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NEW ZEALAND'S MEDICO-LEGAL APPROACH TO DIGITAL HARM: INNOVATION OR CONTINUATION OF TRADITIONAL RESPONSES?

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ABSTRACT

This socio-legal commentary examines the growing issue of digital harm within New Zealand's healthcare system, focusing on recent cases that illustrate the medico-legal system's response to this phenomenon. It investigates various instances to highlight the nature of digital harm in health contexts, questioning whether these incidents represent a novel form of harm enabled by new technologies or merely a reexpression of traditional unethical or unprofessional conduct. The commentary assesses the adequacy of New Zealand's existing medico-legal framework in addressing digital harm and explores whether new legal or policies are necessary. The analysis indicates that current rights and disciplinary mechanisms can effectively handle cases where individuals suffer harm, leveraging established processes. However, the study identifies gaps in the framework, particularly concerning unregistered health providers and harm affecting professions or groups. It notes that these gaps may leave certain vulnerabilities unaddressed, as unregistered practitioners fall outside disciplinary oversight, and collective harm lacks clear remedies. Looking ahead, the commentary suggests that emerging challenges, such as misinformation and vaccine denial related to COVID-19, could test the system's resilience. Given the limited research on digital harm in New Zealand's health sector, this work aims to lay the groundwork for future studies, offering insights into the evolving intersection of digital technology and medico-legal accountability.

Keywords: *digital harm; social media; professional discipline; unregistered providers*

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1. INTRODUCTION

The advent of digital technologies has profoundly transformed contemporary society, with the healthcare sector experiencing some of the most significant shifts. Innovations such as telemedicine, electronic health records, and mobile health applications have revolutionized how care is delivered, improving accessibility, operational efficiency, and patient engagement. These advancements enable seamless communication between providers and patients, facilitate remote consultations, streamline administrative processes, and support cutting-edge treatment modalities. However, alongside these benefits, digital technologies have introduced new challenges, particularly the risk of digital harm. Within healthcare, digital harm refers to adverse actions facilitated by digital platforms—such as social media, messaging apps, or online systems—that can erode patient trust, breach ethical standards, or cause emotional and psychological distress. This article examines the emergence of digital harm in New Zealand's health sector, analyzing how the country's medico-legal framework responds to this evolving issue and evaluating whether existing mechanisms are adequate to address it effectively (Kanungo et al., 2022).

Digital harm in healthcare manifests in diverse ways, ranging from inappropriate provider-patient interactions via text messaging to the misuse of social media for sharing sensitive information or spreading misinformation that undermines public health initiatives. These incidents raise critical questions about the nature of digital harm: does it represent a fundamentally new type of misconduct enabled by technology, or is it merely a digital extension of traditional unethical or unprofessional behaviors? For instance, a healthcare provider sending inappropriate personal messages to a patient via a messaging app may mirror boundary violations seen in face-to-face interactions, but the immediacy, accessibility, and potential anonymity of digital platforms amplify the scope and impact of such actions. This article explores these dynamics through a socio-legal lens, focusing on select cases in New Zealand's health sector to illuminate how digital harm arises and how regulatory bodies address it (Law Commission, 2012).

New Zealand has taken significant steps to address digital harm across society through the Harmful Digital Communications Act 2015 (NZ) (HDCA), a pioneering legislative framework aimed at mitigating harmful online behavior. The HDCA provides remedies for individuals affected by digital harms such as cyberbullying, harassment, or the dissemination of harmful content, offering both civil dispute resolution processes and criminal penalties for egregious violations. Despite its broad scope, the HDCA's application in specific contexts, including healthcare, has faced criticism for limitations in its effectiveness and enforcement (King, 2017; Hunt, 2020). While the HDCA serves as a general tool for addressing digital harm, this article focuses specifically on its relevance to the health sector, where the stakes are elevated due to the trust-based nature of patient-provider relationships and the critical role of healthcare professionals in public health (Harmful Digital Communications Act, 2015).

The medico-legal framework in New Zealand provides a multifaceted approach to addressing digital harm in healthcare, combining rights-based protections with professional disciplinary mechanisms. Central to this framework is the Health and Disability Commissioner, an independent body established under the Health and Disability Commissioner Act 1994 (NZ), which upholds patient rights through the Code of Health and Disability Services Consumers' Rights (the Code). The Code outlines ten enforceable rights for all health and disability service users, including respect, dignity, and protection from harassment, discrimination, or exploitation. Breaches of these rights are investigated by the Commissioner, who issues recommendatory opinions and, in serious cases, may refer matters to the Human Rights Review Tribunal (HRRT) for remedies such as apologies or damages (Health and Disability Commissioner, n.d.; Manning, 2009). For registered health practitioners, additional oversight is provided by the Health Practitioners Competence Assurance Act 2003 (NZ) (HPCAA), which regulates professional conduct and competence. The Health Practitioners Disciplinary Tribunal (HPDT), established under the HPCAA, handles disciplinary proceedings for registered practitioners, addressing issues like professional misconduct, negligence, or actions that discredit the profession, with penalties ranging from fines to deregistration (Health Practitioners Competence Assurance Act, 2003).

