Dee St
MEDICAL CENTRE

OPEN DISCLOSURE POLICY & PROCEDURE 2024

MISSION STATEMENT

We Aim to:

- Provide quality family health care.
- Maintain confidentiality and integrity.
- Keep our skills, knowledge, and systems up to date.
- Work as a team.
- Maintain a friendly and relaxed atmosphere.
- Cater for our culturally diverse community.

PURPOSE

"Right 6 of the Code of Health and Disability Services Consumers' Rights gives all consumers the right to be fully informed (i.e. to receive the information that a reasonable consumer, in his or her situation, would expect to receive). Consumers have a right to know what has happened to them," (Health and Disability Commissioner, 2009).

Right 6(1) further stipulates it is seldom reasonable to withhold information about a patient from that patient.

Dee Street Medical Centre, and the providers within the practice, understand they "have a legal duty to promote the disclosure of such information in accordance with their individual or organisational duty of care" (Health and Disability Commissioner, 2009).

Dee Street Medical Centre understands open disclosure is a process of on-going communication that needs to continue until the patient (and/or the patient's representative or the suitable person who has been informed) has all the information and support needed.

The Health and Disability Commissioner's "Guidance on Open Disclosure Policies" includes more detailed information about the importance of open disclosure and relevant rights under the code (see Appendix A).

PARTIES

All employees, contractors, volunteers, student doctors, student nurses or other health providers working within the premises of Dee Street Medical Centre.

TIMING

After the event has occurred and if the patient is clinically stable, the patient's registered provider will make the first contact within 24 hours of the event occurrence or from the realisation an error or harm has occurred.

If the incident occurred in a team environment, the team will endeavour to meet first and discuss the matter prior to contacting the patient however; this will not be a reason for delaying patient contact. Disclosing the event occurrence to the patient within the first 24 hours will be prioritised over this meeting.

In the immediate aftermath of an adverse event, the providers may not have answers for the event. Disclosing the event occurrence to the patient within the first 24 hours will be prioritised over finding answers.

A registered provider may wish to enlist the services of their insurance provider e.g. Medical Assurance Provider (MAS) for communication guidance. Disclosing the event occurrence to the patient within the first 24 hours will be prioritised over obtaining advice from MAS.

PREPARING FOR THE DISCLOSURE

Within the first 24 hours, prior to first communication with the patient or the patient's representative, personnel employed by Dee Street Medical Centre, will undertake the following:

Incidents involving more than one team member

All employees of Dee Street Medical Centre, who were involved in the event and the patient's registered provider will endeavour to meet in the 24 hour window prior to contacting the patient. The meeting structure will follow the Medical Council of New Zealand's guidelines which suggest the following are discussed:

a) what happened;
b) how it happened;
c) the consequences for the patient, including arrangements for continuity of care;
d) what will be done to avoid similar occurrences in the future; and
e) who should be present when the harm is disclosed to the patient

If the team are unable to meet within the first 24 hours, disclosing information to the patient within the first 24 hours will be prioritised over this meeting.

If the team were unable to meet within the first 24 hours, the initial disclosure may lack some details. In these cases, the initial disclosure will be followed with a more detailed discussion with the patient once the team has had their meeting.

WHO DELIVERS THE DISCLOSURE?

When an error has been made and resulted in-patient harm

If a patient is unintentionally harmed while receiving healthcare services at Dee Street Medical Centre, the patient's registered provider should usually be the person to communicate with the patient and disclose the incident. When the patient's registered provider is not the provider directly responsible or involved in the event, both providers

should be in attendance. The practice manager will only be present when significant harm has resulted.

Rationale: "Research suggests patients prefer to hear from someone with whom they have built a rapport or had previous contact. Disclosures by administrative staff or management alone are not well received, although in some cases, particularly where significant harm has resulted, it may be appropriate for senior management to attend with the individual providers involved" (Health and Disability Commissioner, 2009).

When an error has been made and patient appears to be unharmed

If an error is made in the patient's healthcare delivery, the patient's registered provider at Dee Street Medical Centre may need to disclose this information to the patient or their representative, even when it would appear the patient has been unharmed consequently. The information disclosed to the individual and / or their representative will consider the factors listed in Rule 11 'Limits on Disclosure of Health Information' in the Health Information Privacy Code (1994) (see Appendix B).

Rationale: Notification of an error may be relevant to future care decisions – whether or not to go ahead with the same procedure on another occasion. The error may be relevant to future care decisions and the effects of an error may not be immediately apparent.

WHO RECEIVES THE DISCLOSURE?

When disclosing information to the patient, the registered provider will communicate directly with the patient, ensuring the patient is medically stable enough to absorb the information. It may also be appropriate to ensure a patient advocate is present for the communication, e.g. someone who is interested in the welfare of the patient, whānau / family member, a legal guardian, an enduring power of attorney, etc. "If the patient has died, been significantly compromised, has long-term diminished competence, or is incompetent, disclosure will need to be made to a third party" (Health and Disability Commissioner, 2009). The information disclosed to the individual and / or their representative will consider the factors listed in Rule

11 'Limits on Disclosure of Health Information' in the Health Information Privacy Code (1994) (see Appendix B).

