

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

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.

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Social Policy, Massey University, Palmerston North, New Zealand.

Lisa Tatiana Ralph

February 2003

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.

Acknowledgements

First and foremost, I would like to express my immense gratitude to my supervisors Dr Jocelyn Quinnell and Lesley Patterson whom I admire both personally and professionally. It was a great privilege working with them and the thesis itself has been greatly enhanced by their wisdom, support and encouragement.

Grateful thanks to the Health and Disability Commissioner, Ron Paterson and his helpful team for supporting this research. I would also like to express my thanks to ACC for their support.

Special thanks to Cathy Kern and Jane Chilcott for editing and proof reading. I would also like to thank other friends and family who have supported me in various ways over the past two years of study.

Table of Contents

<i>Title Page</i>	<i>i</i>
<i>Abstract</i>	<i>ii</i>
<i>Acknowledgments</i>	<i>iv</i>
<i>Table of contents</i>	<i>v</i>
<i>List of figures</i>	<i>ix</i>
Chapter One – Introduction	1
1.1 Research Aims and Objectives	1
1.2 Philosophical Basis of Research	3
1.3 Thesis Overview	4
Chapter Two – The Policy Context	6
2.1 The International Policy Context	6
2.2 Models of Social Policy and the New Zealand Policy Context	8
2.3 Health Reforms	15
2.4 ACC Reforms	17
2.5 Conclusion	22
Chapter Three – The Policy Environment	23
3.1 Introduction	23
3.2 ACC Medical Misadventure Legislation 1972-2002	23
3.2.1. Defining Medical Misadventure	23
3.2.2 Personal Injury Caused by Accident	24
3.2.3 Accident Rehabilitation and Compensation Insurance Act (1992) and Subsequent Reporting Requirements	26
3.2.4 “Experience Rating” of Registered Health Professionals	30
3.3 HDC and Professional Bodies to Whom the ACC Reports Medical Error	31
3.3.1 Medical Council	33
3.3.2 Nursing Council	35
3.3.3 Health and Disability Commissioner Act (1994)	37
3.3.4 Complaints Review Tribunal	40
3.4 Public Health Inquiries into Adverse Events Since 1987	40
3.5 Conclusion	44

Chapter Four - Literature Review	46
4.1 Introduction	46
4.2 Injuries Arising from Medical Treatment - Definitions	47
4.3 International Studies Into the Frequency of Medical Error	49
4.4 Frequency of Adverse Events in Hospitals	49
4.5 Preventable Adverse Events	51
4.6 Person Versus Systems Approach	55
4.7 Injury Prevention in a Tort System.....	60
4.8 Injury Prevention in a No-Fault System	63
4.9 Accident Rehabilitation and Compensation Insurance Act (1992) Compared To Other No-Fault Schemes In Terms of Injury Prevention	67
4.10 Conclusion	68
Chapter Five - Methodology	69
5.1 Introduction	69
5.2 Research Design	69
5.3 Research Method and Process	70
5.4 Data Collection Techniques	72
5.5 Data Management, Theory and Analysis	75
5.6 Values and Politics	78
5.7 Ethics	79
Chapter Six - Results	81
6.1 Introduction	81
6.2 Unknown Outcome	83
6.3 Ambiguous Outcome	85
6.4 Injury Prevention Outcome	89
6.5 No Injury Prevention Outcome	91
6.6 Eight Case Studies	91
6.7 Missing Files	98
6.8 Claims Not Reported to the HDC's Office	98
6.9 Conclusion	99
Chapter Seven – Discussion	101
7.1 Introduction	101
7.2 Legislative Intent	101
7.2.1 Rationale Injury Prevention Goal	103

7.2.2	Mandatory Reporting of Medical Error	104
7.2.3	Reporting General Trends	105
7.2.4	Person and Systems Error	105
7.2.5	Fault Versus Avoidability Criteria	106
7.3	Research Results	106
7.3.1	Unknown Outcome	107
7.3.2	Ambiguous Outcome	108
7.3.3	Injury Prevention Outcome	109
7.3.4	No Injury Prevention Outcome	110
7.3.5	Analysis of Eight Case Studies	110
7.3.6	Number of Missing ACC Copy Files	114
7.3.7	Number of Files Not Reported	115
7.4	Conclusion	116
Chapter Eight – Conclusion		120
8.1	The Research Process	121
8.2	Key Findings and Recommendations	121
8.2.1	Finding 1 - The Aims and Goals of the Accident Rehabilitation and Compensation Insurance Act (1992)	121
8.2.2	Finding 2 - Processes and Outcomes of the ACC's Reporting Process in Terms of Injury Prevention	122
8.2.2.1	Unknown Outcome	122
8.2.2.2	Ambiguous Outcome	122
8.2.2.3	Injury Prevention Outcome	123
8.2.2.4	No Injury Prevention Outcome	123
8.2.2.5	Eight Case Studies	123
8.2.2.6	Missing ACC Copy Files	124
8.2.2.7	Number of Claims Not Reported to the HDC	124
8.2.3	Finding 3 - Reflecting on Theoretical Material	125
8.2.3.1	Systems Error	125
8.2.3.2	Fault Versus Avoidability Criteria	125
8.3	Recommendations	126
8.4	Future Research Opportunities	127
References		128

Appendices.....135

Appendix One

 Massey University Human Ethics Research Proposal 135

Appendix Two

 ACC Support Letter 145

Appendix Three

 HDC Support Letter 146

List of Figures

Figure One:	Summary of Medical Misadventure (Accident Rehabilitation Compensation Insurance Act (1992)	2
Figure Two:	ACC Cover for Personal Injury Resulting from Medical Intervention, and Reporting Requirements	7
Figure Three:	Summary of Reporting Structure Under Various ACC Legislation	32
Figure Four:	Injuries arising from medical treatment (within and beyond ACC cover)	48
Figure Five:	Frequency of Adverse Events Per Hospital Admission	53
Figure Six:	The ‘Swiss cheese’ Model of Defences	56
Figure Seven:	Advantages and Disadvantages of a Tort Based System of Compensation in Terms of Injury Prevention	60
Figure Eight:	Advantages and Disadvantages of a No-Fault Based System of Compensation in Terms of Injury Prevention	63
Figure Nine:	Graph Showing Injury Prevention Outcomes	82
Figure Ten:	Injury Prevention Outcomes	83
Figure Eleven:	Criteria for Falling into Category “Unknown Outcome”...85	
Figure Twelve:	Criteria for Falling into Category “Ambiguous Outcome”...87	
Figure Thirteen:	Description of the Injury Prevention Initiatives Taken (in relation to Ambiguous Outcome)	88
Figure Fourteen:	Responsibility for the Injury Prevention Initiative (in relation to Ambiguous Outcome)	89
Figure Fifteen:	Responsibility for Taking the Injury Prevention Initiative (in relation to Injury Prevention Outcome)	90
Figure Sixteen:	Description of Injury Prevention Initiatives Taken (in relation to Injury Prevention Outcome)	90
Figure Seventeen:	No Injury Prevention Initiative Undertaken	91
Figure Eighteen:	ACC Copy Files That Could Not Be Located	98
Figure Nineteen:	Medical Error Findings Reported to the HDC	99

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 professional² 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
<ul style="list-style-type: none">• 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.	<ul style="list-style-type: none">• Adverse outcome of treatment properly given (that is rare and severe).<ul style="list-style-type: none">• 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.

Chapter Two – The Policy Context

In this chapter the policy context in which the medical misadventure legislation, including medical error legislation, has evolved is described. This comprises an outline of the international and national policy context, including health and the ACC policy reform in New Zealand in the 1990s.

2.1 The International Policy Context

The social democratic tradition that was influential in informing social policy in New Zealand often reflects international policy trends, particularly in those countries who are members of the Organisation of Economic Cooperation and Development (OECD). In a general sense, these countries share a common socio-political tradition. Most OECD countries have shifted in their public policy orientation from a post war social democratic policy approach, towards an end of century neo-liberal policy approach.

According to Cheyne, O'Brien & Belgrave (1998), social policy in the immediate post-war period has its roots in both liberalism and socialism. Liberalism which emerged in eighteenth century Europe is strongly committed to the rights of individuals. In general, liberalism encompasses both those proponents who reluctantly accept state intervention in the market as well as those who oppose it. Proponents of social democracy support the use of state intervention which is generally associated with a mixed economy and the application of Keynesian economic management principles. A key tenet of Keynesian economic management is that government investment is central to, and facilitates, economic growth. From the Keynesian perspective capitalism is the most effective form of economic management, and the role of government policy is to complement the market and humanise capitalism. The 'welfare state' is required to create boundaries in which the market operates and to reduce the excesses of market-led operations. Social democracy also includes a commitment to liberal

representative democracy that protects individual liberty (Cheyne et al. 1998:75-76).

In the 1970s increasing concerns around government deficits in OECD countries led to a general shift in the popularity of policies informed by the social democratic tradition to those of the neo-liberal tradition. Neo-liberalism developed from the strand of liberalism that was of the view that the state should have a limited or residual role in the economy by limiting government expenditure and controlling the money supply to stop inflation. Neo-liberal theory endorses the rights of freely choosing individuals who accept responsibility for the choices they make within the market place. From this perspective any attempt by government to alter the distribution of the burdens and benefits of the market is regarded as interfering with the freedom of the individual. Some neo-liberal thinkers argue welfare services should be provided by voluntary groups, private charity, or by the family, while others offer a range of views on the extent to which the government should intervene. For example, most neo-liberals see government as having a role in redistributing resources, to a limited extent, but not being involved in the ownership of the organisations that provide those resources (Cheyne et al. 1998:87-89).

By the 1990s the international shift from Keynesian liberalism to neo-liberalism or to what some analysts term the 'new right' was evident not only in New Zealand, but also in countries such as Britain and the United States. For example, in Britain the Conservative Government (1979-97) made significant neo-liberal changes in key social policy areas in order to reduce assistance levels and curb welfare dependence (Boston 1999). More recently, the British Labour Government led by Tony Blair has announced plans for major social reforms, including greater emphasis on targeted assistance (Boston 1999, p. 4). In the United States, during the 1980s and 1990s both the Republican and Democratic administrations cut welfare programmes and imposed more stringent eligibility criteria (Boston 1999, p. 4). Analysts of the new right in Britain and the United States have noted that the revival of liberalism was also merged with conservatism, with liberalism being the dominant element (Kelsey 1993).

The combining of the traditions of liberalism and conservatism contained basic contradictions, particularly around the role of the state (Kelsey 1992, p. 95). The traditional liberal values of individualism, limited government and the free market did not sit comfortably with the conservative approach to government being used to establish societal order, and authority based on social, religious and moral conservatism. Liberalism and conservatism did, however, share common ground on two key issues. They both rejected state provision of economic and social welfare. The liberals had concerns that the expansion of civil and political rights would affect individual liberty, and the conservatives wanted to 'protect the family' and 'traditional values'. The other area of agreement was civil and political citizenship rights such as rights to free speech, rights to property, equality before the law, and universal suffrage. The result was a new platform of liberal-conservative discourse, with the aim of promoting neo-liberal protection of the free market economy albeit with a strongly conservative anti-egalitarian cultural and social tradition (Kelsey 1993, p. 295).

2.2 Models of Social Policy and the New Zealand Policy Context

Ware and Goodin have developed three models to categorise welfare states (cited in Boston 1999, pp. 5-8). These are a residualist, an insurance based and, a social citizenship model. A residualist model sees the state as having a minimalist or needs-based role where individuals are expected to provide for the bulk of their needs via the market, their family, or through voluntary agencies and charities. The implications are that individuals are responsible for their own well being. Those unable to meet their narrowly defined basic needs through their own efforts are entitled to targeted state assistance which would include education, housing, healthcare, and income maintenance. Any benefits are rigorously means-tested to ensure that state assistance is kept to an absolute minimum. In the residualist model, there is little redistribution of resources to those in need and as a result, substantial inequality is likely. The residualist model has its roots in classical liberalism and has more recently been supported by neo-liberals and neo-conservatives. The United States is the closest example of an OECD country with a residualist model although it does not represent a pure residualist model. Most

other OECD countries also have examples of tightly targeted forms of social provision.

