Medical Misadventure – Legislation, Reporting, and Injury Prevention:

An evaluation of the process of ACC's reporting of medical error findings with regard to injury prevention.

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Abstract

This research investigated and evaluated the reporting process with regard to medical error as under the Accident Rehabilitation Compensation Insurance Act (1992) and the impact of that process with regard to the prevention of injury. It considers:

(a) whether the legislation is consistent with regard to the aim of the prevention of injury;
(b) the outcomes of the reporting process in terms of injury prevention;
(c) if anything else could be done in terms of injury prevention.

Under the Accident Rehabilitation and Compensation Insurance Act (1992) the Accident Compensation Corporation (ACC) was specifically required to 'report the circumstances [of the injury] to the appropriate body with a view to the institution of disciplinary proceedings, and to any other body that may be appropriate' if the Corporation was satisfied that negligence or inappropriate action had caused personal injury (ARCI Act, 1992). Reporting of medical error by health professionals is one mechanism available to the ACC to prevent injury. Reporting to bodies such as the Health and Disability Commissioner's (HDC) office and organisations responsible for the registering of health professionals can result in changes which minimise the re-occurrence of the medical error.

This research is based on a formative policy evaluation. It seeks to improve ACC's medical error reporting process and employs the methodological tools of document research and case studies. The study is based on a random selection of sixty claims accepted on the basis of medical error under the Accident Rehabilitation and Compensation Insurance Act (1992). The process of data analysis was informed by grounded theory in that four analytical categories established were based on similarity of content, according to their injury prevention outcome.

The key findings of this evaluation resulted in recommendations which relate to improving the ACC's medical error reporting process. These may be of interest to those working in the area of policy development and/or process improvement, with regard to the reporting of medical error for the purpose of injury prevention.

It is clear that there is a need for further research into the outcome of injury prevention initiatives undertaken by professional bodies and for the uptake of injury prevention initiatives by the ACC and the HDC's office.

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Chapter One – Introduction

1. 1 Research Aims and Objectives

The focus of this research is medical error covered by the provisions of New Zealand's Accident Compensation Corporation (ACC)[1]scheme. Medical error was originally defined under the medical misadventure provisions in the Accident Rehabilitation and Compensation Insurance Act (1992). The term 'medical misadventure' encompassed injuries caused by the treatment given by a registered health professional[2] in the case of both medical error and medical mishap (see Figure 1). Medical error was defined as 'a failure to observe a standard of care and skill reasonably to be expected in the circumstances' (Accident Rehabilitation and Compensation Insurance Act 1992). A higher threshold of error was required in circumstances where there had been a failure to obtain informed consent; a failure to diagnose correctly; or a failure to provide treatment. For these circumstances, it was only considered to be medical error where there was evidence that negligence had occurred. Alternatively medical mishap was defined as an adverse consequence of treatment 'properly given' if the consequence was rare and severe. The adverse event was considered rare if the probability that it would occur was less than 1% where that treatment was given. An adverse event was considered severe if a person suffered a significant disability lasting more than 28 days or more; hospitalisation was required for more than 14 days; that

[1] When referring to the Accident Compensation Corporation I have used the terms "ACC scheme" or "the scheme". When referring to the organisation responsible for the management and the provision of the scheme I have used the terms "the Corporation" or "the ACC".

[2] Under the Accident Rehabilitation and Compensation Act (1992)
"Registered health professional" means–
(a) Any person who-
(i) Is entitled to practise medicine under the title of medical practitioner pursuant to section 9 of the Medical Practitioners Act 1995; and
(ii) Holds a current certificate issued under that Act or the Medical Practitioners Act 1968 evidencing that entitlement to practise medicine; or
(b) Any person who holds a current annual practising certificate issued by the Chiropractic Board, the Dental Council of New Zealand, the Dental Technicians Board, the Nursing Council of New Zealand, the Occupational Therapy Board, the Pharmaceutical Society of New Zealand, or the Physiotherapy Board; or
(c) Any person registered with the Medical Laboratory Technologists Board, the Medical Radiation Technologists Board, or the Podiatrists Board; or
(d) Any optometrist registered with the Opticians Board:

person was assessed as having an impairment of greater than 10%; or a person died.

Figure 1. Summary of Medical Misadventure (as defined in the Accident Rehabilitation and Compensation Act 1992)

Medical Error	Medical Mishap

• Failure to observe a standard of care reasonably to be expected in the circumstances.
• This may include a failure to diagnose, treat and obtain informed consent if that failure is negligent.
	• Adverse outcome of treatment properly given (that is rare and severe).
	  • It was considered rare if the probability that it would occur was less than 1% where that treatment was given.
	  • It was considered severe if a person suffered a significant disability lasting 28 days or more; hospitalisation was required for more than 14 days; that person was assessed as having an impairment of greater than 10%; or a person died.