DISCLOSURE INCLUSIONS

DISCLOSURE INCLUSIONS

The initial, verbal disclosure should include:

a) acknowledgement of the incident;
b) a sincere apology;
c) no allocation of blame;
d) an explanation of what happened;
e) how it happened; and
f) Where appropriate, what actions have been taken to prevent it happening again.

Rationale: This is the provider's opportunity to say, "We are sorry this happened to you" and to acknowledge the seriousness of an adverse event and the distress that it causes. "Apologies can bring considerable comfort to the consumer and have the potential to assist with healing and resolution (Frenkel & Leibman, 2004 as cited in Health and Disability Commissioner, 2009). In some situations, an apology may be critical to a patient when deciding whether or not to lay a formal complaint.

If the patient is likely to encounter any communication barriers, e.g. English is not his/her first language, is hearing impaired, etc., Dee Street Medical Centre will enlist and finance the services of an interpreter to ensure the information is delivered in a manner the patient will interpret correctly.

The verbal disclosure will be followed-up in writing and the local health and disability consumer advocate details as well as options for laying a complaint will be included.

ADMINISTRATION MATTERS

Details about the incident, any harm, disclosure, on-going communications, and subsequent actions will be fully documented in the patient's records.

STAFF SUPPORT AND TRAINING

Dee Street Medical Centre will ensure all health professionals involved in an event have access to support.

Dee Street Medical Centre will ensure all employees receive on-going training, with an emphasis on communication techniques in relation to open disclosure. In addition, relief workers and providers with independent access agreements will be made aware of the policy, adequately trained and supported in its implementation.

Rationale: "Numerous studies have shown that most errors are made by well-trained people who are trying to do their job, but are caught in a flawed system that predisposes towards mistakes being made" (Leape, 2001 as cited in Health and Disability Commissioner, 2009). Training will be provided so that personnel will be able to respond promptly and confidently when things go wrong. Effective communication skills are especially important when dealing with an emotionally charged situation and are pivotal to the open disclosure process.

HEALTH AND DISABILITY CONTACT DETAILS

Nationwide Health and Disability Commissioner

Freephone: 0800 112 233

Email: hdc@hdc.org.nz

Nationwide Advocacy Service (recommended initial contact)

Freephone: 0800 555 050

Email: advocacy@advocacy.org.nz

Western Bay of Plenty Advocacy Service

Emma Ngawhare

Phone: 07 577 1715

Email: engawhare@advocacy.org.nz

Consumer information regarding the Nationwide Health and Disability Advocacy can be seen in Appendix C.

APPENDICES

APPENDIX A

Health & Disability Commissioner "Guidance on Open Disclosure Policies"

Guidance on Open Disclosure Policies

HDC wishes to promote a clear and consistent approach to open disclosure by health care and disability services providers. It is what consumers want and are entitled to. Right 6 of the Code of Health and Disability Services Consumers' Rights gives all consumers the right to be fully informed (ie, to receive the information that a reasonable consumer in his or her situation would expect to receive). Consumers have a right to know what has happened to them.[1]

Internationally, there is a move towards the development of national standards and organisational policies to promote open disclosure. In New Zealand, provider organisations have a legal duty to take steps to ensure that open disclosure is practised by staff and supported by management.

Set out below are guiding points that provider organisations should consider when developing open disclosure policies:

WHAT SHOULD OPEN DISCLOSURE INCLUDE?

- A consumer should be informed about any adverse event, ie, when the consumer has suffered any unintended harm while receiving health care or disability services.[2]
- An error that affected the consumer's care but does not appear to have caused harm may also need to be disclosed to the consumer. Notification of an error may be relevant to future care decisions — whether or not to go ahead with the same procedure on another occasion. The effects of an error may not be immediately apparent.
- A disclosure should include acknowledgement of the incident, an explanation of what happened, how it happened, why it happened and, where appropriate, what actions have been taken to prevent it happening again. (In some situations specific actions will need to be taken straight away, whereas in other situations where the explanation is still unfolding, the actions that need to be taken may take longer to identify.)
- A disclosure should include a sincere apology.[3] This is the provider's opportunity to say, "We are sorry this happened to you." It is not about allocating blame for the event's occurrence, but acknowledging the seriousness of an adverse event and the distress that it causes. Apologies can bring considerable comfort to the consumer and have the potential to assist with healing and resolution.[4] In some situations, an apology may be critical to the consumer's decision about whether to lay a formal complaint and pursue the matter further.

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[1] Obstetrician and Gynaecologist Dr B, A Report by the Health and Disability Commissioner, case 08HDC08586. Available online at www.hdc.org.nz

[2] Massachusetts Coalition for the Prevention of Medical Errors *When things go wrong: responding to adverse events* (2006) 4.

[3] See NHS National Patient Safety Agency, *Being Open — Saying sorry when things go wrong;* London, November 2009. Available online at: http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077

[4] See D Frenkel and C Leibman, "Words that heal" (2004) 140 *Annals of Internal Medicine* 482; J Robbennolt, "Apologies and legal settlement: an empirical examination" [2003] *Michigan Law Review* 102.

- The consumer should be given contact details and information about the local health and disability consumer advocate as well as options for making a complaint.[5]

WHY IS OPEN DISCLOSURE IMPORTANT?