In the pure form of the insurance based model, social assistance is provided on the basis of previous contributions by the individual, family or employer. The range of social assistance depends upon the contributions made, and not on one's financial need. Under the insurance based model only contributors are eligible for assistance. Those without insurance may receive nothing regardless of their need, unless the model has compulsory or universal coverage. Those with insurance cover may receive assistance despite having no need. For example, a retirement income may be paid despite the recipient having no need for it. Under an insurance based model 'interpersonal' income redistribution will occur (e.g. from those who experience permanent employment to those who experience periods of unemployment), but much of the redistribution will be 'intrapersonal' i.e. over a person's life cycle, for example, from the period spent in the workforce to any period spent unemployed, incapacitated or retired (Boston 1999, pp. 6-7). In an extreme form, this model tends to discriminate against those who are unable to work or who spend much of their working life in unpaid work, such as looking after children. The insurance based model was more common in the late nineteenth and early twentieth centuries than it is today. The insurance based model is found in social policies of most OECD countries where it remains significantly in policy domains such as contributory pensions, health care insurance and unemployment benefits but it is usually supplemented by means-tested, or universal social assistance programmes. New Zealand's ACC scheme is, arguably, an example of the universal form of an insurance based model.

Under the social citizenship model, entitlement to social services and income transfers is based on a person's status as a citizen rather than on income, assets, prior earnings or contribution. Under this model all those in need of, for example, healthcare have a right (within certain limits) to receive the form of assistance they require, free of charge or for only a minimal fee at the point of need funded via general taxation. The social citizenship model aims to provide good quality public services for all, and to ensure that levels of income support are sufficient to enable people to participate in society. The intention is that the cost of social

services is shared by the whole community. It is a model which has its roots in social democratic thinking and emerged in the middle of the twentieth century. The most comprehensive example is found in Scandinavia, although not all social services in Scandinavia are available universally, for example, means testing occurs in the delivery of tertiary education and housing. There is considerable debate on the extent to which income is redistributed under the social citizenship model. Some scholars claim that universal benefits often favour the middle class disproportionately, while critics argue that this model can be expensive because of the range of assistance required and the high levels of payment.

Most OECD countries use elements of all three welfare state models. Boston, (1999, p. 8) argues that between the mid 1930s and the late 1970s there was a general trend away from residualist and insurance based models towards a citizenship model. However, since the early 1980s the trend has been reversed in many countries, including New Zealand. There has been a shift towards neo-liberal models of social policy and the general shift away from the social democratic tradition towards neo-liberalism has influenced the current shape of New Zealand's welfare state. This can be seen in the changing expectations of the role of the state and individual self responsibility as illustrated in the health and the ACC scheme reforms of the 1990s where many of the costs were transferred from the state to the individual.

Kelsey (1993, p. 296) argues that the political analysis of events in Britain and the United States cannot be simply transported to the programme of neo-liberal reform in New Zealand where the political arrangements were quite different. For example, during the 1970s and early 1980s the Muldoon administration had displayed conservatism, but not the liberalism that came to be associated with the emerging new right.

In New Zealand, the shift to the right is demonstrated by the social policy developments in the late 1980s and 1990s of both the Labour and National Governments. Prior to the Fourth Labour Government's successful election in 1984, the bulk of social expenditure including education, healthcare and some forms of income maintenance, was largely non means-tested (Boston 1999). By

the end of the 1980s, much of this social expenditure was to become 'targeted' as neo-liberal policy shifts consolidated.

Kelsey (1993, p. 296) describes the Labour Government's rapid implementation of a range of neo-liberal economic policies in 1994. The direction of Roger Douglas's (Rogernomic's)³ programme to deregulate and globalise the New Zealand economy, to privatise state resources, and to commercialise and centralise the public service. The element of conservatism evident in reforms in Britain and the United States was largely absent from Labour's programme. Many conservatives found Labour's social and foreign policies unpalatable despite having some sympathy with the neo-liberal economic revival undertaken by the Labour Government.

In the mid-1980s, rather than reaching an accord between liberalism and conservatism, the Fourth Labour Government faced the arguably more difficult task of attempting to reconcile liberalism with social democracy. Kelsey (1993, p. 16) argues that the new generation of liberal economists opposed state intervention and blamed the decline of profitability on the effects of the institutional arrangements of the welfare state and of government intervention. According to these economists change required less government, the privatisation of state assets and businesses, an increased emphasis on economic efficiency, a reduction in public expenditure, and a 'rolling back' of the welfare state. Where there was excess in production such capacity was to be sold off, and those sectors of the economy that could not 'survive' economically were to be allowed to fall victim to market pressures. Social priorities were to be reconsidered, e.g. a commitment to the free-market economy, and a reduction in welfarism which was seen to undermine workers' motivation.

Policies implemented during Labour's 1984-1990 term demonstrate a more targeted welfare regime. For example, greater assistance was provided to lower income families through Family Support and Youth Support Families, and part of the Student Allowance for 18 and 19 year olds was means-tested from 1989

³ The term Rogernomics describes the economic programme set by Roger Douglas and a small group of freemarket enthusiasts under the Fourth Labour Government.

(Boston 1999, p. 9). The main thrust of the introduction of user charges was away from a universal system towards a more targeted regime (Ashton 1992, p. 160).

Changes to tax law also influenced the political direction of social policy during the 1990s (Boston 1999, p. 9-10). In the late 1980s, the Labour Government introduced a flattened tax scale and placed a greater reliance on indirect taxes. This had three major implications. There was less progression in the tax system which increased income inequality. And, the top marginal income rate was set at thirty-three cents in the dollar, one of the lowest rates in the OECD. By introducing the flat tax scale, the potential revenue available for social services was reduced and was used as a justification for greater targeting of social services. The flattening of the tax rate made it more easy, politically, to defend a greater degree of targeting on the basis that those on higher incomes could afford to pay for their own social services and on the basis of equity, that with less income redistribution it was necessary to target those with the greater need.

When the National Government was elected in 1990, it set about transforming most aspects of New Zealand's welfare state (Boston 1999, p. 3-5). This transformation included large cuts in the value of most welfare benefits, a significant increase in the degree of targeting in education, healthcare, and income maintenance, and major changes to the ways in which social assistance was delivered. The National Government was particularly concerned at reducing so called 'welfare dependency'. This position was informed by a critique of welfarism which was seen as giving people the 'wrong signals'. According to this perspective, the welfare state had 'encouraged dependency' on welfare benefits, undermined personal responsibility and created perverse incentives, thereby discouraging employment and undermining economic growth (Boston 1999, p. 4). Central to this critique of welfarism are important philosophical and ethical issues concerning the respective roles and responsibilities of individuals and the state.

The introduction of the ACC scheme in New Zealand in 1974 resulted in an arbitrary division in government funding arrangements for health and accidents

that has subsequently remained. Health is funded by general taxation and the ACC scheme is funded by contributions from a mixture of levies and general taxation. A discussion on health policy is therefore pertinent to understanding the context in which the ACC scheme operates within publicly funded healthcare in New Zealand.

Successive New Zealand governments favoured a social democratic approach to health policy since the First Labour Government introduced a comprehensive health service with the Social Security Act (1938). This Act mandated an open-ended commitment to universal access to health care for all citizens (Blank 1994, p. 123). Underlying this legislation was the belief that access to health care should be based upon need rather than on ability to pay. It was akin to the social democratic approach that saw government as having a responsibility to provide a broad range of essential services to all its citizens (Ashton 1992; Blank 1994). Bowie & Shirley (1994, p. 298) explain that following concerns raised by the Medical Association about wanting to retain the 'right' to charge patients directly, a compromise ensured that a publicly provided secondary health care system would be free to the patient, although a small private fee-for-service hospital sector remained. Much primary care was also free, but general practitioners were entitled to charge fees in addition to the payment they received from the Department of Health. This compromise, forged in the 1940s, shaped the health system for most of the post-war period. It led to fragmentation in the health service which resulted in anomalies in the treatment of accident victims which had in turn, developed under different legislation (Bowie & Shirley 1994). For example, under ACC legislation general practitioners were funded at a different rate for consultations than the provisions available to them under the Department of Health. Therefore a person having a general practitioner consultation funded by the ACC scheme could be charged a different fee from the fee they would have been charged if undertaking the same type of consultation funded in part by the Department of Health.

The ACC scheme had had its origins in the Report of the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand, known as the Woodhouse Report (Woodhouse 1967). The Woodhouse Report considered how

best to replace the Workers Compensation scheme that was in place at the time. In replacing the Workers Compensation scheme it provided 24 hour comprehensive compulsory no-fault cover for personal injury. In return for losing the right to sue, the Woodhouse Report recommended that the Tort system be replaced by a system of compensation based on five guiding principles:

- (a) community responsibility;
- (b) comprehensive entitlement;
- (c) complete rehabilitation;
- (d) real compensation;
- (e) administrative efficiency.

(Woodhouse 1967, pp. 177-178).

These principles informed the ACC scheme which was subsequently agreed upon by the two major political parties, National and Labour (ACC 1976). The Accident Corporation Act was passed by the National Government in 1972 and was enacted on 1 April 1974. This legislation was established at a time when serious gaps were recognised in the provision of welfare services (Cheyne et al. 1998). Gaskins (2000, p. 218) notes that at the same time as the Woodhouse Report appeared, the 1972 Report of the Royal Commission on Social Security (Royal Commission Report) was reviewing benefits under social security and health systems. The Royal Commission Report considered three competing welfare criteria aimed at providing different levels of support for recipients: basic subsistence; preserving their capacity for social participation; and maintaining their achieved economic status. The Royal Commission Report integrated personal injury law with social welfare principles and going one step further than expanding the meaning of common law notions of responsibility, the Woodhouse Report argued for an earnings-related benefit in a public welfare scheme invoking common-law standards of entitlement under the Woodhouse principle of 'real compensation' (Gaskins 2000, p. 217). Unlike previous welfare measures, ACC legislation provided for compensation based upon prior earning, reinforcing equality of income (Cheyne et al. 1998). The ACC scheme gained international

attention for building the ‘maintenance of achieved economic status’ approach into legislation (Gaskins 2000, p. 218).

2.3 Health Reforms

In 1991, the then National Government announced radical health reforms based on neo-liberal theory as described in the Green and White Paper, ‘Your Health and Public Health’ (Minister of Health 1991). These reforms closely mirrored the recommendations made in the 1988 Gibbs Report commissioned by the Fourth Labour Government (Blank 1994). Some of the main features of the reforms were the introduction of part-charges for hospital services and a tighter targeting of health care assistance (Boston 1999). As part of the new targeted regime, those on lower incomes were issued with a Community Services card which enabled card holders to be identified as being eligible for targeted services.

The 1991 health reforms fall into the category of what has become known as ‘regulated competition’ (Ashton 1992, p. 148). They are less extreme than the pure market liberal approach which would see no role for government in the provision of healthcare services and would leave access to healthcare completely to the market. This position is reflected in the provision of a minimum level of care for everybody, regardless of income, and the retention by government of its role as the dominant funder of health services.

One of the justifications for reforms based on a neo-liberal approach in health is its benefits to consumers. The argument for health reforms based on market principles using a degree of competition was that it would provide incentives for a more efficient use of scarce resources and that providers would be better motivated to respond to the needs of consumers (Bowie & Shirley 1994, p. 310).