In particular, this research explores how the formal requirements for the reporting of medical error relate to injury prevention. Despite changes in legislation in the last decade, medical error has remained a form of personal injury covered by the ACC scheme. What has changed is the emphasis placed on injury prevention. Reporting of medical error by health professionals is one mechanism available to the ACC scheme to prevent injury which can result in changes to minimise the reoccurrence of the medical error. However, since 1992 the reporting requirements have changed three times, illustrating the political priorities of different policy regimes.

With the introduction of the Accident Rehabilitation and Compensation Insurance Act in 1992 the provisions of New Zealand's ACC scheme were modernised. Under the 1992 Act medical misadventure was defined as an area of personal injury. The ACC scheme not only compensated those who suffered medical misadventure, but was also required to meet a new reporting requirement.

Specifically the Corporation was required to "report the circumstances [of the injury] to the appropriate body with a view to the institution of disciplinary

proceedings, and to any other body that may be appropriate" if the Corporation was satisfied that negligence or inappropriate action had caused personal injury (Accident Rehabilitation and Compensation Insurance Act 1992).

This requirement to report changed twice in the following decade. The Accident Insurance Act (1998) repealed the Accident Rehabilitation and Compensation Insurance Act (1992) and the reporting function was removed. However, the Injury Prevention, Rehabilitation, and Compensation Act (2001) which repealed the Accident Insurance Act 1998 has been reintroduced and the reporting process has been expanded. This is because the current Act has a major focus on injury prevention.

It is the reporting processes around medical error and outcomes with regard to the prevention of injury which are of interest to me. This research is a case study of the relationship between reporting requirements and injury prevention. In particular it evaluates the medical error reporting process as provided under the Accident Rehabilitation and Compensation Insurance Act (1992) and the impact of that process with regard to the prevention of medical error injuries.

The objectives of the research were to:

- identify and describe the aims, processes and outcomes of the ACC's reporting requirements with regard to sixty claims lodged under the Accident Rehabilitation and Compensation Insurance Act (1992);
- explore the extent to which the ACC's reporting of medical error to the Health and Disability Commissioner's (HDC's) Office and professional bodies such as the Medical Council has resulted in outcomes which may assist with injury prevention initiatives; and to
- make recommendations, as appropriate, on how medical error processes might be improved in order to maximise the prevention of injury.

1.2 Philosophical Basis of Research

My interest in the topic of medical misadventure, and more specifically medical error, is a result of my working in the Medical Misadventure Unit of the

Corporation. The choice of topic grew out of my personal and professional curiosity about the journey of 'error findings', typically, situations where a registered health professional had failed to observe a standard of care and skill reasonably to be expected in the circumstances. In particular, I was interested as to whether error findings ended up in some dusty filing cabinet, or were used constructively to develop progressive policy initiatives which would result in the prevention of injury.

Criticisms of the positivist tradition has seen modern social scientists become more aware of the importance of the researcher's philosophical roots in the choice of research design (Marchant & Wearing 1986). Given this, my research is not value neutral in the classic positivist sense which sees research as 'context free', carried out by 'non-people' in 'non-places' (Bell & Newby 1976, p 37). However, one can still do reliable research as 'inside evaluation' that is consistent with the decision makers' goals and values – and perhaps stretches their sights (Weiss 1987, p. 65). For example, I am supportive of the universal provision of social services, including the ACC scheme, and any efforts that may improve them. My research question, research design, and research analysis have been shaped by my 'insider status' as an employee of the Corporation, and by my interest in the area of medical error. This awareness has obliged me to apply special rigor to the conclusions which I reached.

1.3 Thesis Overview

The thesis begins with an outline of the aims, objectives and philosophical basis of the research topic. In Chapter Two the policy context in which the medical misadventure (including medical error) legislation has evolved is explained. Chapter Three explores the policy environment and considers the medical error legislation and agencies on which it impacts. In Chapter Four national and international empirical studies of medical error are outlined and studies of, and conceptual approaches to, medical error are discussed. The ACC scheme is compared with other no-fault schemes. Chapter Five outlines the process of data collection, analysis and determination of key findings. The results are summarised in Chapter Six and Chapter Seven discusses the major findings.

Chapter Eight concludes the study and presents a summary of the key findings and presents recommendations as to how the ACC's medical error reporting process might be improved in order to maximise the prevention of injury.