- Because ethically and legally it is the right thing to do.[6]
- There are a number of rights under the Code of Health and Disability Services Consumers' Rights (the Code) that are relevant to open disclosure (see below).
- Open disclosure standards are included in the revised Health and Disability Services Standards that must be followed by all health and disability services providers certified under the Health and Disability Services (Safety) Act 2001.[7]
- Open disclosure:
  - affirms consumers' rights;
  - fosters open and honest professional relationships; and
  - enables systems to change to improve service quality and consumer safety.
- Because the physical harm from an adverse event is often compounded by an emotional or psychological harm when consumers discover that relevant information has been withheld from them.[8]
- Consumers want to know when things go wrong and why, and providers and provider organisations have a legal duty to promote the disclosure of such information in accordance with their individual or organisational duty of care.
- Consumers want to know what the consequences could be for them and their ongoing care. It is important to discuss how the event could change anticipated care and any effects the consumer may experience as a result.
- Consumers are also interested in any action taken as a result of the error or adverse event. Many are concerned that the same thing does not happen to anyone else, that changes are made to the relevant systems, and that staff learn from the experience.[9]
- It also helps ensure consumers are advised that they may be entitled to compensation under ACC, so appropriate forms can be completed in a timely manner.

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[5] The Nationwide Health and Disability Consumer Advocacy Service can be contacted by phone on 0800 555 050, or by email at advocacy@hdc.org.nz. Further information about the service can be found online at www.hdc.org.nz.

[6] See R Lamb, "Open disclosure: the only approach to medical error" (2004) 14 *Quality and Safety in Health Care* 3.

[7] Ministry of Health, New Zealand Standard *Health and Disability Services Standards*, NZS 8134:2008.

[8] See C Vincent and A Coulter, "Patient safety: what about the patient?" (2002) *Quality and Safety in Healthcare* 11(1): 76–80.

[9] M Bismark, E Dauer, R Paterson and D Studdert, "Accountability sought by patients following adverse events from medical care: the New Zealand experience" (2006) 175 *CMAJ* 889; M Bismark and R Paterson, "'Doing the right thing' after an adverse event" (2005) 1219 *NZMJ* 55; A Witman, D Park and S Hardin, "How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting" (1996) 156 *Archives of Internal Medicine* 2565; M Higorai, T Wong and G Vafidis, "Patients' and doctors' attitudes to amount of information given after unintended injury during treatment: cross-sectional, questionnaire survey" (1994) 318 *BMJ* 640.

WHO SHOULD BE INVOLVED IN THE DISCLOSURE?

- The individual provider with overall responsibility for the consumer's care should usually disclose the incident. Research suggests that consumers prefer to hear from a provider with whom they have built a rapport or had previous contact. Where this provider is not the provider with overall responsibility, both providers should be in attendance.[10]
- Research suggests that disclosures by administrative staff or management alone are not well received, although in some cases, particularly where significant harm has resulted, it may be appropriate for senior management to attend with the individual providers involved.

WHEN/WHERE SHOULD THE DISCLOSURE TAKE PLACE?

- Disclosure should be made in a timely manner, usually within 24 hours of the event occurring, or of the harm or error being recognised.
- Although disclosure to the consumer concerned should not occur until he or she is medically stable enough to absorb the information and is in an appropriate setting, there is likely to be a suitable person (ie, someone who is interested in the welfare of the consumer and is available) who should be informed. This may include an enduring power of attorney or legal guardian.
- In the immediate aftermath of an adverse event, providers may be searching for answers too. In these circumstances it is appropriate to acknowledge the limits of what is known, and to make a commitment to sharing further information as it becomes available.[11]
- It is important to emphasise that open disclosure is not a single conversation, but a process of ongoing communication. Communication should continue until the consumer (and/or the consumer's representative or the suitable person who has been informed) has all the information and support needed.
- If the incident occurred in a team environment, it may be beneficial for the team to meet prior to the disclosure taking place. The Medical Council of New Zealand's guidelines for doctors suggest that the team meet to discuss:[12]
    - what happened
    - how it happened
    - the consequences for the consumer, including arrangements for continuity of care
    - what will be done to avoid similar occurrences in the future
    - who should be present when the harm is disclosed to the consumer.
- It might not be possible, however, for the team to discuss the incident and any harm before a discussion with the consumer takes place. An opportunity for the team to debrief should not unreasonably delay the consumer's (or his or her representative's) receipt of information.
- It may be appropriate for an early initial disclosure to occur, followed by a more detailed discussion with the consumer once the team has had an opportunity to meet.

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[10] New Zealand Medical Council, *Disclosure of harm 'Good Medical Practice'*, December 2004 (available at www.mcnz.org.nz).
[11] M Bismark and R Paterson, "'Doing the right thing' after an adverse event" (2005) 1219 *NZMJ* 55.
[12] New Zealand Medical Council, *Disclosure of harm 'Good Medical Practice'*, August 2008 (available at www.mcnz.org.nz).

HOW SHOULD OPEN DISCLOSURE TAKE PLACE?