The term ‘consumer’ has been applied in relation to health services since the 1960s by social scientists from both the left and right of the political spectrum (Irvine 1996, pp. 192-199). Those on the political right view health services as being like any other commodity where individuals make decisions based upon motivation, knowledge and information about the service. In this way consumers

are seen to be active agents who seek services from providers on the open market. Those on the political left consider health services as varying from other services because of their intrinsic nature. The following three distinguishing features are seen to be key:

- there is thought to be a knowledge imbalance between the provider and the consumer, with the provider having much greater knowledge than the consumer;
- the choice of health services available to a consumer may be minimal as providers often operate in a commercial monopoly;
- unequal power relationships between the provider and consumer. Parsons (cited in Irvine 1996, pp. 197-198) contends that there is a consensus relationship between the provider and patient. The provider is a technical expert who defines and diagnoses an illness thereby legitimising the patient's claim to the role of being sick. Parsons (cited in Irvine 1996, pp. 197-198) considers the idea of consumerism as being dangerous because it has the potential to interfere with the provider's technical role. In response to Parsons, Freidson (cited in Irvine 1996, pp. 198-199) developed an alternative model, of conflict relationship between the patient and the provider. In this model the provider is seen as having the power in the relationship due to the power and status attained through success in political and ideological endeavours. Patients could take a more active role in their relationship with their provider, though such action may be limited given the medical professions' current ability to create monopolies and to act in isolation from lay persons. The implications therefore are that the patient is unable to act as a true consumer in the context of health care delivery. Irvine (1996) notes that other writers advocate the deprofessionalisation hypothesis which sees the medical profession as facing challenges to its dominant position as lay people become less willing to accept the medical professions' power, status and authority. The implication being that patients can, and do, take a more active role in the relationship with a provider.

Bowie & Shirley (1994, pp. 315-316) argue that the 1991 reforms were introduced to achieve efficiency gains by three key strategies user charges, profit-driven

public hospitals and cost-shifting to the voluntary system. The Government's stated intention in introducing user charges into public hospitals was to change people's behaviour by sending price signals to individuals, thereby forcing them to consider carefully whether or not they needed the services. However, as Bowie & Shirley (1994, pp. 315-316) contend there were problems with this notion of user charges. First, much of the public were exempt from charges as they were Community Services card holders. Second, those who were not exempt were likely to have health insurance which covered the co-payments. In most cases, therefore, any incentives to overuse hospital services remained. Further, consumers would have been affected by the requirement that hospitals be profit driven. In practice, this is was likely to mean shifting cost to a voluntary system. For example, the public hospital could reduce the cost of an admission by discharging patients early. In this way the cost of the care was transferred to the family or community.

Throughout the 1990s, the neo-liberal emphasis on the market, and the rights and responsibilities of 'consumers' of health services illustrated how ideas about who was responsible for health shifted: from the state and the provider, to the sick and the consumer. This shift also occurred in the provisions of the ACC scheme.

2.4 ACC Reforms

Neo-liberal theory, along with claims of increasing costs to government and welfare dependency, provided the political justification in the 1990s for the implementation of changes to the ACC scheme.

In the 1990s the National Government's reform programme signaled the most radical reform of the ACC scheme since its inception in 1974. In 1991 the then Minister of the ACC, Bill Birch, claimed that the escalating costs of the ACC scheme, evidence of fraudulent claims, inequitable sharing of costs, and the need for more individual responsibility justified the need for dramatic reform (St John 1999, p. 162). The costs of the ACC scheme had risen, on an average of twenty five percent per annum between 1985 and 1990, and had continued to do so at what was seen as an unacceptably high rate (Birch 1991). The focus was placed

on changing individual behavior as in other reforms of the welfare state, reducing the costs for employers, and making the scheme more closely resemble private insurance, and thereby preparing for privatisation at some future date (St John 1999).

The changes introduced by National's Accident Rehabilitation and Compensation Insurance Act (1992) included:

- 'experience-rating' employers (they received a no claims bonus or discount if the claim numbers were low or a charge if they were high);
- employers could self-insure for the first year's costs in exchange for reduction in premiums;
- earners who had regained eighty-five percent capacity for work after twelve months from the date of accident were not eligible for earnings related compensation;
- non-work accidents would no longer be the responsibility of employers;
- lump sum payments for pain, suffering and loss of enjoyment of life were abolished;
- an independence allowance was introduced to replace existing discretionary payments – this was designed to meet the additional costs of living with a disability, (payment was much smaller in comparison to lump sums);
- non-earning women and families were not compensated for the replacement of domestic services;
- the care of long-term accident victims by family members was no longer paid for;
- rape and sexual abuse cases were not able to access lump sums for mental trauma;
- non-earners were no longer entitled to vocational rehabilitation;
- the definition of personal injury by accident was narrowed and restricted in a number of ways;
- the costs of motor vehicle accidents were to be funded through license fees and a special levy on petrol.

(St John 1999).

The opportunity for employers to self-insure, 'experience-rate', the use of the word 'premiums' in place of 'levy' and the inclusion of the word insurance in the naming of the Act indicated that the National Government was determined to reshape the scheme to make it more closely resemble private insurance (St John 1999, p. 163). The Accident Rehabilitation and Compensation Insurance Act 1992 and subsequent prescriptive regulations for rehabilitation and home help, which had formally been on a discretionary basis, meant that compensation was much less generous than before (St John 1999). This shift to a more residual welfare state implied that individuals were expected to become more responsible for themselves and meant that the cost of the accident was met by accident victims themselves. The impact of the reforms was the greatest for non-earners, especially for women, who because of childcare responsibilities tend to have gaps in employment and earn less than men.

The policies introduced by the National Government in the 1990s reflected the principles of user pays and the limited role for government drawn from neo-liberalism, and created new tensions with the social welfare principles on which the scheme was based. Boston (1992) has noted that these policies breached most of the founding principles of the ACC scheme including comprehensive entitlement, complete rehabilitation and real compensation.

Campbell (1996, pp. 228-229) argues that there was a gradual decline in the focus on injury prevention from the time the ACC scheme was introduced in 1974 (under the 1972 Act) to the Accident Rehabilitation and Compensation Insurance Act (1992). In 1974 a department was established within the Corporation to promote all aspects of injury prevention with the main focus being to encourage and assist employers to upgrade their safety performance and to provide training courses. Since 1974, there has been a gradual decline in commitment to injury prevention as is seen in the Accident Rehabilitation and Compensation Insurance Act (1992), which provided for safety programmes only if they were likely to be cost-effective. However, as Campbell (1996) contends, it is difficult to gauge cost-effectiveness when it is often based upon measures, such as the accident frequency rate, which have not been found to be reliable guides to safety performance.

St John (1999, pp. 164-171) describes how the 1992 reforms attracted criticisms from both sides of the political spectrum. On the political left, the unions and other pressure groups condemned the 1992 Act as seriously undermining the social contract with New Zealanders who had given up the right to sue in exchange for what had become an inferior system of limited compensation. Yet on the political right, the Business Roundtable considered that the scheme's basic features of being a monopoly and of no-fault were unsound, and argued that the changes did not go far enough to resolve the confusion between insurance and welfare. The Employers' Federation argued that the ACC scheme should first be corporatised to reduce the risk of political interference, and then be opened up to competition.

The 1996 Coalition Agreement between National and New Zealand First pledged to 'rebuild public confidence in ACC by restoring it to a world leading, 24 hour, comprehensive but affordable accident cover' (cited in St John 1999, p. 168). In December 1998 the Coalition Government passed the Accident Insurance Act (1998) which placed the ACC scheme further on the path towards privatisation with its introduction of competition in the provision of accident insurance in the workplace. From 1 July 1999, employers and self-employed people were able to choose their own registered provider of workplace injury insurance (ACC 1999). This introduced a degree of competition which was intended to create incentives to reduce costs. The state retained public ownership to the extent that the ACC scheme remained responsible for non-work accidents and was the default insurer for the self-employed (ACC 1999).

Stritch (1998) and Gorman (2000) have criticised the rationale that privatisation of the workers compensation system under the Accident Insurance Act (1998) would result in improved cost efficacy. Further, Gorman (2000) argues that the general experience is that costs and premiums increase under privatisation.

In response to such concerns, the step towards privatisation proved to be temporary when, in November 1999, the Labour-Alliance Coalition Government introduced the Accident Insurance (Transitional Provisions) Bill which came into

effect on 1 April 2000 (ACC 2000a). This reinstated the ACC scheme as the sole provider of accident insurance and proposed a return to Woodhouse principles with injury prevention being a major focus (ACC 2000a). The subsequent Injury Prevention, Rehabilitation, and Compensation Act (2001) was promoted as a further step in the restoration of the original ACC scheme (ACC 2002). The 2001 Act endorses the ACC scheme's leadership role in injury prevention. Under the Injury Prevention, Rehabilitation, and Compensation Act (2001), the ACC is required to undertake and support new initiatives in injury prevention. Other changes include provision for a framework to collect, co-ordinate and analyse injury-related information, and a requirement to disclose to government agencies information relating to medical error, medical mishap and child and work-related injuries (ACC 2002, p. 65). Seasonal and temporary workers, and those on parental leave, are entitled to fair compensation and a new form of lump sum compensation is introduced for permanent impairment (ACC 2002).

The stated purpose of the Injury Prevention, Rehabilitation, and Compensation Act (2001) is to 'enhance the public good and reinforce the social contract represented by the first accident compensation scheme for managing personal injury' and includes the overriding goal of minimising the overall incidence of injury in the community through establishing as a primary function for the ACC scheme, the promotion of measures to reduce the incidence and severity of personal injury. In response to this goal the ACC is currently working with other government agencies to develop a New Zealand Injury Prevention strategy. Another priority for the ACC is undertaking a comprehensive review of medical misadventure.

Instead of 'experience-rating' employers, the ACC assesses work sites and sets levies at a level to reflect the assessment. A good assessment will result in a lower levy and a poor assessment will result in a higher levy. Once the work place has been assessed it does not matter how many accidents the firm has, it still pays the same levy. This model is linked to a community responsibility model.

2.5 Conclusion

In this chapter I have explained the international trend towards policies informed by neo-liberalism and how they have in turn informed government policy in New Zealand. These policies represent a shift to a more residual welfare state as illustrated in health and the ACC policy. The implications are that there was a shift of responsibility to the individual creating tensions with the Woodhouse principles. Changes in the Injury Prevention, Rehabilitation, and Compensation Act (2001) illustrate a shift away from neo-liberalism with the return to Woodhouse principles and a focus on injury prevention shifting back towards social democratic principles.

The next chapter begins with an exploration of the policy environment and outlines the ACC legislation as it relates to medical misadventure (and medical error) and the agencies the legislation impacts. The chapter concludes with a discussion on public inquiries, including the Cull (2001) Report, that have informed and continue to inform health and the ACC legislation.

Chapter Three – The Policy Environment

3.1 Introduction

The focus of this research is medical error, and in particular an evaluation of the reporting process as under the Accident Rehabilitation and Compensation Insurance Act (1992) and the impact of that process with regard to the prevention of injury. Chapter One covered the aims, objectives and philosophical basis for the research. Chapter Two outlined the policy context in which the ACC scheme evolved. This chapter begins with an exploration of the policy environment and outlines the ACC legislation as it relates to medical misadventure and medical error and the agencies on which the legislation impacts. A discussion on public inquiries, including the Cull (2001) Report, that have informed and continue to inform health and the ACC legislation, concludes the chapter.

3.2 ACC Medical Misadventure Legislation from 1972 – 2002

Three key changes in the area of medical misadventure (and medical error) legislation are discussed in this section. Changes to the definition of medical misadventure, changes to the reporting function of the ACC scheme, and the introduction of ‘experience-rating’ of registered health professionals.

3.2.1 Defining Medical Misadventure

Injuries caused by medical intervention were accepted as a criteria for ACC cover prior to the Accident Rehabilitation and Compensation Insurance Act (1992). However, it was this Act which defined medical misadventure for the first time (see page one for definition). The phrase medical misadventure was not used in the Woodhouse Report. The Commissioners, however, did recommend that in general, the ACC scheme should cover injuries as set out in the World Health Organisation’s classification manual of diseases, injuries and causes of death.

This manual included a category of Therapeutic Misadventure and Late Complications of Therapeutic Procedures (Collins 1992, p. 142).