This article analyzes a curated selection of cases adjudicated by the Health and Disability Commissioner or the HPDT, focusing on incidents involving digital harm, particularly those marking the first consideration of specific technologies like text messaging or social media. Cases involving privacy breaches, such as unauthorized access to health records, are excluded, as these are governed by the Privacy Act 2020 (NZ), which provides a distinct complaint pathway. The selected cases are categorized based on key factors: the presence of a provider-consumer service relationship under the Code, the registration status of the provider (registered or unregistered), and whether the harm impacts individuals or groups, such as entire professions or communities. This categorization enables a nuanced understanding of digital harm's scope and nature in healthcare and facilitates an assessment of the medico-legal framework's adequacy in addressing it (Paterson & Manning, 2017).

The analysis addresses two fundamental questions. First, does digital harm constitute a novel form of harmful behavior unique to digital technologies, or is it a reexpression of pre-existing unethical or inappropriate conduct in a digital context? Second, are New Zealand's current rights-based and disciplinary mechanisms sufficient to manage digital harm in healthcare, or do affected individuals need to rely on alternative remedies, such as those offered by the HDCA? By exploring these questions through case studies, the article provides practical insights for healthcare providers on preventing digital harm, emphasizing measures like establishing clear boundaries for digital communication and adhering to ethical guidelines (Geraghty et al., 2021).

The study identifies critical gaps in the medico-legal framework, particularly in regulating unregistered health providers and addressing harm to groups. Unregistered

providers, such as counsellors or alternative therapists, fall outside the HPCAA's disciplinary scope, limiting accountability for their actions. Similarly, cases where digital harm affects collectives—such as professions or communities—pose challenges, as the Code is primarily designed to protect individual rights, and remedies for group harm are less clear (Paterson & Manning, 2017). The article also considers emerging challenges, such as the spread of COVID-19-related misinformation and vaccine denial, which could strain the medico-legal system's capacity to balance professional accountability with freedom of expression rights under the New Zealand Bill of Rights Act 1990 (NZ) (Rychert et al., 2022).

Given the limited research on digital harm in New Zealand's health sector, this article serves as a foundational exploration of its medico-legal implications. By analyzing early cases and evaluating the strengths and weaknesses of the existing framework, it aims to guide health providers, policymakers, and researchers in addressing this growing challenge. The findings highlight the need for continuous scrutiny of how digital technologies shape healthcare interactions and underscore the importance of adapting legal and regulatory frameworks to ensure patient safety, professional integrity, and public trust in an increasingly digital healthcare landscape (Trethewey, 2020).

The significance of this study lies in its contribution to understanding the intersection of digital technology and medico-legal accountability in New Zealand's health sector. By examining real-world cases, it sheds light on the practical challenges of addressing digital harm and identifies areas where the medico-legal system excels or falls short. For healthcare providers, the article offers actionable insights into mitigating digital risks, such as adopting robust policies on digital communication and enhancing training on ethical conduct in digital spaces. For policymakers, it highlights the need for potential legislative reforms to address gaps, particularly regarding unregistered providers and group harm. As digital technologies continue to evolve, this analysis provides a critical starting point for future research, encouraging further exploration of how New Zealand's medico-legal system can adapt to meet the demands of a digital healthcare environment while safeguarding consumers and professionals alike (Cho & Lee, 2016).

2. UNDERSTANDING DIGITAL HARM

Digital harm is a broad and evolving concept, shaped by the diverse ways digital technologies are used and misused. Its definition varies depending on the context, reflecting the complexity of its impact. Kanungo et al. (2022) note that research on digital harm is fragmented, with limited consensus on its core elements and effective strategies to address it, underscoring the need for clearer frameworks (Kanungo et al., 2022). Despite this, there is growing clarity around what constitutes 'digital' and 'harm' in this context. Digital harm encompasses negative outcomes from the misuse of technologies such as social media, mobile apps, text messaging, or other electronic platforms, often resulting in emotional, psychological, or reputational damage.

In 2012, New Zealand's Law Commission, an independent body focused on law reform, provided a foundational analysis of digital harm, identifying its unique characteristics compared to offline communication (Law Commission, 2012). These include rapid dissemination, global accessibility, the persistence of digital content, and the potential for anonymity, which amplify the reach and impact of harmful actions. Digital harm may manifest as cyberbullying, harassment, criminal acts, or unwanted communications, with consequences ranging from physical fear and humiliation to severe emotional distress. These features distinguish digital harm, making it a pressing concern in regulatory and legal discussions.

Within healthcare, digital harm takes on specific forms, often tied to the misuse of digital tools by practitioners. Much of the literature emphasizes social media misuse, highlighting risks such as blurred professional boundaries, which can lead to ethical and legal violations (Geraghty et al., 2021). For instance, sharing patient information on social platforms can breach confidentiality, while inappropriate messaging can erode trust. Other studies point to distractions caused by smartphone use during clinical practice, which may compromise patient care (Cho & Lee, 2016), and the spread of medical misinformation, which undermines public health (Trethewey, 2020). However, less attention has been paid to how practitioners' misuse of digital tools directly harms consumers, whether within or outside professional relationships. This gap highlights the need for targeted research to understand digital harm's implications in health settings and inform robust responses.

3. NEW ZEALAND'S LEGISLATIVE APPROACH TO DIGITAL HARM

New Zealand has actively addressed the rising issue of digital harm through the Harmful Digital Communications Act 2015 (HDCA), prompted by increasing concerns over cyberbullying, particularly among teenagers, with high-profile cases from the United Kingdom and United States highlighting the urgency for action. The Law Commission, in its 2012 review, identified digital harm as a novel challenge that existing laws struggled to address effectively, necessitating a tailored legislative response (Law Commission, 2012). The HDCA aims to mitigate harmful digital interactions by establishing both civil and criminal frameworks to protect individuals from serious emotional distress caused by electronic communications.