- Disclosures should generally be made to the individual consumer and any family/whanau/key support people the consumer wishes to have present.
- In some situations where the consumer has died, has been significantly compromised, has long-term diminished competence, or is incompetent, disclosure will need to be made to a third party.
- In circumstances where discussion with the consumer is not possible or appropriate, his or her representative, or a suitable person (who is interested in the welfare of the consumer and is available), such as the consumer's next of kin or designated contact person, should be informed.
- Consideration must be given to the consumer's cultural and ethnic identity and first language, and the support needed.
- Details about the incident and any harm, the disclosure, and any subsequent action should be fully documented in the consumer's records.
- It is important that health professionals and other personnel involved also have access to support. Numerous studies have shown that most errors are made by well-trained people who are trying to do their job, but are caught in a flawed system that predisposes towards mistakes being made.[13]
- Provider organisations need to take steps to ensure that the policy is applied in practice. Ongoing staff training on open disclosure needs to take place so that staff are able to respond promptly and confidently when things go wrong. All personnel, including providers with independent access agreements and relevant contractors such as relief providers, also need to be aware of the policy, and adequately trained and supported in its implementation.
- Training in communication is especially important.[14] An adverse event or incident is emotionally charged for all parties, and specific skills are required to deliver bad news in a sincere, compassionate and thoughtful way. Effective communication and empathy is pivotal to the open disclosure process.[15]

RELEVANT RIGHTS UNDER THE CODE

- Right 1 provides that consumers have the right to be treated with respect. Respect requires a truthful and sensitive discussion about any harm or incident affecting the consumer.
- Under Right 4(1) providers have an obligation to provide services with reasonable care and skill. Provider organisations have an organisational duty of care which includes the need to have a policy on open disclosure that is well understood and implemented by all personnel.
- The provision of information in a form, language, and manner that enables the consumer to understand the information provided is required by Right 5(1). Right 5(2) also applies as it requires an environment supporting open, honest and effective communication.

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[13] L Leape, "Preventing Medical Accidents: Is 'systems analysis' the answer?" (2001) 27 *American Journal of Law and Medicine* 145.

[14] See Massachusetts Coalition for the Prevention of Medical Errors, *When things go wrong: responding to adverse events* (2006) 19.

[15] See Australian Council for Safety and Quality in Healthcare, *Open disclosure: health care professionals handbook* (2003) 13.

- Right 6(1) affirms the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. It is seldom reasonable to withhold information about a consumer from that consumer.
- Health and disability services providers have a duty of open disclosure under Right 6(1)(e) according to legal, professional, ethical, and other relevant standards.
- Right 6(3) gives consumers the right to honest and accurate answers to questions relating to services, including information about the identity and qualifications of providers and how to obtain an opinion from another provider.
- Right 6(4) gives consumers the right to receive, on request, a written summary of information provided.
- Right 8 — the right to have a support person(s) present — is particularly relevant in distressing situations and when people receive bad news or a shock.
- Right 10 also requires providers to ensure that consumers are made aware of their right to complain and provided with information about the complaint process and their options.

APPENDIX B

Health Information Privacy Code 1994, Rule 11, retrieved from: https://www.privacy.org.nz/assets/Files/Codes-of-Practice-materials/HIPC-1994-2008-revised-edition.pdf

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Health information privacy rules

Rule 11: LIMITS ON DISCLOSURE OF HEALTH INFORMATION

(1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds, that—

(a) the disclosure is to—

(i) the individual concerned; or

(ii) the individual's representative where the individual is dead or is unable to exercise his or her rights under these rules; or

(b) the disclosure is authorised by—

(i) the individual concerned; or

(ii) the individual's representative where the individual is dead or is unable to give his or her authority under this rule; or

(c) the disclosure of the information is one of the purposes in connection with which the information was obtained; or

(d) the source of the information is a publicly available publication; or

(e) the information is information in general terms concerning the presence, location, and condition and progress of the patient in a hospital, on the day on which the information is disclosed, and the disclosure is not contrary to the express request of the individual or his or her representative; or

(f) the information to be disclosed concerns only the fact of death and the disclosure is by a health practitioner or by a person authorised by a health agency, to a person nominated by the individual concerned, or the individual's representative, partner, spouse, principal caregiver, next of kin, whānau, close relative, or other person whom it is reasonable in the circumstances to inform; or

(g) the information to be disclosed concerns only the fact that an individual is to be, or has been, released from compulsory status under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the disclosure is to the individual's principal caregiver.

(2) Compliance with subrule (1)(b) is not necessary if the health agency believes on reasonable grounds that it is either not desirable or not practicable to obtain authorisation from the individual concerned and that—

(a) the disclosure of the information is directly related to one of the purposes in connection with which the information was obtained; or

(b) the information is disclosed by a health practitioner to a person nominated by the individual concerned or to the principal caregiver or a near relative of the individual concerned in accordance with recognised professional practice and

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the disclosure is not contrary to the express request of the individual or his or her representative; or

(c) the information—

(i) is to be used in a form in which the individual concerned is not identified; or

(ii) is to be used for statistical purposes and will not be published in a form that could reasonably be expected to identify the individual concerned; or

(iii) is to be used for research purposes (for which approval by an ethics committee, if required, has been given) and will not be published in a form that could reasonably be expected to identify the individual concerned; or

(d) the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to—

(i) public health or public safety; or

(ii) the life or health of the individual concerned or another individual; or

(e) the disclosure of the information is essential to facilitate the sale or other disposition of a business as a going concern; or

(f) the information to be disclosed briefly describes only the nature of injuries of an individual sustained in an accident and that individual's identity and the disclosure is—