The Accident Compensation Act (1972) did not contain a direct reference to medical misadventure. Provision for those suffering personal injury as a result of medical intervention was first expressly included in the ACC scheme as a result of the expansion of the definition of 'personal injury by accident to include 'medical, surgical, dental, or first aid misadventure' in November 1974 with the Accident Compensation Amendment Act (1974). However, neither personal injury nor misadventure were defined at this point (Birch 1991), nor were they defined in the subsequent Accident Compensation Act (1982). In order to have a claim accepted under the 1972 legislation, its subsequent amendments, or the Accident Compensation Act (1982), there needed to be proof of a personal injury caused by and as a consequence of a damaging event (an accident). However, there was no requirement to prove fault on behalf of the registered health professional (McGregor Vennell 1993). It was left to the ACC, the Accident Compensation Appeal Authority, and the Courts, to interpret whether or not a claim for injury caused by 'medical, surgical, dental or first aid misadventure' would be covered by the ACC scheme.

The Accident Rehabilitation and Compensation Insurance Act (1992) introduced significant changes in the way that the ACC responded to claims of medical error resulting in personal injury and the then National Government introduced criteria for medical misadventure (including medical error). The prescription of criteria was introduced on the grounds that both a lack of definition, and the fact that medical misadventure was not a term used in overseas legislation, was leading the ACC Appeal Authority and the courts to interpret the legislation in a way that extended the boundaries of the scheme (Birch 1991).

3.2.2 Personal Injury Caused By Accident

Under the Accident Rehabilitation and Compensation Insurance Act (1992) conditions for ACC cover were separately identified. The definition of personal injury caused by accident (PICBA) included personal injury as a result of external

force. For example, if a person accidentally severed their finger with a knife the force of the knife would be considered an external force and the injury would be covered under the Act. However, the definition of PICBA specifically excluded any of the specified occurrences 'that (are) treatment by or at the direction of a registered health professional' (Accident Rehabilitation and Compensation Insurance Act 1992). This meant that all claims resulting from treatment had to be considered under the medical misadventure criteria. As a result of this inclusion in the definition, claimants who did not meet the prescriptive criteria for medical misadventure were unable to be considered under the PICBA category and therefore did not gain cover under the ACC scheme (Corkill 2002). If, for example, a person had been having treatment and the registered health professional severed the person's finger, the person might not be eligible for cover. This could occur if the ACC did not consider the registered health professional was in error in severing the finger, and that the injury did not meet the mishap criteria because the injury was not rare (i.e. would occur in more than 1% of cases where that treatment is given). Yet the same injury would be covered had the person cut their own finger.

Collins (1995) evaluated the medical misadventure provisions under the Accident Rehabilitation and Compensation Insurance Act (1992). A key focus of Collins' study was to understand why the medical misadventure process evolved in the way it did. She found that medical misadventure policy appeared to have been driven by political goals rather than by a concern about the impact on potential claimants. Further, she argues that the reduction of the number of claims eligible under the medical misadventure criteria under the Accident Rehabilitation and Compensation Insurance Act (1992) should be seen in the context of the National Government's promise to the business community to restrain government spending during the early and mid 1990s.

In terms of the criteria for medical misadventure, the Accident Insurance Act (1998) extended cover to include personal injury that was an infection suffered by a spouse or child or other dependent, spread as a result of contact with a person with a medical misadventure claim.

The definition of medical misadventure is extended under the Injury Prevention Rehabilitation and Compensation Act (2001) in two ways. First, medical error could be attributed to an organisation where the error 'cannot readily be attributed to a particular registered health professional involved in the provision of treatment'. Further, if the failure in question consists solely of a delay, or failure attributable to the resource allocation decisions of the organisation, it is not considered to be medical error. Second, cover for medical misadventure now includes personal injury that is an infection suffered by any third party, spread as a result of contact with a person with a medical misadventure claim. The intent was to extend the previous criteria to cover persons other than the spouse, child or other dependent. It was considered that the original criteria was too narrow because it did not cover parents, grandparents or other carers. The possibility of a third party passing on an infection to another third party was not considered.

3.2.3 Accident Rehabilitation and Compensation Insurance Act (1992) and Subsequent Reporting Requirements

Changes were made to institute disciplinary procedures for the medical profession for the first time with the introduction of the Accident Rehabilitation and Compensation Insurance Act (1992). The reporting requirements in relation to medical misadventure are described below and summarised in Figure 2.

Figure 2. ACC Cover for Personal Injury Resulting from Medical Intervention, and Reporting Requirements

Legislation	Medical misadventure as a personal injury	Reporting Requirements
Accident Compensation Act (1972)	Not expressly covered	Nil
Accident Compensation Amendment Act (1974)	Expanded the definition of personal injury by accident to include 'medical, surgical, dental, or first aid misadventure'	Nil
Accident Compensation Act (1982)	Same coverage	Nil
Accident Rehabilitation and Compensation Insurance Act (1992)	Medical misadventure (both medical error and medical mishap) defined for first time	Reporting requirements if the ACC considers there has been negligence or inappropriate action
Accident Insurance Act (1998)	Same coverage Plus infection suffered by a spouse or child or other dependent, if result of contact with a person with a medical misadventure claim	Nil
Injury Prevention, Rehabilitation, and Compensation Act (2001)	Same coverage, plus <ul style="list-style-type: none"> • Medical error may be attributed to an organisation • Infection suffered by any other third party 	Extensive reporting requirements

In the late 1980s the scheme had been criticised by advocacy groups for not establishing an alternative means for calling medical practitioners to account for alleged negligence, in the absence of the ability to sue (Birch 1991). Criticism came from both the left and right of the political spectrum including those who

supported the neo-liberal concept of consumer which saw consumers as having a right to seek redress when services purchased on the open market had failed to meet expectations. McGregor Vennell (1993, p. 29) explains that since the early 1970s there had been rising public dissatisfaction with a disciplinary system that dealt with complaints outside of the ACC scheme⁴, this was seen as focussing on internal professional issues rather than on responsibility to patients and was highlighted in 1988 with the Cartwright Inquiry into the treatment of Cervical Cancer at National Women's Hospital in 1988. Since then, there has been an increased awareness of patient rights, and advocacy groups have developed. Rather than returning to the right to sue, the National Government introduced legislation to effect changes in disciplinary procedures for the medical profession and, where appropriate, in other health professions (Birch 1991).

Under the Accident Rehabilitation and Compensation Insurance Act (1992), if the Corporation was satisfied that there may have been negligence or inappropriate action, the ACC was required to "report the circumstances to the appropriate body with a view to the institution of disciplinary proceedings, and to any other body that may be appropriate" (Accident Rehabilitation and Compensation Insurance Act 1992). Despite the possibility that there was an implicit intent that reporting may occur for injury prevention purposes, the explicit focus of the reporting function in the 1992 Act was disciplinary action rather than injury prevention. The significance of the shift in reporting under the Accident Rehabilitation and Compensation Insurance Act (1992) was that a registered health professional could be held responsible for their actions. This was in recognition that the organisation Corporation, as an administrator of a no-fault scheme, was not a disciplinary body. However, the act of reporting to a professional body could result in a range of outcomes for the registered health professional, and shift the responsibility for injury from the state as the funder of the scheme to the organisation, and ultimately to the health professional 'service provider' as an individual.

⁴ The disciplinary system is explained on page thirty one.

Under the Accident Insurance Act (1998), the most significant change for medical misadventure was that all reporting requirements ceased. However, ACC could pass information about registered health professionals' performance to relevant agencies through provisions under the Privacy Act (1993) and the Health Information Privacy Code (1994), as both allow for such reporting to occur where matters of public interest arise.

It is not known why the National led Coalition Government chose to remove the reporting requirements at a time when the public was wanting more accountability from health professionals, as illustrated in a number of high profile inquiries (these are discussed later in this chapter). The decision not to require the ACC to report findings of negligence or inappropriate action may have been because the Government considered the mechanism was superfluous given the enactment of the HDC Act (1994). The HDC Act (1994) allowed the public to go the HDC directly with any complaints against registered health professionals. The removal of the reporting function may also have been as a result of privacy concerns around information relating to health professionals and claimants.

As noted in Chapter Two, the Injury Prevention, Rehabilitation, and Compensation Act (2001) introduced by the Labour-Alliance Coalition Government had as its major focus, injury prevention. It reintroduced and expanded reporting requirements for medical misadventure as follows:

- the ACC may at any time bring to the attention of, or refer to any appropriate person or authority, any matters concerning medical error or medical mishap if ACC considers it necessary or desirable to do so in the public interest (whether for reasons of public health or public safety);
- the ACC must report any incident it accepts as medical error to the relevant professional body and to the HDC;
- the ACC must also report any concerns about a registered health professional's competency to the relevant professional body;
- the ACC has discretion to report an incident it accepts as medical mishap to the relevant professional body and the HDC;

- the ACC has discretion to report an incident it accepts as medical error or medical mishap to the Director General of Health (DGOH) or employers of registered health professionals (if the ACC considers it appropriate);
- in exercising discretion the ACC must consider where public interest and trends of incidents of that kind requires reporting;
- in addition to reporting on medical misadventure claims, there is discretion for the ACC to report incidents of a similar nature to medical misadventure, to the HDC or the DGOH where injuries have arisen following treatment by a treatment provider (who is not a registered health professional) or a person who holds himself or herself out as a provider of treatment or services. For example, a masseuse who advertises themselves as a provider of treatment.

3.2.4 ‘Experience-rating’ of Registered Health Professionals

A further development in the interest of holding health professionals accountable for their actions under the Accident Rehabilitation and Compensation Insurance Act (1992) was provision for ‘experience-rating’ of health professionals. This action provided a mechanism whereby the ACC could calculate premiums according to the number of claims the health professional had against them. Miller (1993) argued that the introduction of such premiums with regard to medical error was a positive step which deters health provider negligence. However, he also warned that ‘experience-rating’ could discourage the filing of medical misadventure claims.

While the provision to ‘experience-rate’ health professionals remains in subsequent legislation it has never been enacted. Some of the arguments for not collecting premiums are that it would be unjust to expect health professionals to fund medical mishap claims for treatment ‘properly given’. However, if the ACC only instituted premiums for medical error, which account for only a small percentage of claims, the administrative burden is unlikely to prove cost-effective. In addition there are concerns it could create an adversarial climate and delay the timeliness of claims, and that health professionals would merely pass the charges on to their patients.

‘Experience-rating’ of health professionals was consistent with the introduction of ‘experience-rating’ for work injuries under the Accident Rehabilitation and Compensation Insurance Act (1992) where the intent was to internalise the cost of accidents (Miller 1993, p. 1086). The purpose of that ‘experience-rating’ system is to reward safe employers and to penalise unsafe employers within a levy class.

3.3 HDC and Professional Bodies To Whom the ACC Reports Medical Error

Under the Accident Rehabilitation and Compensation Insurance Act (1992), if the Corporation was satisfied that there may have been negligence or inappropriate action, it was required to “report the circumstances to the appropriate body with a view to the institution of disciplinary proceedings, and to any other body that may be appropriate”. The structure of the various jurisdictions to which the ACC reports medical error findings are complex and have undergone marked transformation since 1992. The structure of the various jurisdictions is discussed below, and summarised in Figure 3.

Figure 3. Summary of Reporting Structure Under Various ACC legislation

Year	ACC legislation and reporting requirements	Professional Body	HDC	Complaints Review Tribunal
1992	Accident Rehabilitation and Compensation Insurance Act (1992) (effective from 1 July 1993) <ul style="list-style-type: none"> Reporting requirements introduced 	Legislation governing professional bodies, for example, Medical Practitioners Act (1968) and the Nurses Act (1977)(which includes midwives)		Human Rights Act (1993)
1995		Medical Practitioners Act (1995)	HDC Act (1994) Effective from 1 July 1996	
1998	Accident Insurance Act (1998) (effective from 1 July 1999) <ul style="list-style-type: none"> No reporting requirements (earlier reporting requirements repealed) 			
2001	Injury Prevention, Rehabilitation, and Compensation Act (2001) (effective from 1 April 2002) <ul style="list-style-type: none"> Reporting requirements reintroduced and expanded 			

For the purposes of reporting, the appropriate body responsible for disciplinary action under the Accident Rehabilitation and Compensation Insurance Act (1992) was the professional body that was responsible for the registration of the health professional to which the medical error had been attributed. For example, where an error was attributed to a registered nurse, the medical error would be reported to the Nursing Council of New Zealand (Nursing Council).