The HDCA defines digital communication broadly to encompass any electronic medium, including text messages, images, recordings, or other content transmitted digitally, ensuring adaptability to emerging technologies. Harm is defined as "serious emotional distress," though this term has been left to judicial interpretation, with early court rulings, such as *Police v B* (2017), facing criticism for their application (Police v B, 2017). The Act outlines communication principles to identify harmful behaviors, such as harassment, threats, obscene content, false allegations, breaches of confidentiality, incitement to harm, or denigration based on protected characteristics. Criminal provisions target severe offenses, like sharing intimate visual recordings without consent, commonly known as "revenge porn."

To facilitate resolution, the HDCA established a civil process through Netsafe, an Approved Agency that offers services like advice, negotiation, mediation, and conciliation. If unresolved, complainants can seek non-monetary court remedies, such as take-down orders or apologies, under the Act's provisions. The HDCA's scope extends beyond public platforms, applying to private interactions, including those involving health and disability providers. This is particularly relevant when providers engage with consumers outside professional contexts, such as personal communications that cause harm.

The HDCA's design aims to future-proof New Zealand's response to digital harm by accommodating new technologies and evolving forms of misuse. Its application to healthcare settings ensures that harmful actions by providers, whether professional or personal, can be addressed, though its effectiveness depends on judicial interpretations and the robustness of Netsafe's processes. By providing a dedicated framework, the HDCA complements existing medico-legal systems, offering a pathway for individuals to seek redress when harmed digitally, particularly in sensitive sectors like healthcare.

4. NEW ZEALAND'S MEDICO-LEGAL FRAMEWORK

New Zealand's medico-legal system provides a robust structure for addressing breaches of consumer rights and professional misconduct in healthcare, including issues related to digital harm. Operating alongside the Harmful Digital Communications Act 2015 (HDCA), this framework comprises two primary components: a rights-based system for all health and disability service consumers and a disciplinary process for registered health practitioners. These mechanisms ensure accountability and protection, particularly when digital technologies are misused, causing harm to individuals or groups.

At the heart of the consumer rights system is the Code of Health and Disability Services Consumers' Rights (the Code), established under the Health and Disability Commissioner Act 1994. The Code outlines ten enforceable rights for all users of health and disability services, deliberately broad to encompass diverse care settings. Key rights relevant to digital harm include respect, dignity, independence, freedom from discrimination, harassment, coercion, and exploitation, alongside a general entitlement to services meeting legal, professional, and ethical standards (Health and Disability Commissioner, n.d.). For example, a healthcare provider sending inappropriate text messages to a patient could breach rights to respect and freedom from harassment. Complaints about Code violations are handled by the Health and Disability Commissioner, an independent watchdog tasked with promoting and protecting consumer rights (Manning, 2009). The Commissioner investigates serious breaches, issuing recommendatory opinions that may lead to remedies such as apologies or practice improvements. In significant cases, complainants can pursue further action through the Human Rights Review Tribunal (HRRT), which can award damages up to NZD 350,000, though this maximum has never been granted.

The Code applies to all health and disability providers, registered or unregistered, ensuring wide coverage. However, registered health practitioners, such as doctors, nurses, and pharmacists, face additional oversight under the Health Practitioners Competence Assurance Act 2003 (HPCAA). The HPCAA regulates practitioner competence and fitness to practice, establishing the Health Practitioners Disciplinary Tribunal (HPDT) as the sole disciplinary body. The HPDT addresses cases under Section 100 of the HPCAA, which outlines grounds for proceedings, including professional misconduct (encompassing malpractice or negligence), actions discrediting the profession, criminal convictions reflecting adversely on fitness to practice, or practicing outside one's scope. Digital harm, such as a nurse posting derogatory comments about patients on social media, could constitute misconduct by bringing the profession into disrepute. HPDT penalties include fines up to NZD 30,000, censure, practice conditions, suspension, or deregistration, providing strong deterrents for misconduct.

The HDCA and HPCAA intersect in cases of severe digital harm. Criminal convictions under Sections 22 or 22A of the HDCA, which carry up to two years' imprisonment, exceed the HPCAA's three-month threshold for disciplinary action based on convictions (Section 100(1)(c)). This linkage ensures that registered practitioners committing serious digital offenses, such as sharing intimate images without consent, face professional consequences. Additionally, Code breaches involving digital harm by registered practitioners may lead to HPDT proceedings initiated by the Director of Proceedings, an independent office with prosecutorial authority. Such cases are typically pursued under professional misconduct grounds (Section 100(1)(a) or (b)), ensuring dual accountability through rights-based and disciplinary pathways.

The medico-legal system's response to digital harm varies by case context, categorized by the provider-consumer relationship and provider registration status. Cases within a service relationship, where the Code applies, are addressed through Commissioner investigations and potential HRRT remedies. For registered practitioners, HPDT proceedings add disciplinary measures. Cases outside a service relationship, such as a practitioner harassing a non-patient online, may still fall under HPDT jurisdiction if the conduct discredits the profession. Harm to groups, such as a practitioner's public social media posts targeting a community, tests the system's boundaries, as the Code focuses on individual rights, though the HPDT can address professional discredit (Paterson & Manning, 2017).