(i) by a person authorised by the person in charge of a hospital; or

(ii) to a person authorised by the person in charge of a news medium—

for the purpose of publication or broadcast in connection with the news activities of that news medium and the disclosure is not contrary to the express request of the individual concerned or his or her representative; or

(g) the disclosure of the information—

(i) is required for the purposes of identifying whether an individual is suitable to be involved in health education and so that individuals so identified may be able to be contacted to seek their authority in accordance with subrule (1)(b); and

(ii) is by a person authorised by the health agency to a person authorised by a health training institution; or

(h) the disclosure of the information is required—

(i) for the purpose of a professionally recognised accreditation of a health or disability service; or

(ii) for a professionally recognised external quality assurance programme; or

(iii) for risk management assessment and the disclosure is solely to a person engaged by the agency for the purpose of assessing the agency's risk—

and the information will not be published in a form which could reasonably be expected to identify any individual nor disclosed by the accreditation, quality assurance, or risk management organisation to third parties except as required by law; or

(i) non-compliance is necessary—

(i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or

(ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation); or

(j) the individual concerned is or is likely to become dependent upon a controlled drug, prescription medicine, or restricted medicine and the disclosure is by a health practitioner to a Medical Officer of Health for the purposes of section 20 of the Misuse of Drugs Act 1975 or section 49A of the Medicines Act 1981; or

(k) the disclosure of the information is in accordance with an authority granted under section 54 of the Act.

(3) Disclosure under subrule (2) is permitted only to the extent necessary for the particular purpose.

(4) Where, under section 22F(1) of the Health Act 1956, the individual concerned or a representative of that individual requests the disclosure of health information to that individual or representative, a health agency—

(a) must treat any request by that individual as if it were a health information privacy request made under rule 6; and

(b) may refuse to disclose information to the representative if—

(i) the disclosure of the information would be contrary to the individual's interests; or

(ii) the agency has reasonable grounds for believing that the individual does not or would not wish the information to be disclosed; or

(iii) there would be good grounds for withholding the information under Part 4 of the Act if the request had been made by the individual concerned.

(5) This rule applies to health information about living or deceased persons obtained before or after the commencement of this code.

(6) Despite subrule (5), a health agency is exempted from compliance with this rule in respect of health information about an identifiable deceased person who has been dead for not less than 20 years.

Note: *Except as provided in rule 11(4), nothing in this rule derogates from any provision in an enactment which authorises or requires information to be made available, prohibits or restricts the availability of health information, or regulates the manner in which health information may be obtained or made available: Privacy Act 1993, section 7. Note also that rule 11, unlike the other rules, applies not only to information about living individuals, but also about deceased persons: Privacy Act 1993, section 46(6).*

Note: *Rule 11(1)(f) was amended by Amendment No 4. Rule 11(1)(g) was inserted by Amendment No 3, which also amended rule 11(6). The terms "health professional" and "registered health professional" were changed to "health practitioner" by Amendment No 6.*

COMMENTARY

Rule 11 places limits on the disclosure of information. Unlike rule 6, it does not *oblige* an agency to disclose information. Instead it *allows* disclosure if an exception to the rule applies. However, an agency may decide not to disclose even though an exception to the rule applies. The decision to disclose, when permitted by the rule, remains within the agency's discretion.

A number of factors may bear upon that decision, such as the ethical code of the particular health professional or duties of confidentiality. Ethical and professional obligations might impose stricter limits on disclosure than those of rule 11.

Under the code, individuals do not have a general right of veto over the disclosure of their health information. However, a number of exceptions within rule 11 allow certain disclosures, *except* where the individual has vetoed that disclosure. That veto only affects the use of that particular exception and does not prevent disclosure where another exception applies.

Health agencies should take steps to ensure that all staff (including volunteers) are familiar with the grounds for disclosure of health information, their own responsibilities and the agency's procedures and safeguards.

RULE 11 PERMITTED DISCLOSURE

A health agency may disclose health information where it believes on reasonable grounds that one of the exceptions set out in rule 11(1) apply:

(1)(a) & (b) Disclosure is to, or authorised by, the individual concerned

If disclosure is to the individual concerned privacy issues are unlikely to arise. However, care must be taken in disclosing information to ensure that information about other individuals is not disclosed in breach of rule 11.

Authorisation need not be in writing, but the agency disclosing the information must believe on reasonable grounds that disclosure has been authorised. Note that

authorisation means more than just consent; it implies a general understanding of what is being agreed to by the individual concerned.

Information may be disclosed to a representative, or disclosure authorised by a representative, where the individual cannot exercise his or her rights under the code. "Representative" is defined in clause 3. Under section 22F of the Health Act 1956, a representative also has the ability to directly request access to information about an individual. See 'Requests under section 22F of the Health Act' page 67.

Hospitals might seek an individual's authorisation to certain disclosures by involving the individual in the preparation of a discharge plan.

Disclosure authorised by the individual, or by his or her representative, is almost always preferable to relying on some other ground for disclosure in rule 11.

(c) Disclosure is a purpose for which the information was obtained

This exception includes instances where information is required for further treatment of the individual or where the information is required for administrative aspects of care and treatment, or for monitoring that care and treatment. If information was obtained for an anticipated purpose, under rule 3 the individual should already have been notified of that purpose.