Each professional body has its own organisational structure as governed by its respective statute. For example, the Nursing Council is governed by the Nurses

Act (1977) and the Physiotherapist Board is governed by the Physiotherapist Act (1949). The disciplinary process the professional body could take varies depending upon the professional body and the Act under which they are established. This has resulted in complex disciplinary procedures especially where medical errors have occurred as a result of a multi-disciplinary team. The respective disciplinary tribunals assess matters of professional conduct, have the ability to suspend a registered health professional from practice, to award fines payable to the professional body, and to ensure that the same thing does not happen again (St George 1999, p. 75). Hearings in respect of disciplinary charges may have to be conducted in three or more separate hearings if the adverse medical outcome occurs as a result of a multi-disciplinary team (Cull 2001, p. 99).

Cull in her influential report, proposed that the ACC, as the insurer, should not conduct its own investigations into medical error (Cull 2001). Instead the ACC scheme should make a preliminary inquiry before compensation payments are made. The HDC would then undertake a thorough investigation to establish whether an incident was rare or severe, or was an error. If, after the HDC's more thorough investigation, it was revealed that entitlement payments made by the ACC were unnecessary, refunding would occur (subject to further policy planning and discussion).

Two professional bodies that are responsible for the registration of the largest number of registered health professionals are the Medical Council of New Zealand (Medical Council) and the Nursing Council.

3.3.1 Medical Council

In 1993, when the ACC first began reporting medical error, the Medical Council governed by the Medical Practitioners Act (1968), had a three-tier professional disciplinary structure. The choice of which disciplinary tribunal a case was referred to was largely dependent upon the strength of the allegation. The tribunals were: the Medical Council; the Medical Practitioners Disciplinary Committee; and the Divisional Disciplinary Committee. The Medical Council considered the more serious cases of 'disgraceful conduct in a professional

respect' (Collins 1992, p. 220). The Medical Practitioners Disciplinary Committee heard cases of 'professional misconduct' and 'conduct unbecoming of a medical practitioner' (Collins 1992, p. 220). The Divisional Disciplinary Committee with the least jurisdiction, heard 'minor' cases of 'conduct unbecoming a medical practitioner' (Collins 1992, p. 220). Each body had the power to carry out a range of disciplinary actions dependent upon its findings (Collins 1992).

The Medical Practitioners Act (1995) superseded the Medical Practitioners Act (1968) and, as a result, the functions of the Medical Council changed. It continued to be the statutory body for registering all medical practitioners in New Zealand but was no longer responsible for disciplinary procedures except for complaints involving incidents that occurred before 1 July 1996 (St George 1999). This was a move away from disciplinary action to that of ensuring that professional competency was maintained.

As St George (1999) outlines, the Medical Council's principle purpose under the Medical Practitioners Act (1995), is to protect the health and safety of members of the public by recommending or providing mechanisms to ensure that medical practitioners are competent to practice medicine. In addition to registration, the Medical Council has responsibilities in the areas of doctors' education, standards, conduct, and health. If, after considering a complaint at an assessment committee the Medical Council considers that further action should be taken, it has three options: to review the fitness of the medical practitioner; to review the competence of the medical practitioner; or to refer the matter to the Medical Practitioners Disciplinary Tribunal set up under the Medical Practitioners Act (1995).

Under the Medical Practitioners Act (1995), the Medical Practitioners Disciplinary Committee can impose a number of penalties including:

- striking off the register of medical practitioners;
- suspension for up to 12 months;
- fines;
- censure;

- conditions on practice for up to three years;
- orders to pay costs.

(St George 1999).

3.3.2 Nursing Council

By way of comparison the Nursing Council, is the statutory body established by the Nurses Act (1977). The Nurses Act sets out a number of legal functions concerning the enrolment or registration of nurses, and registration of midwives. These functions include the suspension or restriction of an enrolled nurse, a registered nurse or a registered midwife's practice as a result of disciplinary action (Nursing Council 2001).

The Preliminary Proceedings Committee (PPC) has the function of investigating complaints made against enrolled nurses, registered nurses, or registered midwives and referring those complaints to the Nursing Council for further inquiry where there may be a case to answer (Nursing Council 2001). The Convener of the PPC decides whether or not to investigate the complaint and refer it to the PPC. The PPC may take the following actions:

- frame and refer charges of professional misconduct to the Nursing Council; or
- refer the complaint to the Nursing Council; or
- decide to take no further action.

If the Nursing Council finds that the conduct of the nurse or midwife amounts to professional misconduct, the Council may make certain orders. Orders can include any of the following:

- removal of the nurse or midwife's name from the Register or Roll;
- suspension for a period not exceeding one year;
- limits on practice subject to such conditions as the Council may specify;
- imposition of a fine;
- censure (a formal written reprimand);
- an order that the nurse/midwife pay costs and expenses of and incidental to the investigation by the Committee and inquiry by the Council; and

- an order for publication of a notice stating the effect of the order(s) in the Gazette and Kai Taiki: Nursing New Zealand, or other publications as directed by the Council.

(Nursing Council 2001)

Other professional bodies have similar procedures to those followed by medical practitioners and nurses. It is also noted that, since I began my thesis, the Labour Led Coalition Government has introduced changes in order to improve the complaints processes and to ensure that health professionals retain their competence. The proposed Health Professionals' Competency Assurance Bill will replace the current eleven health occupational regulatory statutes and, if enacted, will address safety and quality standards in the health sector (Davis, Lay-Yee, Brait, Schug, Scott, Johnson, and Bingley 2001). The principal purpose of the Health Professionals' Competency Assurance Bill (2002) is to protect the health and safety of the public by establishing processes to ensure that registered health professionals are competent to practice. The Bill proposes to:

- establish the framework for the regulation of health professionals where there is a risk of harm to the public;
- establish registering authorities for each profession;
- empower the Minister of Health to appoint members of registering authorities and audit their processes to minimise their ability to operate restrictive practices;
- establish the functions of registering authorities;
- empower registering authorities to:
 - i. assess the qualifications and experience of practitioners and register them in an appropriate scope of practice;
 - ii. review the ongoing competence of practitioners and require them to participate in competence improvement programmes if necessary;
 - iii. certify that practitioners are competent to practice;
 - iv. suspend practitioners if there is a risk of harm to the public
 - v. include a list of licensed tasks which can be practiced only by practitioners who are certified as being qualified and competent to do so;

- vi. provide for declared quality assurance activities to improve the practice or competence of health professionals.

(Minister of Health 2001)

Professional bodies provide registration for registered health professionals and manage competency issues including those raised by consumers. Consumers can also lay complaints with the Health and Disability Commissioner.

3.3.3 Health and Disability Commissioner Act (1994)

The concept of a Health and Disability Commission was introduced by the Fourth Labour Government and continued in the political process after the National Government was elected in 1990 (Wealleans 1998). The HDC Act (1994) came into effect 1 July 1996. It provided for a Health and Disability Commission whose purpose was 'to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights' (HDC Act, 1994).

From 1 July 1996 the Health and Disability Commission became the appropriate body to report to on matters of negligence or inappropriate action (except where the date of injury was prior to 1 July 1996). From the 1 July 1996 the HDC Act (1994) was the primary vehicle for dealing with complaints about any health and disability services provider in New Zealand, and any complaints to professional bodies had to be referred to the HDC for investigation before the professional body could take disciplinary action (St George 1999, pp. 70-72).

Robyn Stent, the former Health and Disability Commissioner, contends that as well as providing a mechanism for resolving relevant complaints on behalf of consumers directly with the service provider, the HDC ensures quality services for the public and proper accountability of health professionals and others, by providing for an independent investigation of complaints by the Commissioner (Health and Disability Commissioner 1991, p. 1). The HDC legislation is

deliberately consumer-focused, and recognises the imbalance of knowledge and power which exists between consumers and providers, and seeks to achieve a greater level of partnership between these groups.

Central to the HDC's role is the Code of Health and Disability Services Consumers' Rights. This Code became law on 1 July 1996 as a regulation under the HDC Act (1994). The Code covers all registered health professionals and extends to any person or organisation providing or holding themselves as providing a health service to the public or a section of the public.

In summary the Code has ten rights as follows:

1. the right to be treated with respect;
2. the right to freedom from discrimination, coercion, harassment, and exploitation;
3. the right to dignity and independence;
4. the right to services of an appropriate standard;
5. the right to effective communication;
6. the right to be fully informed;
7. the right to make an informed choice and give informed consent;
8. the right to support;
9. rights in respect of teaching and research;
10. the right to have a complaint taken seriously.

(HDC Act, 1994)

The HDC Act (1994) and the Code aim to resolve complaints at the lowest appropriate level. If the Health and Disability Commissioner decides to action the complaint, the Commissioner may refer the complaint to the appropriate advocacy service to support consumers in reaching clear decisions with the aim of resolving the complaint (where there are not wider public interest or professional conduct issues), or commence an investigation. An investigation may result in:

- arranging for mediation;

- the matter being referred to the appropriate agency where there is a significant breach of duty of misconduct, and, in serious cases, this may include the police;
- the matter being brought to the attention of any appropriate person or authority where the Commissioner considers that it is in the public interest to do so, for reasons of public health or public safety, or for any other reason;
- the Commissioner consulting with another rights agency, such as the Human Rights Commission following which the complaint, or any aspect of it, may be referred to another agency to ensure it is dealt with appropriately.

(St George 1999, p. 74)

If an investigation reveals a breach of the Code, the Commissioner may take the following actions (this may include implementing appropriate systems to ensure it does not happen again):

- report his or her opinion to the provider and make recommendations;
- report and make recommendations to the Minister of Health, a health professional body, a purchaser, or any other appropriate person;
- complain (or assist someone making a complaint) to a professional body;
- refer the case to the Director of Proceedings of the HDC who makes the decision whether or not to take proceedings in respect of a complaint against the provider. Proceedings may occur in the Complaints Review Tribunal and the various health professional disciplinary bodies. If the Director of Proceedings decides not to take proceedings, the health professional body can reconsider the complaint and decide to lay disciplinary charges. Where the Director of Proceedings decides not to institute proceedings in the Complaints Review Tribunal, the consumer may do so on his or her own account.

(St George 1999, pp. 74-5)

3.3.4 Complaints Review Tribunal

The Complaints Review Tribunal established by the Human Rights Act (1993) has the power to award a remedy for the consumer (St George 1999, p. 75). It hears proceedings brought under the Human Rights Act (1993), the Privacy Act (1993) and the HDC Act (1994). The Tribunal has the ability to award a number of remedies including:

- declaring that the action of the provider is in breach of the Code;
- issuing an order restraining the provider from continuing or repeating the breach, or from engaging in, or causing or permitting others to engage in, conduct of the same kind as that constituting the breach;
- awarding damages of up to \$200,000;
- issuing an order that the provider perform specified acts with a view to redressing any loss or damage suffered by the consumer as a result of that breach;
- any other relief which the Tribunal thinks fit.

(St George 1999, p. 76)

The Complaints Review Tribunal is limited in its ability to award damages if a person has suffered personal injury covered by the ACC scheme (St George 1999). If a person has a claim accepted by the ACC scheme, no damages other than punitive damages may be sought or awarded (St George 1999). This is because under the ACC scheme, claimants lose the right to sue for compensatory damages.

3.4 Public Health Inquiries into Adverse Events Since 1987

In recent years the development of the ACC policy and health policy in general has been influenced by a series of well-publicised public inquiries and their subsequent reports. These inquiries have been instituted variously by the Minister of Health, the Director General of Health, and the HDC.

