"Privacy, public interest and surgical outcome data"

Speech by John Edwards, Privacy Commissioner

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Good afternoon

Publishing surgical outcome data means that aspects of your work may end up in the public domain.

This may be uncomfortable, so I want to explain how the law applies to this kind of information.

There are two laws in question here. First, there is the Official Information Act (OIA), which deals with information held by public sector organisations.

The second is the Privacy Act, which deals with personal information – that is, information about an identifiable individual.

The OIA's overall premise is that members of the public have the right to see any information held by public organisations, while the Privacy Act's overall premise is that nobody has the right to see someone's personal information without his or her consent.

Both laws have a number of exceptions.

There are situations – such as surgical outcome data – where a piece of information is both personal and official. In these cases, the OIA trumps the Privacy Act. The public's right to official information supersedes an individual's right to privacy.

However, one of the exceptions to the OIA is when the impact to an individual's privacy is *greater* than the public interest in the information. In these situations, the organisations can withhold information.

It's important to note that requestors don't need to demonstrate public interest. This is taken as a given.

It's up to the organisation to demonstrate that releasing the information would compromise someone's privacy more than it would serve the public interest.

When an organisation withholds information from a requestor under one of the exceptions to the OIA, the requestor can complain to the Ombudsman, who decides whether the organisation was right to withhold the information or not.

When the organisation has withheld information in order to protect an individual's privacy, the Ombudsman consults with my office before issuing his or her decision.

I want to work through some recent Ombudsman decisions that show the role we play and how the law is applied in cases of official information that is also personal information about a medical professional.

Midwives and complaints history

The first case I'll talk about is not about a surgeon, but rather a midwife.

She had lost name suppression after a serious misconduct charge.

After this information was made public, a journalist made an OIA request to the Health and Disability Commissioner asking for details of past complaints about her.

The HDC declined, citing the midwife's privacy; the journalist complained to the Ombudsman.

The Ombudsman consulted my office, and we advised that releasing this information in isolation would have a significant negative impact on the midwife's privacy.

This was particularly true because the complaints in question had not been upheld – so there would be an impact on her privacy, but limited public interest.

All they convey is a single perspective of a single case. On their own, they do not tell people much about a medical practitioner's competence.

Surgeon complaint data

Another case in this vein involved a surgeon's personal information – including his complaint history.

Someone alleged to a DHB, the Medical Council and other organisations that a particular surgeon was not qualified.

A journalist then made an OIA request for information about any investigation into his qualifications, as well as his complaint history and statistics about the volume and type of procedures he had undertaken.

The relevant DHB declined her request, citing the surgeon's privacy. The case made its way to the Ombudsman.

During the Ombudsman's investigation, the Association of Salaried Medical Specialists made a submission to the Ombudsman, arguing (among other things) that the details of the investigation into his qualifications should not be released because the investigation had concluded that the allegations were without substance.

They went on to argue that had the investigation found him to be practising without the proper qualifications, this would have been escalated to a public forum, as the public interest in knowing about an unqualified surgeon far outweighs that surgeon's privacy.

Since this had not been the case, there was no need to publicise the fact that his qualifications had been investigated and found to be in order.

The public interest of knowing that a surgeon had been investigated and exonerated was low in relation to the impact publicising this information could have on his privacy.

I agreed with this argument.

The same argument applies to the approach I took with his complaint history. As with the midwife, I argued that complaint history should not be released. Complaints that were not upheld did not serve the public interest more than they would harm the surgeon's privacy.

What's more, hospitals and oversight bodies like the HDC have processes to deal with complaints. As with any employment relationship, I do not think the public has an unfettered right to see the private details of someone's performance. Some of those details are between an employee and his or her employer or professional body.

The ASMS also argued that releasing statistics about the volume and types of surgeries he had performed would have a similar disproportionate impact on his privacy, due to the fact that the casual observer would make judgements without knowing necessary contextual information.

I did not agree with this argument. I argued that this information should be released.

While the information is personal information, it is not private enough to withhold.

The privacy exception did not apply, so the public had the right to see the information.

I disagreed with the ASMS because this data is much easier to contextualise than complaint data.

For example, if a surgeon has significantly fewer procedures than his or her colleagues for a given time period, it's easy to include a sentence explaining why this was the case.

Perhaps the surgeon started work partway through the year, or has a larger amount of non-clinical work such as teaching or management.

And if there is no explanation for an anomaly in the amount of procedures a surgeon performs, then something may not be working.

Since I found the privacy impact of publishing this information to be low, I did not assess the public interest, as the starting point of the OIA is that the public has the right to all official information, unless one of the exceptions applies.

Surgical outcome data

The most recent, and relevant Ombudsman decision in this area was about surgical outcome data.

A journalist made an official information request to a number of DHBs asking for the number of surgeries each surgeon had performed, the type of surgery, the number of patients who had complications and the number of patients who died within 30 days of their surgery.

As with the other cases, this case ended up on the Ombudsman's desk.

Now, if the number of procedures a surgeon undertakes is public information, then wouldn't the outcomes of those procedures also be public?

The answer is not usually.

Surgical outcome data has the same drawbacks as complaint data.

When it is published without proper context, people can get the wrong impression about its meaning.

For example, experienced surgeons in highly specialised areas may have higher mortality rates because they operate on the highest-risk cases.

These surgeons' high mortality rates are not a negative reflection on their skills. Rather, it is a reflection on their experience level and choice of specialty.

Surgical outcomes are also not completely within the surgeon's control.

As I'm sure you know, surgery is a team sport. Individual surgeons have significant control over the outcome, but they don't have *total* control over the outcome.

Hospital infrastructure, patient compliance with ongoing care and the actions of other medical staff all play significant roles.

So my view on outcome data is the same as my view on complaint and volume data: there is a high public interest in surgical data, but there is limited public interest in inaccurate data.

Isolated surgical outcome data, without proper context or standardisation, can give an inaccurate picture of a surgeon or a DHB's performance, and therefore have a disproportionately negative effect on an individual's privacy.

Summary: it's about data quality

To summarise: while surgical outcome data is public information, it needs to be accurate, high quality data that gives give a true picture of the healthcare system.

DHB's are currently unable to deliver this information, but that does not mean that they should withhold surgical outcome data in perpetuity. Rather, they should develop frameworks to report risk-adjusted, standardised outcome data.

The Ombudsman has recommended that the Ministry of Health put together a framework to deliver this data by 2021. I support this recommendation.

This framework should give DHB's the ability to fulfil their obligations under the OIA without having a disproportionate impact on any individual's privacy.

In the meantime: get up to speed on privacy

In the meantime, you can get up to speed on your privacy obligations.

Surgeons handle a significant amount of personal information, and a privacy breach can reduce patient trust in a big way.

My office has a number of resources on our website to help you avoid a breach by developing day-to-day awareness.

First, there's our online education. This is free online training with a module devoted to health information (Health101). You can do this training at your own pace, from anywhere.

We've also recently launched 'Ask Us'. This is an interactive online FAQ with lots of answers to privacy questions built in. You just type in your question.

It's a great way to get quick answers without having to call someone or write an email. And if you can't find what you're looking for, there's a place to let us know – we're constantly refining existing answers and adding new ones.

Thank you.

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