This framework demonstrates flexibility in handling digital harm, leveraging existing rights and disciplinary tools to address both individual and professional misconduct. However, gaps exist, particularly for unregistered providers outside service relationships, where neither the Code nor HPDT applies, forcing reliance on the HDCA or other laws. The cases analyzed in this study illustrate how these systems

operate, highlighting their strengths and limitations in managing the evolving challenge of digital harm in healthcare.

5. NON-REGISTERED PROVIDER CASE

This section examines a case of digital harm within a healthcare service relationship involving a non-registered provider, highlighting the limitations of New Zealand's medico-legal framework when addressing such misconduct. The case, documented in the Health and Disability Commissioner's opinion 09HDC01409, involved a counsellor, Ms. C, who provided services to an 18-year-old client with a mental health condition (Health and Disability Commissioner, 2010). As counsellors are not registered under the Health Practitioners Competence Assurance Act 2003 (HPCAA), this case underscores the challenges of regulating non-registered providers who misuse digital communication tools, such as text messaging, in professional settings.

The client, who exhibited suicidal ideation, had entered a "no-suicide" contract with Ms. C. After a single session, the client cancelled follow-up appointments but later texted Ms. C to inquire about discontinuing his psychiatrist-prescribed antipsychotic medication. Ms. C responded via text, endorsing the cessation of medication provided the client had robust therapeutic support, and suggested arranging another appointment (Health and Disability Commissioner, 2010). Tragically, the client died by suicide two weeks later, prompting his mother to lodge a complaint with the Commissioner, alleging a breach of the Code of Health and Disability Services Consumers' Rights, specifically the right to services of an appropriate standard (Right 4).

The Commissioner's investigation identified multiple shortcomings in Ms. C's practice, including overstepping her professional scope by advising on medication, a domain reserved for medical professionals, and failing to coordinate with other providers. The use of text messaging as a primary communication method was particularly problematic, given its limitations in conveying nuanced clinical advice. The Commissioner noted that while text messaging may be suitable for younger clients, it carries risks such as misinterpretation, lack of confidentiality, and excessive accessibility, which can undermine therapeutic boundaries (Health and Disability Commissioner, 2010). In this case, texting was deemed inappropriate for delivering complex mental health advice, especially to a vulnerable client requiring comprehensive support.

The Commissioner concluded that Ms. C breached Right 4 of the Code, recommending that she revise her practice and apologize to the client's family. Although the breach enabled the family to pursue remedies through the Human Rights Review Tribunal (HRRT), it is uncertain whether they did so. As a non-registered provider, Ms. C was not subject to the disciplinary measures of the Health Practitioners Disciplinary Tribunal (HPDT), raising questions about the adequacy of consequences for unregistered practitioners. This case illustrates a gap in the medico-legal framework, as the Code-based regime may not impose sufficiently robust accountability for non-

registered providers, potentially leaving harmed consumers without meaningful recourse (Paterson & Manning, 2017).

The case serves as a cautionary tale for healthcare providers about the risks of digital communication, particularly in mental health contexts. Text messaging, while convenient, is ill-suited for delivering critical clinical advice, as it lacks the depth and oversight required for effective care. The Commissioner advised limiting texting to administrative tasks, such as appointment scheduling, to mitigate risks (Health and Disability Commissioner, 2010). This case highlights the need for clear guidelines on digital tool use in healthcare and underscores the broader challenge of regulating non-registered providers to prevent digital harm.

6. REGISTERED PROVIDER CASES

The misuse of digital communication tools by registered healthcare providers within a service relationship can lead to significant ethical breaches and legal consequences, as illustrated by two pivotal cases in New Zealand's medico-legal framework. These cases, involving a mental health nurse and a general practitioner, demonstrate how text messaging, while convenient, can facilitate inappropriate interactions that harm patients and undermine professional standards (Health Practitioners Disciplinary Tribunal, 2009; Health and Disability Commissioner, 2014). Governed by the Health Practitioners Competence Assurance Act 2003 (HPCAA) and the Code of Health and Disability Services Consumers' Rights, registered providers face scrutiny from both the Health and Disability Commissioner (HDC) and the Health Practitioners Disciplinary Tribunal (HPDT), highlighting the system's capacity to address digital harm while revealing the risks posed by digital technologies in clinical settings.

The first case, documented in HPDT decision 211/Nur08/112D, involved a mental health nurse's management of a female patient, Ms. B, who had a history of severe mental health issues, including an eating disorder, self-harm, depression, and multiple suicide attempts (Health Practitioners Disciplinary Tribunal, 2009). The patient's care team approved text messaging via the nurse's work mobile phone as a communication method, deemed suitable given Ms. B's needs. However, the nurse's decision to share his personal mobile number after his work phone battery failed marked a critical misstep. This action led to frequent texting unrelated to clinical care, fostering a personal and eventually sexual relationship alongside the ongoing professional one. The culmination of this misconduct was the nurse sending an explicit image of his genitalia to Ms. B after her clinical care had been transferred to another provider, a clear violation of professional boundaries.