One major inquiry was in response to allegations initially raised in *Metro* magazine in relation to the treatment of cervical cancer patients at National Womens' Hospital in the 1970 and 1980s (Bunkle & Coney 1987). The Ministerial Inquiry was convened by Dame Sylvia Cartwright in 1988 (Corkill 2002). The Inquiry released its report which found damning evidence of unethical practices in medical research, and a negative impact of research on the health of women (Davis & Ashton 2001, p. 17). The Report led to a major review of cervical screening and of the method of treating abnormalities. More generally the Report resulted in much tighter ethical requirements for medical research, especially in the requirement of informed consent. It may have also been the catalyst for the HDC Act (1994) and the Code of Rights for Consumers of Health and Disability Services (Cheyne, O'Brien & Belgrave, 1998, p. 227).

The HDC undertook three major inquiries in the late 1990s into events at Canterbury Health Limited, and two others at Gisborne Hospital (Corkill 2002). In 1998 an inquiry into the deaths of four patients at Christchurch Hospital drew attention to numerous issues that had arisen out of the continuous restructuring and re-organisation of the health system since 1993 (Health & Disability Commissioner, 1999). In addition to weakness and problems in the administrative and organisational structure within the hospital, the inquiry noted problems which stemmed from the pressures on providers to perform without adequate funding.

In 1999-2000, as result of a concern about the admitted reuse of syringes by an anaesthetist, and because of significant errors with testing that had occurred within the hospital laboratory, the HDC undertook an inquiry into Gisborne Hospital. The subsequent report included recommendations for significant changes to its quality assurance systems, incident reporting, testing and complaint procedures.

In 1999, a Ministerial Inquiry was set up to examine concerns around the under-reporting of cervical smear abnormalities in the Gisborne Region. The Inquiry arose in response to a court case on the issue, involving a pathologist Dr Bottrill's reading of a smear test at his Gisborne laboratory. The Inquiry released a report in April 2001 concluding that the unacceptable level of under-reporting at Gisborne Laboratories between 1990 and March 1996 was in part due to factors relating to

Dr Bottrill's own actions (Duffy, Barrett and Duggan 2001). For example, factors such as inadequate participation in continuing medical education and a lack of awareness that the laboratory's practices put patients at risk. The report also concluded that between 1990 and 1996 there were systematic problems with the delivery of cytology services in New Zealand, for example, that the National Cervical Screening Register was not functioning optimally (Duffy, Barrett and Duggan 2001)

In 2000, the Minister of Health, the Honourable Annette King, commissioned Wellington barrister Helen Cull to conduct a review into the processes concerning adverse medical events in New Zealand. This inquiry arose from publicity concerning disciplinary proceedings against a Northland gynecologist, Dr Parry. Also there was particular concern around the ability of practitioners to continue to practice despite a history of repeated complaints (including the number of accepted ACC claims) (Corkill 2002). The terms of reference for the review required consideration of the regulatory and institutional barriers that might impede the timely identification and investigation of adverse medical outcomes by medical practitioners. It was intended that the review would help direct future legislative change in order to ensure future legislation would better protect the public. One key finding of the review, published in March 2001, was that there were up to fourteen organisations that could potentially undertake an investigation into the same medical event contemporaneously, or cumulatively, without reference to the other (Cull 2001, p. 15). Lengthy processes with a multiplicity of agencies processing the same complaints made the complaints process confusing, difficult to access and costly.

Cull (2001, pp. 15-16) identified nine principle problems with the processes concerning adverse medical events:

- multiple complaint processes;
- time delays in processing complaints (depending upon the agency concerned ranged from 42 weeks up to 3 years including appeals);

- no interaction between agencies to enable disclosure of relevant information (at this time the Accident Insurance Act 1998 was enacted – the ACC scheme was not required to report medical misadventure claims);
- difficult to access due to the general lack of knowledge on how the process works, the way the complaint is treated, the failure of agencies to refer patients to the appropriate complaint mechanism;
- no centralised database to detect repeated poor practice;
- no reporting of poor practice by colleagues or other health professionals;
- no powers of suspension prior to charge being made even if a potential public risk is identified;
- insufficient entitlement and cost recovery through the ACC scheme or the Complaints Review Tribunal;
- the ACC scheme's failure to meet needs - no access to entitlements while claim is awaiting a decision, no other agency checking entitlements paid are accurate.

Cull (2001, pp. 16-17) made a number of key recommendations that were specific to the ACC scheme, including:

- support of the Injury Prevention, Rehabilitation, and Compensation Bill amendments to the ACC legislation to enable the ACC scheme to report medical error and mishaps (where appropriate) as an interim measure;
- mechanisms to be put in place to protect the disclosure of relevant health information by and to agencies such as the ACC scheme, the HDC and the Medical Council, and the Medical Practitioners Disciplinary Committee in the interests of public health or public safety;
- a long term goal of a 'one stop shop' to conduct all investigations into adverse events;
- the ACC's involvement in the long term should be limited to the purposes of providing entitlements and not conducting investigations.

Cull's review was critical of the way the ACC determined cover on a claim (Cull 2001). Cull (2001) argued cases of medical error may go undetected and therefore unreported in a system that favours accepting claims under the umbrella of

medical mishap rather than under medical error. This was because under the Accident Rehabilitation and Compensation Insurance Act (1992) there was an incentive, in terms of timeliness, to have a claim accepted under mishap rather than medical error. Medical mishap claims had a faster process than was the case with the process for medical error where claims were required to go through a committee process to obtain advice from an advisory committee. Claimants were not able to access the ACC scheme entitlements until the ACC had reached its decision. The same level of entitlements was available to the claimant regardless of whether the claim was accepted on the basis of medical error or medical mishap. If there was evidence that the claim met the criteria for medical mishap there was pressure to make this finding without the more exhaustive investigation of the medical error aspect.

Cull's (2001) recommendation of a 'one stop shop' approach to investigating adverse medical events would allow patients to better identify and access patient complaint mechanisms. Given the HDC's current role as principal complaint mechanism for patients, she argued that the HDC could undertake the investigation for all purposes including disciplinary proceedings, compensation entitlements and any other costs or damages, thus eliminating the need for multiple investigations. Where competence issues arose as a result of HDC's investigations, this aspect could be referred to the relevant professional body for a Competence Review of the registered health professional or further investigation, if the professional body felt it was necessary. Both the Cull Report and the Gisborne Inquiry have been key influences in the development of the Health Professionals' Competence Assurance Bill (2002), and in the proposed amendments to the HDC Act (1994), and the Injury Prevention, Rehabilitation, and Compensation Act 2001.

3.5 Conclusion

This chapter began with an outline of the medical misadventure legislation since 1974 which, at times, has included the requirement for medical error to be reported to the appropriate body such as the professional body or the HDC. I have expanded on the range of actions that the HDC and the professional body

can take in terms of injury prevention. I have also discussed public inquiries into medical injury that have occurred in the last 15 years and how they have provided some of the impetus for the changes in the ACC and health legislation.

The next chapter provides an overview of international empirical studies on the frequency of medical error and adverse events, theoretical conceptual issues, and a discussion on the advantages and disadvantages of a tort system versus a no-fault system in terms of injury prevention.

Chapter Four – Literature Review

The previous chapter began with an outline of the medical misadventure legislation since 1974 and discussed the range of actions that the HDC and the professional body can take in terms of injury prevention. Public inquiries into medical injury that have occurred in the last fifteen years were also discussed and comment was made on how they have provided some of the impetus for the changes in the ACC and health legislation.

This chapter reviews literature on medical error and adverse medical events. It is divided into three sections: section one outlines empirical research into the frequency of medical error; section two describes conceptual approaches to medical error; and section three compares and contrasts the tort and no-fault systems in terms of injury prevention.

4.1 Introduction

The ACC commissioned CM Research to carry out a customer satisfaction survey in 1996. Their qualitative data showed that while medical misadventure claimants were happy with the service they received, they were significantly less satisfied with the compensation they received as compared to the total ACC scheme population. One reason for this dissatisfaction was found to be that their expectations for lodging the claim is that that disciplinary action with regard to the respective health professionals were not met even when the claim was accepted (CM Research 1996). The conclusion drawn was that claimants wanted, as a result of lodging their claims, more accountability from health professionals.

The literature demonstrates that many patients lodge complaints or claims when things go wrong in order to prevent the same thing from occurring again.

Vincent, Ennis & Audley (1993, p. 163) suggest that when a patient has been injured when receiving medical treatment they want an assurance that some action will be taken to prevent someone else from suffering in the same way.

Vincent, Martin & Ennis (1991, p. 394) state that a key reason for studying medical accidents is to ‘highlight deficiencies in medical practice and provide guidelines for changes in practice and future research’.

4.2 Injuries Arising from Medical Treatment - Definitions

There is no universal definition to describe injuries arising from medical treatment. The definition of medical misadventure which encompasses both medical error and medical mishap is unique to the ACC legislation and is outlined in Chapter One. The term is not universally applied in the literature although the World Health Organisation uses the term in the classification of causes of morbidity and mortality for the purpose of collecting health statistics. In this chapter I will use the terms as applied in the literature to which I refer.

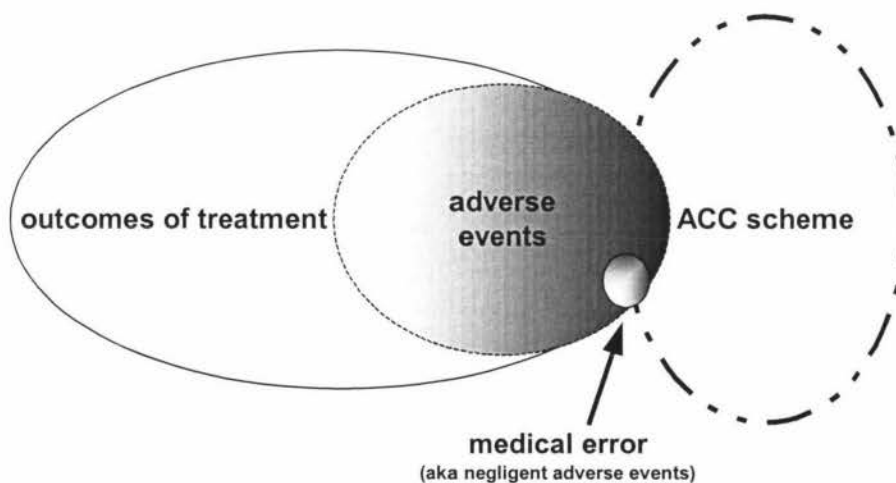
The HDC defines a complaint as ‘any allegation that a healthcare or disability services provider is, or appears to be, in breach of the Code’ (HDC, 2002, p. 27). Unlike the ACC legislation the HDC Act (1984) does not require that a personal injury has occurred. Although the Cull Report (2001) does not define the term ‘adverse medical events’, this term is used to describe complaints made by consumers.

In discussing the empirical studies on the frequency of injuries arising from medical injury in this chapter, I will use the four general terms Kohn, Corrigan & Donaldson (2000, p. 28) use to describe injuries arising from medical treatment: adverse events; medical errors; preventable adverse events; and negligent adverse events i.e. an adverse event is defined as an injury caused by medical management rather than the underlying condition of the patient. An error is defined as the failure of a planned action to be completed as intended (i.e. error of execution), or as the use of a wrong plan to achieve an aim (i.e. error of planning). An adverse event attributable to error is defined as a preventable adverse event. Negligent adverse events represent a subset of preventable adverse events that satisfy the legal criteria used in determining negligence (i.e. whether the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question).

The diagram in Figure 4 (not proportional) shows that medical error sits both inside and outside the ACC scheme (ACC 2002b). The portion outside the scheme includes medical error that is not reported to the ACC. It also includes medical error that is not covered by the scheme, error as the result of non-registered health professionals and treatment providers, and error that leads to mental injury.

Note that the shading of medical error indicates that there are different degrees of injury severity resulting from negligence in treatment given (ACC 2002b, p. 8). A health professional may be negligent in giving the treatment, and this might result in a very minor injury.

Figure 4 – Injuries arising from medical treatment (within and beyond ACC cover) (ACC 2002b, p. 8)



4.3 International Studies Into the Frequency of Medical Error

International studies have demonstrated that there are a high number of adverse events per hospital admission. This is discussed and illustrated in Figure 5.