(d) Information sourced from a publicly available publication

Information that has been obtained from a publicly available publication such as a website, telephone directory, published report or public register (eg. register of births, deaths and marriages) can be disclosed. This exception applies only if the agency has actually sourced the information from the publicly available publication. It is not sufficient that information held by the agency might alternatively have been obtained from a publicly available publication.

(e) Disclosure of general information about a hospital patient on a particular day

Many hospitals have operational procedures (such as a patient enquiries line) for the disclosure of general information about an individual's presence and location in hospital and condition. General information may be conveyed, such as confirmation that a named patient has been admitted and that he or she is comfortable, stable, etc. Location information may also be provided to assist visitors. This exception does not permit the disclosure of detailed particulars of the patient's treatment or prognosis.

The individual may veto the disclosure of such information. For most non-urgent admissions hospitals should make their policy known in advance – perhaps through their admission forms – so that patients can choose to veto or "opt-out" of this potential disclosure of their information.

(g) Release from compulsory status

Health agencies may inform an individual's principal caregiver of the individual's release, or imminent release, from compulsory status under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

"Principal caregiver" is defined in clause 3 as the friend of the individual or the member of the individual's family group or whānau who is most evidently and directly concerned with the oversight of the individual's care and welfare.

Information about release from compulsory status can be disclosed under this exception, However, principal caregivers and other family members may well want to know more than the bare fact of release, and this extra disclosure would not be permitted by rule 11(1)(g). Therefore, additional disclosures should be addressed by the preparation of a discharge plan with the individual's involvement.

RULE 11(2) FURTHER PERMITTED DISCLOSURES

Disclosure is also allowed under subrule (2) in a number of circumstances where it is not desirable or practicable to obtain individual authorisation. This covers circumstances where the individual may not be competent to provide their consent, cannot be found, or has explicitly refused to provide consent.

The requirement to, where possible, obtain authorisation before disclosure is more stringent than the equivalent provision in the Privacy Act. This is because of the perceived sensitivity of health information and the importance of maintaining individual autonomy in respect of it.

(2)(a) Disclosure for directly related purpose

Directly related purposes are purposes closely connected with the purpose for which the information was collected. They are purposes that could reasonably be assumed to be within the expectations of the person from whom the information was collected. This may include, for example, disclosure of information for peer review and quality audit.

Disclosure for debt collection (or limited disclosure essential for reimbursement by a funder) would normally be a purpose directly related to billing purposes (which might involve disclosure of name, address and other limited details).

(b) Disclosure of information to nominated person, principal caregiver or near relative

Health agencies will need to have clear operational procedures in place to establish the identity of the person to whom the information is being disclosed. While individuals do not generally have a legal right of veto over the disclosure of their health information, when disclosing information under this provision regard should be had to any express wishes of the individual concerned.

Difficulties may arise with patients who move in and out of psychiatric institutions and the care of a family member or caregiver. Often at the time of re-admission such patients may be hostile to their caregivers and veto the giving of any information to them. There is no easy solution to this issue but the rule does require respect for clear instructions by the patient.

Discretion and skill should be exercised by agencies when broaching the subject (eg. obtaining "standing" instructions during a calm lucid period rather than in the heat of an angry re-admission) and in discussing the limits of any refusal to authorise disclosure (eg. acknowledging the patient's right to keep details of treatment private while negotiating to seek permission to tell a family member at least that the patient is okay). Even where the patient does refuse authorisation to disclose, the matter should be raised again later and not left in an unsatisfactory state.

Where a clinician considers a psychiatric patient does not currently have the mental capacity to give or withhold consent, disclosure may be made to, or with the authority of, a representative (see rule 11(1)).

(c)(i), (ii) Individual not identified

Health practitioners sometimes use actual case studies in peer group discussions (only with other practitioners) to improve competence generally. Sometimes patient authorisation is obtained. Exception (c)(i) can be relied on when it is not practicable to obtain authorisation and when the individual concerned is not identified (eg. by reading extracts from the notes or circulating copies with identifying details masked).

The statistical purposes exception in (c)(ii) also prohibits any publication in a form that could reasonably be expected to identify any individual.

Additional to this provision, section 22H of the Health Act permits the disclosure of "anonymised" health information that does not permit the identification of the person to whom it relates.

(c)(iii) Disclosure for research purposes

When an agency is approached by a researcher seeking the disclosure of health information, it first needs to satisfy itself that ethical approval has been obtained (if required) and that the information will not be published in a form that could identify any individual. The agency being asked to disclose information will probably also want to be satisfied as to security safeguards and the manner of approach to the individual (if any). These issues should be anticipated by the researcher and addressed expressly within the protocol, with the ethics committee and in the approach to the agency.

A researcher should also anticipate any disclosures inherent in a research proposal and address those in the protocol for the ethics committee's consideration. The committee may wish to place conditions on the use or disclosure of the information.

See also Health Research Council, *Guidelines on Ethics in Health Research* (2005), Part 6, "Health Research and Privacy: Guidance Notes for Health Researchers and Ethics Committees" (printed in 1/4 *Human Rights Law and Practice*, March 1996, 196-210), and the currently applicable Ministry of Health operational guidelines for ethics committees.

