substantiated. In the case of HDC it will be relevant whether a breach was found and, if so, the seriousness of that breach. However, the lack of an investigation does not necessarily mean there is no public interest in release. The vast majority of complaints made to HDC are not subject to formal investigation,⁷ although they <i>‘undergo thorough and extensive assessment, including obtaining and analysing provider responses, clinical records, and expert advice as appropriate’</i>.⁸
<p>Extent to which information about the complaint is already in public domain</p>	<ul style="list-style-type: none"> If information about the complaint is already in the public domain, this may increase the public interest in disclosure of a summary about the outcome of the complaint. The purpose of such disclosure would be to demonstrate that appropriate action has been taken to investigate the complaint and institute any protective measures or remedial action.
<p>Age of complaint information</p>	<ul style="list-style-type: none"> The public interest in disclosure may be lower if the complaints are historical and have minimal relevance.

recurrent complaints: a national study of healthcare complaints in Australia’. BMJ Qual Saf 2013; 22:532–540. Retrieved from <http://dx.doi.org/10.1136/bmjqs-2012-001691>.

⁵ Paterson, R. *‘Not so random: patient complaints and “frequent flier” doctors’*. BMJ Qual Saf 2013; 22:525–527. Retrieved from <http://dx.doi.org/10.1136/bmjqs-2013-001902>.

⁶ Opinion of Ombudsman David McGee, January 2013, ref 311710 (unpublished).

⁷ Approximately 95 per cent of complaints made to HDC are not subject to formal investigation: Health and Disability Commissioner, *Annual Report for the year ended 30 June 2015*, p 13.

⁸ Information provided by HDC to Ombudsman, April 2016.

Is the public interest met through existence of the HDC and Medical Council?

11. The public interest in disclosure should not be discounted simply because of the assumed proper oversight of the HDC and regulatory bodies such as the Medical Council.
12. The oversight of these agencies is vital in addressing the public interest in patient safety and practitioner accountability. However, there is also a public interest in promoting the accountability of the agency that received the complaint for the performance of its functions in assessing and investigating that complaint and ensuring appropriate remedial action is taken.
13. Other public benefits may accrue from greater transparency in this area, including possible incentives for practitioners to improve and maintain service standards and to take appropriate action to resolve a complaint, and enabling people to make an informed choice before engaging the services of a practitioner.

Relevance of whether the requester is a member of media

14. The public interest considerations in favour of disclosure may differ depending on the nature of the requester. Given the important democratic and constitutional role of the media in informing members of the public, there may be a stronger public interest in disclosure to a media requester. As the courts have recognised (in articulating the rationale for openness in judicial proceedings), the media act as the '*surrogates of the public*'.⁹

Application of general principles

15. A blanket approach to withholding practitioner complaint histories on privacy grounds is not supported by the OIA.
16. In certain circumstances, taking account of the factors set out above, there may be a public interest in 'lifting the veil' on a health practitioner's complaint history sufficient to outweigh their individual privacy interests.
17. The public interest may not necessarily require full disclosure of the precise information sought by the requester. It may instead be appropriate to strike a balance between competing private and public interests by releasing summary information, with contextual statements and subject to any necessary caveats regarding matters such as:
 - a. the number and nature of complaints;
 - b. the steps taken to assess and investigate or otherwise resolve those complaints;and

⁹ *R v Liddell* [1995] 1 NZLR 538, 546-547.

- c. the outcome of any investigation, including remedial actions taken.
18. On receipt of an OIA request for information about a health practitioner's complaint history, HDC should weigh the factors set out above in the context of the specific case and consider whether some information needs to be disclosed to meet the public interest.
 19. When HDC forms the view that some information does need to be disclosed, it will be best practice to make the practitioner aware of its decision, in advance of any proposed release—giving the practitioner an opportunity to make HDC aware of any relevant factors that it should take into account in its decision making.
 20. HDC may also need to weigh the privacy interest of the complainant, if that person is not the requester, and consider consulting them. An extension of the time limit for making and communicating a decision on the OIA request may be made for that purpose.
 21. On investigation and review of HDC decisions on requests for health practitioner complaint histories, the Ombudsmen will as a matter of standard practice request a copy of the information at issue. Additional information may also be required to gain a better understanding of the various competing interests. This may include (if it is not already covered by the request):
 - a. copies of the previous complaint(s);
 - b. copies of the triage form in respect of the provider (including information from their registration authorities); and
 - c. copies of HDC's decision letters on the previous complaints.

In some cases it may be necessary to see the entire HDC file.

This additional information will assist the Ombudsmen to fully understand the number and nature of complaints, the steps taken to investigate or otherwise resolve those complaints, relevant practitioner history, and the outcome of any HDC assessment and investigation, including remedial actions.