4.4 Frequency of Adverse Events in Hospitals

The frequency of medical error and adverse events has been highlighted as a major public concern. Kohn et al. (2000) report the results of various studies into medical error including the most extensive study of adverse events, the Harvard Medical Practice Study - a study of more than 30,000 randomly selected discharges from 51 randomly selected hospitals in New York State in 1984. It was estimated in the study that the number of deaths due to medical error was possibly as high as 98,000 (Kohn et al. 2000, pp. 30-31). The rate of adverse events in the study, as determined by a prolonged hospital stay or disability at the time of discharge or both, occurred in about 3.7 percent of hospitalisations (Kohn et al. 2000, p. 30). However, it is noted that this study was done almost twenty years ago and there could have been some improvements since then. A further study in Colorado and Utah reviewed over 33.6 million admissions to hospitals in the United States in 1997. This study found that adverse events occurred in 2.9 percent of cases (Kohn et al. 2000, p. 1). The authors extrapolated that at least 44,000 Americans die in hospitals each year as a result of preventable medical errors (Kohn et al. 2000, p. 31).

The methodological approach used in the Harvard Medical Practice Study was based on the application of a two stage retrospective review of a sample of medical records. This methodology was subsequently also applied in British, Australian and New Zealand contexts (Davis, Lay-Yee, Brait, Schug, Scott, Johnson & Bingley 2001, p. 2). The 'Adverse Events in British Hospitals' study found that 10.8% of patients experienced an adverse event, with an overall rate of adverse events of 11.7% when multiple adverse events were included (Vincent, Neale & Woloshynowych 2001, p. 517). In the 'Quality in Australian Healthcare' study, adverse events were reported in 16.6% of admissions (Vincent et al. 2001). The same methodological approach was used by Davis et al. (2001)

in the first nationally representative study of the quality and safety of care provided in New Zealand public hospitals. This study of 'Adverse Events in New Zealand Public Hospitals' found the overall rate of admissions associated with an adverse event to be 12.9 percent (Davis et al. 2001, p. 59).

The Davis report provides base parameters necessary to inform an understanding of the quality of care in New Zealand public hospitals (Davis et al. 2001). It is cautious about what conclusions can be drawn on a sample of approximately 1% of public hospitals in a one year period in 1998 (Davis et al. 2001). The limitations of the New Zealand research are that the level of adverse events that occur in public hospitals providing acute care with less than 100 beds, and specialist public institutions, private hospitals, or primary care is not known. The method chosen captured only those adverse events that were recorded and it was found that 10% of the medical files in the sample which should have been available could not be located.

New Zealand, Australia and the United Kingdom reported a rate two or three times higher than that of the United States despite the fact that all share similar medical traditions in training and practice (Davis et al. 2001, p. 36). One reason for the disparity could be the difference in the purpose and context of the study (Davis et al. 2001). In the United States, the research was done for medico-legal purposes whereas in the United Kingdom, Australia and New Zealand the purpose was to improve the quality of healthcare (Davis et al. 2001, p. 63). This was borne out by a closer investigation of the Australian and United States data sets which showed similarities in the more serious events recorded, cases that involved less serious events were not found to be as prevalent in the United States data (Davis et al. 2001, p. 63). The assumption is that the less serious events were not recorded although they occurred. Davis et al. (2001, p. 65) consider such data to be of great potential significance to quality improvement because much can be learnt in terms of improving the quality of healthcare from cases involving less serious events.

4.5 Preventable Adverse Events

In terms of injury prevention it is important to note that not all medical errors and adverse events are preventable (Fitzjohn, 2001). For example, an unexpected reaction to a particular drug where there is no potential to prevent similar unexpected reactions in other patients. In comparison, a preventable event would be, for example, where a health professional provides a pharmaceutical to a patient who has a known allergy. In such cases, hospital protocols can be implemented to minimise the potential for the reoccurrence of such an error. In considering whether an event is preventable, current medical knowledge and available technology is taken into account (Davis et al. 2001).

The ACC scheme's medical misadventure criteria covers both preventable and non-preventable injury. Medical error claims are by nature preventable and are likely to be categorised as negligent adverse events, a subset of preventable adverse events, if they met the legal criteria for determining negligence, as they result from a lack of care and skill on behalf of a registered health professional and include a negligent failure to obtain informed consent, diagnose correctly or provide appropriate treatment – all of which are preventable. In contrast medical mishap claims generally involve entirely appropriate management and fall into the non-preventable category of claims. It seems clear that when finding ways to reduce the number of injuries arising from medical treatment it is appropriate that the focus should be on medical error claims.

Studies of adverse effects conducted in the United States, United Kingdom, Australia and New Zealand also analysed the number of adverse events which were considered to be preventable. The range of preventable incidents varied from 48-62.5 percent of the respective total number of adverse events across the United States, United Kingdom, Australia and New Zealand.

In the Harvard Medical Practice study, the proportion of adverse events attributed as preventable was 58 percent of the total number of adverse events, with the study in Colorado and Utah finding that the proportion of adverse events that were preventable was 53 percent (Kohn et al. 2001, p. 30). The Adverse Events

in British Hospitals study found that 48 percent of adverse events were considered preventable while the Quality in Australian Healthcare study found that about half of adverse events were considered preventable (Vincent et al. 2001).

In the study of Adverse Events in New Zealand Public Hospitals, Davis et al. (2001) found that in 62.5 percent of cases there was evidence of preventability. Preventability was categorised according to likelihood of the adverse event being preventable. The categories ranged from 'slight to modest' evidence to 'virtually certain' evidence of preventability. New Zealand's rate of preventability is considerably higher than that of the United States, United Kingdom and the Australia. One reason for the difference could be that the criteria for 'evidence of preventability' in the Davis study (2001) included cases where there was 'slight to moderate evidence of preventability'. It is unclear whether the other studies included cases where there was slight to moderate evidence of preventability in their criteria for preventability.

Figure 5 – Frequency of Adverse Events Per Hospital Admission

This table outlines the total number of adverse events compared with preventable adverse events for each country.

Country	Total adverse events	Proportion of adverse events that were considered to be preventable	Study
United States	3.7%	58%	The 'Harvard Medical Practice' study was undertaken in 1984.
	2.9%	53%	The Colorado and Utah study was undertaken in 1992.
United Kingdom	10.8% (or 11.7% if include overall multiple adverse events)	48% of overall multiple events	The 'Adverse Events in British Hospitals' study was undertaken in 1998.
Australia	16.6%	50%	The 'Quality in Australian Healthcare' study was first published in 1995.
New Zealand	12.9%	62.5% (This includes adverse events where there is thought to be a slight to modest evidence of preventability)	The 'Adverse events in New Zealand Public Hospitals' study was undertaken in 1998.

Fitzjohn (2001) argues that the ACC's scheme would be better placed to focus on injury prevention if the criteria for acceptance focussed on preventable injuries rather than on fault or rarity. For example, instead of requiring proof of fault or mishap where the adverse consequence has to be rare, a better criteria would be to base it on the concept of avoidability akin to the Swedish No-Fault Compensation Scheme. In order to determine eligibility in the Swedish scheme, the authority asks whether:

- (1) an injury resulted from treatment; and
- (2) if the treatment in question was medically justified; and

(3) whether the outcome was unavoidable (Studdert & Brennan 2001, p. 217).

If the answer to the first query is 'yes', and the answer to either the second or third question is 'yes' and, the patient has spent at least ten days in the hospital or has endured more than thirty sick days, the claimant receives compensation (Studdert & Brennan 2001, p. 217).

Fitzjohn (2001) argues that in terms of compensation there may be social justice reasons for wanting to compensate non-preventable injuries where someone has suffered a rare complication of treatment. However, there may be more convincing reasons for compensating preventable injury on equity grounds, on the basis that patients who suffer preventable injury have been deprived of the opportunity to receive high quality and appropriate care (Fitzjohn 2001). Issues over patient safety offer even more compelling reasons for compensation schemes based on preventability criteria (Fitzjohn 2001). As the New Zealand scheme requires medical error to be attributed to a registered health professional - except for the ability to attribute medical error in certain situations to an organisation under the Injury Prevention, Rehabilitation, and Compensation Act (2001) there may be reluctance on the part of a health professional or patient to lodge a claim. Fitzjohn (2001) argues that claims are not lodged for many avoidable injuries in New Zealand because they do not meet the rarity criteria. For example, post operative infection would not be rare, although, in some circumstances a post operative infection could be preventable. Further, he argues that because these claims are not lodged, potential gains in injury prevention are lost. Although New Zealand's no-fault approach provides the potential for administrative capacity to track and analyse errors and the systems of care that give rise to them, Fitzjohn (2001) argues that in practice, the ACC legislative requirement of proof of error can frustrate the achievement of that goal.

In summary, international evidence demonstrates there are a high number of adverse events (range 2.9 to 16.6% of total hospital admissions) a significant proportion of which are preventable (range 48 to 62.5 %). Fitzjohn (2001) suggests that legislation that focuses on avoidability, rather than on medical error, may encourage more people to lodge claims. This would help in developing more accurate information on adverse events. However, in the absence of legislation

based on avoidability, the ACC scheme is still well placed in terms of injury prevention, to take an active role on the basis that claims that are reported as medical errors generally fall into the class of preventable injuries.

4.6 Person Versus Systems Approach

Both the tort and no-fault systems of compensation for injury arising from medical treatment tend to focus on the actions of a particular registered health professional or professionals. Reason (2000) has raised awareness of why the consideration of only the registered health professional's actions may not be the best way to reduce the reoccurrence of a medical error.

Reason (2000, pp. 768-770) puts forward two approaches for viewing human error – the 'person approach' and the 'systems approach'. The person approach has the most long-standing and widespread tradition and is dominant in medicine.

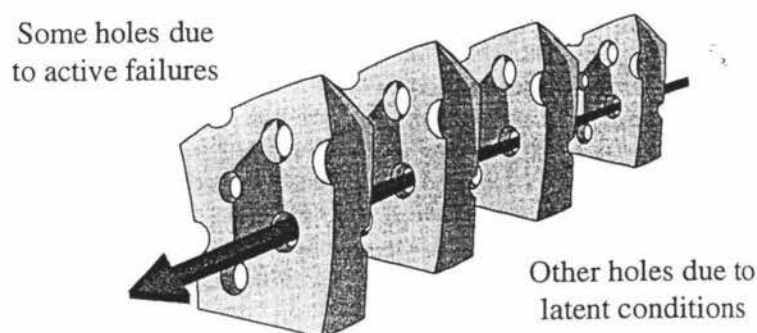
The person approach focuses on individual error, for example, blaming the individual for forgetfulness and/or inattention. From this perspective, attempts to prevent an error from occurring include establishing written procedures, taking disciplinary measures, the threat of litigation, retraining, and generally naming, blaming, and shaming the individual or group of individuals concerned.

Supporters of this approach consider error to be a morality issue and that failure of morals leads to bad outcomes. Psychologists call this the 'just world' approach. However, while it may seem straightforward and quite satisfying to be able to blame an individual or a group of individuals if something goes wrong, Reason (2000) argues that such an approach can result in a situation where attempts to prevent an error made by an individual may not be sufficient to prevent that error from reoccurring in the future.

The alternative model is the systems approach which concentrates on the conditions under which individuals work and seeks to develop strategies to reduce or prevent error in the entire organisation. Reason (2000) argues that a more systems based approach for viewing medical error is an essential tool in reducing incidents. He uses the Swiss cheese model of defences to describe the multi-

layered system of defences used in high technology systems such as hospitals and civil aviation (see Figure 6). Some defences are engineered, for example, automatic shutdowns and physical barriers. Some rely on people (surgeons, pilots, etc), and yet others depend on procedures and administrative controls. The purpose of such defences are to protect both potential victims and resources from known risks and, in the main, work well. However, no system is without its failures.

Figure 6 – The ‘Swiss cheese’ Model of Defences (Reason 1998, p. 296)



Defensive layers do not remain in one piece but like slices of Swiss cheese have many holes. However, the holes in Reason’s model are continually opening and shutting, and shifting their location. While the presence of a hole itself may not cause a bad outcome this can occur when many layers line up at a particular moment in time and permit a trajectory of accident opportunity (Reason 2000, p. 769).