(d) Disclosure necessary to prevent or lessen a serious and imminent threat to public health or public safety or the life or health of an individual

This exception sets a high bar for disclosure, and should not be used lightly. In order to disclose under this exception, an agency needs to believe on reasonable grounds that it is not practicable or desirable to obtain individual authorisation and that:

- there is a serious threat to public health, public safety or the life or health of an individual;
- the threat is imminent;
- the disclosure of the information would prevent or lessen that threat; and
- the disclosure of the information is necessary to prevent or lessen the threat.

When considering whether the disclosure is "necessary", agencies should consider whether the threat could be prevented or minimised in some way that does not involve the release of sensitive or confidential information.

The disclosure must be made to a person who can do something to prevent or lessen the threat. To address an imminent threat, the recipient of the disclosed information would need to have the power to act *urgently* to achieve a *tangible result in the particular case.* Disclosure to someone who does not have such power may merely be an inroad into medical confidence and privacy that does not carry with it any corresponding assurance of benefit to the public interest.

Even if disclosure is warranted, it should only be to the extent necessary to prevent or lessen the threat – rule 11(3). A decision to disclose will only justify the disclosure of information that is necessary to prevent or lessen the threat. Agencies need to decide how much information needs to be disclosed. It may not be necessary for the whole file to be disclosed.

Generally, if there is an official with powers to deal with such a threat, such as a police officer, then disclosure to that responsible authority will be an appropriate response. As a matter of good practice, the purpose of the disclosure should be made clear so that the person receiving the information knows the limited purpose to which it can be put.

(e) Disclosure essential to facilitate sale of business

It is unlikely that disclosure of personally identifiable health information would be essential to facilitate the sale of a business. In most cases, non-identifiable information should satisfy all reasonable requirements. Any information obtained must not be used for any purpose other than to facilitate the sale.

(f) Disclosure by hospital to news media of accident victim injuries

Clear procedures are needed to establish the good faith of the person making a request and to give effect to a veto by the patient or representative. There is benefit in liaising with the local news media to ensure these procedures are known and workable. The exception allows only for the release of very basic details of injuries where it is

not practicable or desirable to seek authorisation. Where greater detail is proposed to be given to the media (ie. with authorisation of individual or representative, as may happen with public figures) suitable staff briefing and management involvement should help avoid difficulties with the media.

(g) Disclosure in relation to health education

Express authorisation will normally be required before involving patients in health education. However, sometimes it will be necessary for the educator to view the records of possible subjects to check whether they would be suitable. This exception will allow the chosen subjects to be approached to see if they are willing to participate.

(h) Accreditation, quality assurance or risk assessment programmes

To ensure higher standards in the health and disability sectors, there is growing use of formal accreditation and quality assurance programmes. To carry these out it is sometimes necessary to disclose identifiable patient information – often on a random basis. See Health Practitioners Competence Assurance Act 2003, Part 3, for provisions concerning Ministerial authorised quality assurance activities in relation to health services provided by health practitioners.

The investigation of specific complaints would not fall under any of these categories, nor would the exercise of statutory powers to investigate fraud or verify payment (eg. section 22G Health Act, which is set out in the appendix).

(i) Non-compliance necessary for maintenance of law, enforcement of law, protection of public revenue, or conduct of proceedings

Health information may be disclosed if it is necessary to avoid prejudice to the maintenance of the law by a public sector agency such as the Police or agencies with laws to administer, such as ACC.

The Evidence Act 2006 prohibits the disclosure by medical practitioners or clinical psychologists of some information in civil and criminal proceedings (section 59).

See also section 22C of the Health Act, set out in the appendix, which allows (but does not require) the disclosure of health information to certain statutory officials, on request.

(j) Drug seekers

Section 20 of the Misuse of Drugs Act 1975 and section 49A of the Medicines Act 1981 are set out in the appendix. Consideration should also be given to the rule 3 obligations, if applicable, at time of information collection. It is suggested that a warning notice be displayed in the reception or waiting room explaining that information about suspected drug seekers may be disclosed, where appropriate.

(k) Authority under section 54

In rare circumstances, the Privacy Commissioner may authorise an agency to disclose information in a way that would otherwise breach rule 11. This power is reserved for

cases where an exemption from the rule will substantially benefit the public interest or involve a clear benefit to the individual concerned. The Commissioner *cannot* grant an authority if the individual has specifically refused to authorise the disclosure.

Section 54 is designed for exceptional cases, rather than for ongoing situations. Agencies that believe a particular type of disclosure is likely to breach rule 11 and that the same matter is likely to recur need to consider altering their procedures to bring the activity in line with rule 11 (for example, by obtaining individual authorisation in advance) or advising individuals at the point of collection of the proposed disclosure (rule 3).

See the Office of the Privacy Commissioner's "Guidance Note to Applicants seeking Exemption under Section 54 of the Privacy Act 1993", www.privacy.org.nz.

SUBRULE (3): DISCLOSURE ONLY TO EXTENT NECESSARY

When disclosures are made without the authorisation of the individual concerned, the disclosure should be made only to the extent necessary to meet the particular purpose or permitted request. Ideally, requests for unauthorised disclosure should be satisfied without disclosing any personally identifying information at all, for instance by providing generic or anonymised information.

SUBRULE (4): REQUESTS UNDER SECTION 22F OF THE HEALTH ACT

Rule 11(4) modifies the effect of section 22F(1) of the Health Act 1956, which is set out in the appendix. Section 22F(1) requires any person holding health information to disclose that information in certain circumstances.