The HPDT responded decisively, cancelling the nurse's registration, censuring him, imposing a NZD 500 fine, and ordering a NZD 5,000 contribution toward costs. Conditions for potential re-registration included completing postgraduate ethics and boundaries training, working under supervision for 18 months, and undergoing medical and psychiatric evaluations to ensure fitness to practice (Health Practitioners

Disciplinary Tribunal, 2009). While the primary issue was the unethical sexual relationship, described as "fundamentally unprofessional," the immediacy and privacy of text messaging exacerbated the misconduct by enabling unmonitored communication. This case underscores how digital tools can erode clinical oversight, facilitating relationships that breach ethical standards and harm vulnerable patients. The technology's role in lowering barriers to inappropriate behavior highlights the need for strict protocols governing digital communication in healthcare.

The second case, HDC opinion 13HDC00733, involved a male general practitioner (GP) who developed an inappropriate relationship with a young female patient recently discharged from mental health services (Health and Disability Commissioner, 2014). The patient's discharge plan had discontinued text-based support to promote independence, yet the GP provided his personal mobile number, bypassing the practice's monitored text system. Over five to six weeks, he sent approximately 50 text messages expressing romantic attraction and proposing non-clinical meetings, despite the patient's consistent rejection and discomfort. The patient expressed confusion over the GP's dual role as a healthcare provider, highlighting the blurred boundaries caused by his actions.

The Commissioner found the GP's conduct constituted harassment, breaching Right 2 of the Code (freedom from harassment), and violated Right 4(2) by failing to meet ethical standards (Health and Disability Commissioner, 2014). The case was referred to the Director of Proceedings, who initiated HPDT proceedings, resulting in a nine-month suspension, censure, conditions on practice, and cost contributions. This robust response addressed both the patient's rights and the GP's professional accountability, demonstrating the medico-legal system's effectiveness in handling digital harm. Notably, the GP claimed his clinical consultations remained professional, suggesting a perceived distinction between in-person and digital interactions (Health and Disability Commissioner, 2014). This perception, as noted by Basevi et al. (2014), underscores a critical misunderstanding: digital communications are not exempt from the ethical obligations governing patient interactions, and violations carry real consequences.

Both cases illustrate how digital tools, particularly text messaging, enable or amplify ethical breaches within service relationships. The immediacy, accessibility, and privacy of texting can foster inappropriate familiarity, bypassing the oversight inherent in traditional clinical settings (Basevi et al., 2014). While the primary harm stemmed from unethical conduct sexual relationships or harassment the technology's role was significant, providing a platform for unmonitored and inappropriate exchanges. These incidents highlight the need for registered providers to apply the same ethical rigor to digital interactions as to face-to-face encounters, recognizing that digital spaces are extensions of the professional environment.

The medico-legal framework proved effective in addressing these cases, with the HDC and HPDT imposing remedies and penalties that protected patients and upheld

professional standards. The Code-based process allowed for consumer redress, while HPDT disciplinary actions ensured accountability for registered practitioners. Notably, the Harmful Digital Communications Act 2015 (HDCA), enacted after these cases, would likely offer little additional recourse, as the medico-legal system adequately addressed the harassment and misconduct (Health and Disability Commissioner, 2014). However, these cases serve as cautionary tales for healthcare providers, emphasizing the importance of maintaining professional boundaries in digital communications and adhering to ethical guidelines.

These examples also underscore broader implications for healthcare practice. Providers must be trained to use digital tools judiciously, limiting texting to administrative purposes (e.g., appointment confirmations) and ensuring clinical communications occur through monitored channels (Basevi et al., 2014). Professional bodies should develop clear guidelines on digital communication, emphasizing the risks of personal device use and the need for oversight. As digital technologies continue to permeate healthcare, these cases highlight the importance of aligning technological adoption with ethical and legal standards to prevent harm and maintain public trust in the profession.

7. A CASE STUDY

The advent of social media platforms, such as Snapchat, has introduced new avenues for digital harm in healthcare, as evidenced by a 2021 case marking the Health and Disability Commissioner's (HDC) first examination of such misconduct (Health and Disability, 2021). This case, 20HDC00906, involved a 21-year-old Maori nursing student and casual healthcare assistant, Mr. C, employed at a private rest home in Auckland. His actions highlight the risks of social media misuse within a service relationship, where digital tools can exacerbate breaches of patient rights and professional ethics, leading to widespread harm through the rapid, uncontrolled sharing of sensitive content (Nightingale, 2020).

Mr. C photographed two elderly rest home patients, one with advanced dementia unable to consent, using his personal mobile phone. He shared these images with his "close friends list" on Snapchat, a platform known for ephemeral content (Health and Disability Commissioner, 2021). However, recipients edited and captioned the photos, returning them to Mr. C, who then redistributed the altered versions on Snapchat. One recipient, claiming offense on behalf of the patients, escalated the issue by posting the images on Facebook and sharing them with media outlets, resulting in public exposure (Nightingale, 2020). This sequence underscores the unique challenge of digital harm: once shared, content can be screenshot, forwarded, and disseminated beyond the sender's control, amplifying the breach's impact (Law Commission, 2012).

The Commissioner found Mr. C breached Right 1(1) of the Code of Health and Disability Services Consumers' Rights by failing to treat the patient with respect and Right 3 by not upholding the patient's dignity (Health and Disability Commissioner, 2021). The decision highlighted the inherent risks of social media, noting Mr. C's

acknowledgment of the ease with which images could be captured, edited, and shared. The Commissioner criticized his lack of foresight regarding the broader consequences of online dissemination, a phenomenon flagged by the Law Commission (2012) as a defining feature of digital harm due to its persistence and accessibility.

The case also raises concerns about mobile phone use in healthcare settings, where devices provide instant access to cameras and the internet, increasing the risk of privacy violations. Mr. C agreed to refrain from carrying his phone during future work shifts, a self-imposed measure reflecting the need for workplace policies restricting personal device use (Health and Disability Commissioner, 2021). The Commissioner recommended that Mr. C apologize to the patient's family and undertake a reflective exercise, noting his remorse and the "difficult lesson" learned. However, the severity of the breach prompted a referral to the Director of Proceedings to consider Human Rights Review Tribunal (HRRT) action, signaling a strong stance against social media misuse (Health and Disability Commissioner, 2021).

This case demonstrates the medico-legal framework's ability to address digital harm within service relationships, with the Code providing a basis for accountability. The Harmful Digital Communications Act 2015 (HDCA) could offer additional remedies, such as content removal orders under Section 19, but the HDC's response was sufficient here. The incident underscores the need for healthcare providers to recognize the ethical obligations extending to digital platforms, emphasizing training and policies to prevent similar breaches (Geraghty et al., 2021). As social media becomes integral to communication, this case serves as a warning of its potential to harm patients and damage professional reputations when misused.

8. A CASE ANALYSIS

This section explores the complexities of addressing digital harm caused by registered healthcare providers outside a service relationship, where no professional-client interaction exists, using a 2010 case as a key example (Health Practitioners Disciplinary Tribunal, 2010). The case illustrates how New Zealand's medico-legal framework, specifically the Health Practitioners Competence Assurance Act 2003 (HPCAA), can hold registered practitioners accountable for misconduct that discredits their profession, even in non-clinical contexts. However, it also highlights a significant regulatory gap for unregistered providers, who fall outside such disciplinary mechanisms, underscoring the limitations of existing systems in fully addressing digital harm (Paterson & Manning, 2017).

The case, HPDT decision 300/Nur09/139P, involved a 58-year-old registered nurse, Mr. D, who initiated inappropriate contact with a 14-year-old girl with an intellectual disability at Rotorua Hospital's Children's Ward (Health Practitioners Disciplinary Tribunal, 2010). Mr. D, not involved in her care, met the girl in the hospital cafeteria and provided his personal mobile phone number. Over several months, he sent her text messages, calls, cards, and gifts with sexual undertones, persisting even after relocating to Saudi Arabia for work and despite requests from the girl's family to stop.

To facilitate ongoing communication, Mr. D purchased a mobile phone for the girl, bypassing parental oversight, which exacerbated the inappropriate nature of his actions.

The HPDT addressed the absence of a service relationship by invoking Section 100(1)(b) of the HPCAA, which allows disciplinary action for professional misconduct likely to bring discredit to the practitioner's profession at the time of the conduct (Health Practitioners Disciplinary Tribunal, 2010). The Tribunal determined that Mr. D's actions, occurring while he was a practicing nurse, constituted such misconduct, regardless of the lack of a clinical relationship. The HPDT cancelled his registration, censured him, and imposed NZD 15,600 in costs, reflecting the severity of his unethical behavior. The primary harm stemmed from grooming, a serious ethical violation, but text messaging amplified the misconduct by enabling persistent, unmonitored contact across geographical distances.

This case demonstrates the medico-legal framework's flexibility in addressing digital harm by registered providers outside service relationships, leveraging professional misconduct provisions to protect public trust in healthcare (Health Practitioners Disciplinary Tribunal, 2010). The use of digital tools, particularly texting, facilitated the nurse's ability to maintain inappropriate contact, highlighting the technology's role in extending the reach of unethical behavior. The HPDT's ruling sets a precedent for disciplining registered practitioners in similar scenarios, such as those involving misinformation or vaccine denial, where professional conduct impacts public perception (Rychert et al., 2022).

However, a critical gap emerges for unregistered providers, who are not subject to HPDT oversight. If Mr. D had been an unregistered practitioner, such as a counsellor or naturopath, the medico-legal framework would offer limited recourse, as the Health and Disability Commissioner's jurisdiction requires a service relationship, and the Harmful Digital Communications Act 2015 (HDCA) focuses on individual harm (Paterson & Manning, 2017). The HDCA allows remedies like apologies or cessation orders under Section 19, but these lack the disciplinary impact of HPDT penalties, such as deregistration or fines, and do not address professional reputational harm (Harmful Digital Communications Act, 2015). This regulatory shortfall, noted by Paterson and Manning (2017), underscores the need for legislative reform to extend accountability to unregistered providers, particularly as digital platforms increase the potential for harm.

The case underscores the importance of ethical training for all healthcare providers, emphasizing that digital interactions, even outside clinical roles, carry professional responsibilities. It also highlights the need for policies restricting personal device use in healthcare settings to prevent misuse (Geraghty et al., 2021). As digital harm evolves, addressing these gaps will be crucial to ensure comprehensive protection for individuals and the integrity of healthcare professions.

9. A LANDMARK CASE IN HEALTHCARE

The concept of digital harm extending beyond individuals to groups, such as professional communities or the public, presents unique challenges within New Zealand's medico-legal framework. This section examines a groundbreaking 2020 case, HPDT decision 1114/Nur20/468P, which marked the Health Practitioners Disciplinary Tribunal's (HPDT) first consideration of social media comments by a registered health practitioner that caused harm to collective entities (Health Practitioners Disciplinary Tribunal, 2020). The case underscores the capacity of digital platforms, particularly social media, to amplify professional misconduct, while highlighting the medico-legal system's ability to address such harm through existing disciplinary mechanisms. However, it also raises questions about the system's scope when dealing with amorphous groups and potential freedom of expression defenses, pointing to future challenges in regulating digital conduct (Rychert et al., 2022).