The people who may request a disclosure of information under section 22F are:

- the individual concerned;
- the individual's representative; and
- a person who is providing, or is going to provide, health or disability services to the individual.

Under section 22F, a valid request may only be refused where the holder of the information believes the individual does not want the information disclosed, where refusal is authorised by the Health Information Privacy Code, or where the person holding the information has a lawful excuse (such as a statutory obligation of confidentiality or one of the grounds in sections 27-29 of the Privacy Act) to refuse the request.

If the agency refuses the request a complaint may be lodged with the Privacy Commissioner under section 22F(4).

Rule 11(4) requires section 22F requests from the individual concerned to be treated as if they were information privacy requests under rule 6. An agency *may* (but is not required to) refuse to disclose information to a representative if:

- the disclosures would be contrary to the individual's interests;
- the individual does not or would not want the information released; or
- there would be good grounds to refuse the individual concerned access under sections 27-29 of the Privacy Act.

Section 22F and its interactions with rule 11(4) are technically complex, but relatively straightforward in practice. For instance, the mother of an eight year old girl asks a GP to provide a copy of her daughter's test results. Because the child is under 16, the mother is considered to be her daughter's representative. Therefore, the GP must provide the information unless he or she believes that to do so would not be in the child's interest, or that the child would not wish the information to be disclosed.

If either of these is the case, the GP may refuse the mother's request. The GP may also refuse the request if one of the section 27-29 grounds for refusal applies (see commentary to rule 6, page 38). In any case, the GP would have to carefully consider his or her ethical obligation to the patient before acting contrary to the patient's expressed wishes.

Common sense and medical ethics suggest that consultation with the individual concerned, where practical, will be a vital step in resolving difficult section 22F dilemmas.

OTHER ENACTMENTS

A number of other enactments authorise or require personal information to be made available. Others prohibit or restrict disclosure of certain information. Some of these are set out in the appendix (eg. see sections 22C, 22D and 22F of the Health Act). It is possible here only to mention a few provisions. Agencies that are subject to these statutes should know of their existence.

Examples of enactments authorising or requiring disclosure

One example is section 11 of the Social Security Act 1964. Demands from the Ministry of Social Development under section 11 of the Social Security Act are constrained by the *Code of Conduct for Obtaining Information under Section 11 Social Security Act 1964.* For instance, the code does not permit the Ministry to seek, from a hospital or health professional, an opinion as to whether a beneficiary is married (or in a relationship in the nature of marriage). Nor is it entitled to seek information concerning any confidential communication to a health practitioner for the purpose of diagnosis or treatment. Copies of the code of conduct may be obtained from the Ministry of Social Development at www.msd.govt.nz. The Privacy Commissioner can investigate breaches of that code.

APPENDIX C

Nationwide Health and Disability Advocacy Patient Information

Contact details for the Nationwide Health & Disability Advocacy Service

Free phone: 0800 555 050
Free fax: 0800 2787 7678
Email: advocacy@advocacy.org.nz

Kaitaia	09 408 0006
Whangarei	09 430 0166
North Shore	09 441 9001
Central Auckland	09 525 2700
West Auckland	09 838 8068
South Auckland	09 273 9549
Thames	07 868 5318
Hamilton	07 834 3960
Tauranga	07 577 1715
Rotorua	07 349 0182
Turangi	07 386 5207
Gisborne	06 868 3590
Napier	06 835 1640
New Plymouth	06 759 2111
Wanganui	06 348 0074
Palmerston North	06 353 7236
Porirua	04 237 0418
Lower Hutt	04 570 0850
Wellington	04 389 2502
Nelson	03 544 4116
Christchurch	03 377 7501
Timaru	03 687 2291
Dunedin	03 479 0265
Invercargill	03 214 0415

Nationwide Health & Disability Advocacy Service

Free support or guidance with resolving your concerns about a Health or Disability Service.

Free phone 0800 555 050

A service provided under the Health & Disability Commissioner Act 1994

The Code of Health and Disability Services Consumers' Rights

Everyone using a health and disability service has the protection of the Code of Health and Disability Services Consumers' Rights.

An independent Commissioner promotes and protects these rights under the Health and Disability Commissioner Act 1994.

Your Rights when receiving a Health or Disability Service

- Respect
- Fair Treatment
- Dignity and Independence
- Proper Standards
- Communication
- Information
- It's Your Decision
- Support
- Teaching and Research
- Complaints

More detailed information about the Code of Rights and Health and Disability Commissioner is available by visiting ***www.hdc.org.nz*** *or by contacting the Nationwide Health and Disability Advocacy Service.*

Nationwide Health & Disability Advocacy Service

The Nationwide Health and Disability Advocacy service operates independently of the Commissioner, the Ministry, purchasers, health care providers and disability services providers.

Advocates employed in the service provide a free complaint resolution service. The advocate will support or guide you to express, and try to resolve your concerns directly with the provider of the service.

Advocates promote awareness of the rights of health and disability service consumers by providing free education to consumers, those providing health and disability services, and community groups.

More detailed information about the Nationwide Health and Disability Advocacy Service and role of the advocates is available by visiting:

advocacy.hdc.org.nz

by contacting **0800 555 050**

or calling one of the advocacy phone numbers listed on the next page.

REFERENCES

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