The case involved a registered nurse who, in 2019, posted derogatory comments on a public Facebook page targeting Māori nurses in Taranaki, describing them as "lazy, dishonest, and unprofessional" and identifying specific workplaces, departments, and an individual, risking their identification (Health Practitioners Disciplinary Tribunal, 2020). This was not the nurse's first offense; similar remarks in 2018 led to a mandate for cultural competence training, which she failed to complete. The specificity of the 2019 comments heightened their impact, as evidenced by testimony from a Māori registered nurse at a two-day hui for Māori nursing students. She reported that the posts caused significant distress and anger, disrupting the event and affecting attendees' morale (Health Practitioners Disciplinary Tribunal, 2020).

The HPDT recognized the case as a novel issue, addressing the extent to which health practitioners must avoid social media posts that offend colleagues, health consumers, and the broader public. To inform its decision, the Tribunal reviewed international disciplinary cases involving racist or discriminatory social media posts, which consistently deemed such actions as serious misconduct that discredited professions (Health Practitioners Disciplinary Tribunal, 2020). These precedents were directly applicable, reinforcing the HPDT's authority to act on similar grounds under the Health Practitioners Competence Assurance Act 2003 (HPCAA).

The nurse did not invoke a freedom of expression defense under the New Zealand Bill of Rights Act 1990, instead claiming her comments were truthful based on personal experience a justification the HPDT dismissed as baseless (Health Practitioners Disciplinary Tribunal, 2020). A rights-based defense could have complicated the case, potentially challenging the boundaries of professional misconduct, and may emerge in future disputes. The Tribunal identified multiple harmed groups: individual Māori nurses potentially identifiable by the posts, Māori nurses as a collective, Māori healthcare consumers who rely on non-discriminatory care, professional colleagues, nursing organizations, and the nursing profession at large, which suffered reputational damage (Health Practitioners Disciplinary Tribunal, 2020).

The HPDT classified the nurse's actions as professional misconduct under HPCAA Section 100(1)(b), citing their potential to bring discredit to the profession. Combined with a separate charge of practicing while suspended, the Tribunal imposed severe penalties: cancellation of registration, a two-year ban on re-registration, mandatory education and supervision upon reinstatement, and censure (Health Practitioners Disciplinary Tribunal, 2020). This decisive response sent a clear message that social media misuse harming groups would face stringent consequences, reflecting the HPCAA's aim to protect public trust in healthcare.

The case highlights the unique nature of digital harm enabled by social media's reach and permanence, which can rapidly disseminate harmful content to wide audiences (Law Commission, 2012). Unlike individual harm cases addressed by the Health and Disability Commissioner (HDC), group harm falls outside the HDC's jurisdiction, which focuses on consumer rights violations. The HPDT's authority to consider professional discredit under HPCAA provides a critical mechanism for addressing such cases, aligning with the Act's public protection mandate (Health Practitioners Competence Assurance Act, 2003). However, the case's focus on identifiable groups (e.g., Māori nurses) raises questions about the system's applicability to broader, less defined groups, such as the general public, where harm is harder to quantify.

Future challenges may involve cases where practitioners invoke freedom of expression rights, particularly in contentious areas like vaccine misinformation, which could test the balance between individual rights and professional obligations (Rychert et al., 2022). The HPDT's reliance on international precedents suggests a robust framework, but evolving social media dynamics may require refined guidelines to clarify acceptable conduct. The case also underscores the need for ongoing education on cultural competence and digital ethics, as the nurse's prior failure to complete training contributed to her recidivism (Geraghty et al., 2021).

This landmark decision demonstrates the medico-legal system's adaptability in addressing novel forms of digital harm to groups, leveraging existing disciplinary tools to uphold professional standards. However, it also highlights the need for proactive measures, such as enhanced training and social media policies, to prevent such misconduct and maintain public confidence in healthcare professions.

10. PARAPHRASED GAPS IN ADDRESSING DIGITAL HARM IN HEALTHCARE

New Zealand's medico-legal framework effectively addresses digital harm by registered health practitioners, but significant gaps remain, particularly for unregistered providers causing harm to groups or individuals outside service relationships. The primary shortfall lies in the lack of disciplinary mechanisms for unregistered practitioners, such as counsellors or naturopaths, who are not governed by the Health Practitioners Competence Assurance Act 2003 (HPCAA) or professional bodies (Paterson & Manning, 2017). Unlike registered providers, whose misconduct can lead to deregistration or fines via the Health Practitioners Disciplinary Tribunal (HPDT),

unregistered providers face no equivalent professional consequences, even when their actions, such as racist digital communications, discredit their occupation. This gap undermines public trust and highlights the need for regulatory reform to extend accountability to unregistered occupations.

Another critical limitation is the inability to address digital harm by unregistered providers when no service relationship exists. The Health and Disability Commissioner's jurisdiction, under the Code of Health and Disability Services Consumers' Rights, requires a provider-consumer relationship, leaving victims of non-service-related harm without recourse through this avenue (Health and Disability Commissioner Act, 1994). While the Harmful Digital Communications Act 2015 (HDCA) offers remedies like apologies or cessation orders for individual harm, these lack the punitive or disciplinary impact of HPDT sanctions and do not address group harm (Harmful Digital Communications Act, 2015). Alternative legal pathways, such as the Harassment Act 1997, may apply, but they are not tailored to healthcare contexts and offer limited remedies compared to medico-legal processes.

These gaps underscore the need for legislative changes to regulate unregistered providers, potentially by encouraging professional registration to enable disciplinary oversight. Enhanced policies and training on digital ethics could also mitigate risks, ensuring all providers uphold professional standards in digital interactions (Geraghty et al., 2021). Addressing these deficiencies is crucial to comprehensively protect individuals and groups from digital harm in healthcare settings.

11. EMERGING CHALLENGES AND FUTURE DIRECTIONS

The COVID-19 pandemic has introduced new dimensions of digital harm within New Zealand's health sector, particularly through the spread of vaccine denial, promotion of unproven treatments such as Ivermectin, and the dissemination of general misinformation related to the virus. These issues pose significant risks due to the public's reliance on health providers for accurate and trustworthy information. The potential for harm is amplified in healthcare settings, where misinformation can undermine public health efforts and erode trust in medical professionals. While media reports indicate numerous complaints lodged with the Health and Disability Commissioner and the responsible authorities under the Health Practitioners Competence Assurance Act (HPCAA), no definitive cases have yet progressed through these channels as of early 2023.

For registered health practitioners, the medico-legal system is equipped to address such misconduct through disciplinary pathways, primarily under charges of professional misconduct. These charges can apply regardless of whether the harm affects an individual or a broader group, leveraging the flexibility of the HPCAA. For instance, professional misconduct charges could address actions that discredit the profession or compromise public safety. The Health and Disability Commissioner may also investigate complaints involving both registered and unregistered providers, particularly when individual consumer rights are breached. Such breaches often relate

to the obligation to provide services that meet legal, professional, and ethical standards, as outlined in right 4(2) of the Code of Health and Disability Services Consumers' Rights. In these cases, affected individuals may pursue remedies through the Human Rights Review Tribunal (HRRT), which can award damages for breaches of the Code.

A significant challenge on the horizon is the potential invocation of freedom of expression arguments under the New Zealand Bill of Rights Act 1990 (BORA). Section 14 of BORA guarantees the right to freedom of expression, and section 6 mandates that laws be interpreted in a manner consistent with BORA where possible. This was briefly explored in a 2021 judicial review case, which was settled before reaching a substantive hearing. Future cases involving vaccine misinformation or similar conduct may see providers invoking BORA to defend their actions, arguing that their public statements fall within protected speech. Such arguments could complicate professional misconduct proceedings, particularly when the harm is directed at large, undefined groups like the general public. These cases may test the boundaries of the medico-legal system's ability to balance individual rights with the need to protect public health and maintain professional standards.

The medico-legal framework's ability to address digital harm will likely continue to evolve as new technologies and forms of communication emerge. The challenge lies in ensuring that disciplinary and regulatory responses remain robust and adaptable, particularly in addressing misinformation that affects public trust in healthcare. As these issues develop, the interplay between freedom of expression and professional accountability will be a critical area for legal and policy consideration, potentially requiring clearer guidelines or legislative amendments to strengthen the system's response to digital harm in health contexts.

12. CONCLUSIONS

The cases analyzed highlight a range of serious misconduct by health providers in New Zealand, including breaches of ethical boundaries, professional negligence, and actions exceeding providers' scopes of practice. Digital technologies, such as text messaging and social media, have facilitated and intensified these behaviors, enabling harm to reach broader audiences with greater immediacy. However, these instances of digital harm do not necessarily represent entirely new forms of misconduct. Instead, they often reflect traditional unethical or unprofessional behaviors amplified by digital tools. The existing medico-legal framework, encompassing the Code of Health and Disability Services Consumers' Rights and the Health Practitioners Disciplinary Tribunal (HPDT), has proven capable of addressing these issues effectively. Aggrieved consumers have access to remedies through the Health and Disability Commissioner and the Human Rights Review Tribunal, while registered practitioners face disciplinary actions under the Health Practitioners Competence Assurance Act (HPCAA). Notably, consumers have not needed to rely on the Harmful Digital Communications Act (HDCA) for redress, underscoring the robustness and adaptability of the medico-legal system in handling digital harm within healthcare settings.

A significant limitation, however, is the system's inability to regulate unregistered providers, particularly when harm occurs outside a service relationship or affects groups rather than individuals. This gap, a long-standing issue in New Zealand's medico-legal framework, highlights the need for legislative reform to extend oversight to unregistered practitioners, such as counsellors or alternative therapists, who may cause harm through digital means. Addressing this would require political commitment to enhance regulatory mechanisms, potentially through mandatory registration for certain professions.

The cases also serve as a cautionary reminder for health providers about the responsible use of digital technologies. The immediacy of digital communication, its potential for rapid and uncontrolled dissemination, and the risk of inappropriate interactions outside clinical oversight pose significant hazards. These risks are not unique to New Zealand and reflect global challenges in healthcare settings. Looking ahead, the medico-legal system will face challenges in addressing digital harm related to misinformation, particularly around vaccines, where freedom of expression arguments under the New Zealand Bill of Rights Act may complicate disciplinary proceedings. These evolving issues will test the system's ability to balance professional accountability with individual rights, necessitating ongoing vigilance and potential policy adjustments to ensure consumer protection and public trust in healthcare.

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