Reason (2000, p. 769) considers there are two reasons why holes arise: active and latent conditions. Further he claims that nearly all adverse events involve a combination of these two sets of conditions. Active conditions are the unsafe acts such as slips, lapses and mistakes of a person who is in direct contact with a patient or system. Active failures have a direct and usually short-lived impact on the integrity of the defences. For example, at Chernobyl, the operators violated procedures which then triggered the catastrophic explosion. Reason (2000, p. 769) argues those who adopt the person approach often look no further than identifying the unsafe actions of an individual and miss the multi-faceted cause of an adverse event which often is a result of historical events and has developed through the various levels of the system.

Latent conditions are the inevitable ‘resident pathogens’ within a system (Reason 2000, p. 769) which arise from decisions made by designers, builders, and top level management. Reason (2000, p. 769) argues latent conditions have two kinds of adverse effect. They can:

- translate into error provoking conditions within the workplace (such as time pressure, inadequate staffing levels, or poor equipment);
- create long-lasting holes or faults in the defences (for example, procedures or alarms that do not work).

Latent conditions may lie dormant for many years before they combine with active failures and local triggers to create an accident opportunity. Though active failures are often hard to predict, latent conditions can be identified and remedied before an adverse event occurs.

Reason’s conclusion that latent conditions can be corrected more readily than active conditions leads him to challenge the traditional approach to viewing error management which attempts to make individuals less fallible. He considers that a systems approach can provide a more comprehensive management programme which can be aimed at several different targets: the person; the team; the task; the workplace; and the institution as a whole (Reason 2000, p. 769).

To demonstrate the effectiveness of identifying and addressing systems flaws, Reason (2000) has used industries such as aviation, mining, and road safety as examples. Such industries are comparatively far more advanced than those in the medical domain in terms of progress towards safe systems, and despite seeming remote from the medical domain can offer valuable lessons.

Over the past fifteen years or so, a group of social scientists has been studying safety successes in three organisations which are dependent upon high reliability: nuclear aircraft carriers; air traffic control systems; and nuclear power plants (Reason 2000, p. 770). The aim of the research was to learn more about adverse events and how they could be best avoided. Investigations revealed that the challenges facing these organisations are two fold (Reason 2000, p. 770). First,

the organisations are managing complex, demanding technologies and need to avoid major failures that could cripple or even destroy the organisation concerned (Reason 2000, p. 770). Second, the organisations have had to maintain a capacity for meeting periods of very high peak demand (Reason 2000, p. 770). The defining characteristics identified in such organisations studied were that:

- they were complex, internally dynamic, and intermittently intensely interactive;
- they performed exacting tasks under considerable time pressure;
- they carried out these demanding activities with low incident rates and an almost complete absence of catastrophic failures over several years.

(Reason 2000, p. 770)

Reason (2000) concluded that such high reliability organisations offer an excellent example of the systems approach. They develop a culture of anticipating the worst and seek to ensure that at every level the organisation is equipped to deal with it. Though no organisation is immune to adverse events, organisations such as these have learnt to convert occasional setbacks into improving the system.

The ability to attribute medical error to an organisation has only recently been possible under the ACC legislation. Prior to the enactment of the Injury Prevention, Rehabilitation, and Compensation Act (2001) on 1 April 2002, medical error could only be attributed to 'a registered health professional'. This is consistent with the person approach described by Reason (2000).

While it may appear that the Injury Prevention, Rehabilitation, and Compensation Act (2001) endorsed the systems approach, including for the first time the ability to attribute medical error to an organisation, closer investigation reveals that this was not the case (Coates & McKenzie 2002, p. 142). In assessing whether or not a medical error has occurred, the Act requires that there is *first* an attempt to attribute medical error to a registered health professional. It is only where medical error cannot 'readily be attributed' to an individual that consideration can be given to attributing the error to an organisation (Injury Prevention,

Rehabilitation, and Compensation Act 2001). Coates & McKenzie (2002, p. 142) argue that the change is a positive step, in that it will improve the fairness of the process so that a patient who suffers as a result of medical error is not declined cover simply because the error cannot be attributed to an individual (Coates & McKenzie 2002, p. 142).

The 2001 Act, however, is not seen as a move from attributing responsibility to individuals to attributing responsibility to the system. In itself the change is unlikely to assist in reducing the 'blame mentality' that some feel prevails in the health sector (Coates & McKenzie 2002, p. 142). Coates & McKenzie (2002) note that one of the purposes of the ACC legislation is to ensure fair compensation for loss from injury. To this extent the legislation is seen to be entirely reasonable. However, the express 'overriding goals' of the new Act are the minimisation of 'both the overall incidence of injury in the community and the impact of injury on the community' (Coates & McKenzie 2002, p. 142). According to Coates & McKenzie (2002) many experts believe that one way of reducing the incidence of injury from medical error is by eliminating the 'blame' culture from the hospital environment. Coates & McKenzie (2002, p. 142) state that if this view is correct, then the amendment may prove to be a step in the wrong direction in that it may actually accentuate the blame culture.

Although a systems based scheme should maximise injury prevention, there will always be 'active' situations where a registered health professional has been in error. In Brennan's opinion (1991) a scheme needs to ensure that it has a system in place to remove any registered health professional whose current practice could well cause injury. The Health and Disability Commissioner supports this view in respect of the HDC complaints resolution work. He states that although there needs to be 'recognition of the role that systems failures play in adverse events, and a quality improvement focus, this does not remove the need for individuals to be held accountable for their own short comings in appropriate places' (Health and Disability Commissioner 2002, p. 5)

4.7 Injury Prevention in a Tort System

Ability to reduce the number of medical errors is likely to depend on the extent to which a country learns from the medical errors that have occurred. Some countries follow a tort model (e.g. Australia and the United States), some a no-fault model (e.g. New Zealand), though most no-fault models do not bar tort claims. The advantages and disadvantages of each system in terms of injury prevention are briefly discussed and summarised in Figures 7 and 8.

Figure 7 - Advantages and Disadvantages of a Tort Based System of Compensation in Terms of Injury Prevention

Advantages	Disadvantages
Financial deterrent to individuals and institutions (though limited because of indemnity insurance).	Tends to focus on a person approach rather than systems based therefore opportunity lost to consider latent conditions.
Common Law Judgement provides a standard as a means of securing medical accountability or a ‘moral beacon’ to be used as guidelines on which health professionals can model their behaviour.	Incentive for providers to hide errors which in turn increase risk of error and unsafe acts.
	Can encourage a rise in defensive medicine.

In a tort system a breach of duty, such as a medical error, can lead to personal and institutional liability for damages. The three goals of a tort system are compensation, deterrence and justice (Bovbjerg & Sloan 1998). Within the tort system there exists financial incentives to identify a particular individual’s error in order to qualify for compensation (Vincent et al. 1993, p. 206). Two ways that tort can provide incentive for injury prevention are: imposing a ‘tax’ for medical error, and by providing a potentially important source of information about the required standards for medical practice as a means of securing medical accountability (Furrow 2001, p. 382).

Furrow (2001, p. 382) is of the opinion that ‘liability judgments’ and the costs associated in settling such cases, are a form of infrequent taxation of medical

errors, such as an Internal Revenue Service Audit. The possibility of being sued constrains poor performance and adds economic burdens that help to reinforce good medical practice (Furrow 2001, p. 382). This is despite the fact that common law judgments are usually strongly influenced by the medical profession, in that the courts are dependent upon opinions provided by the medical profession to guide their deliberations. Nevertheless tort is likely to impose financial burdens on providers (and their malpractice insurer) for medical errors where good practice was ignored or poor practice allowed (Furrow 2001, p. 382).

Furrow (2001, p. 382) also argues that common law judgement, as evidenced in Case Law, states minimum principles for generally accepted medical practice and reports that the generalised threat of being sued forms part of market forces which spur the evolution of medical practice toward more effective practice. In some areas the risks of being sued have acted as a catalyst for innovation in products, such as products liability where the risk of a lawsuit has promoted innovation in response to the judicial costs imposed (Furrow 2001, p. 382). Further, with the increased emergence and availability of clinical guidelines, lawyers can introduce evidence of emerging guidelines as a way of arguing for a standard of care that the defendant failed to satisfy.

It is argued that tort also provides a 'moral beacon' for healthcare providers by which they can benchmark their behaviour (Furrow 2001). It does this through a process of court decisions based on legal rules and jury instruction that guide health professionals' thinking and practice. For example, the informed consent doctrine has forced medical recognition of the needs of patients for information (Furrow 2001, p. 382). Furrow (2001, p. 382) argues that this 'moral beacon' should be valued as a way to illuminate rude, thoughtless, or dangerous conduct by providers. Medical errors are not solely driven by systems and their deficiencies. Providers as failed moral agents can also at times treat their patients badly and tort suits can shed light on poorly designed institutional systems (Furrow 2001, p. 382).

The view that tort can constrain poor performance is consistent with the key emphasis of neo-liberal theory which leaves exchanges to the market where it is considered that government alone cannot improve the outcome. Supporters of this approach argue that the market provides an incentive to change individual behavior. As Furrow (2001) has outlined, when this principle is applied to the tort system, it may provide maximum incentive for a registered health professional to reduce error because of its direct effect on the registered health professional's income.

Under the ACC scheme, claimants lose the right to sue for compensatory damages. While exemplary or punitive damages are not barred by the ACC scheme cover and a lawsuit could be brought, there has, only been one case where the Court has awarded damages against a registered health professional in New Zealand (Paterson 2001, p. 10). Paterson (2001, p. 10) notes that the key legal issue in such a case focuses on whether the cause of negligence or gross negligence would meet the threshold of being deliberate or highhanded or in flagrant disregard of the safety of a patient. With only one case having met this threshold it seems unlikely that the threat of exemplary damages would create a deterrence mechanism for registered health professionals in New Zealand.

The tort system is also criticised for a rise in the practice of defensive medicine, generally understood to mean unnecessary care given by physicians in response to the threat of lawsuits, for example, undertaking excessive reviews. The costs of defensive medicine are ultimately met by the consumer.

The extent to which tort systems prevent injury is unclear. For example, Runciman, Merry, & McCall Smith (2001) stipulate that existing legal or disciplinary processes are an important part of responding to the needs of those who have been injured, but that they have a minor role in improving patient safety overall. Leape, Woods, Hatlie, Hatlie, Kizer, Schroeder & Lundberg (1998) reported that the disciplinary approach in the United States tort system had little impact on reducing patient harm.

4.8 Injury Prevention in a No-Fault System

Compensation schemes that do not rely on determination of negligence are usually referred to as ‘no-fault’ systems. The New Zealand and Finnish schemes are the only schemes that include an explicit criteria for fault (ACC 2002, p. 15). Others in operation internationally include, for example; Sweden and Finland (Studdert, Thomas, Zbar, Newhouse, Weiler , Bayuk & Brennan 1997). Although other no-fault schemes do not have a specific category for claims arising from negligence, most schemes do cover it, as did the ACC scheme prior to the enactment of the Accident Rehabilitation and Compensation Insurance Act (1992). The advantages and disadvantages of a no-fault system in terms of injury prevention are discussed below and summarised in Figure 8.

Figure 8 - Advantages and Disadvantages of a No-Fault Based System of Compensation in Terms of Injury Prevention

Advantages	Disadvantages
<ul style="list-style-type: none">• Ability to collate data for injury prevention purposes on individual claims as well as general trends.	<ul style="list-style-type: none">• Can provide little incentive to improve practice if health professionals do not have to pay premiums.
<ul style="list-style-type: none">• Where the scheme is not funded by health professionals (and there is no requirement to find fault) there can be greater incentive to lodge claims, therefore increased volume of information available to incorporate into injury prevention initiatives.	<ul style="list-style-type: none">• No fault schemes tend to focus on compensation, if a scheme has an injury prevention focus that includes the potential for disciplinary action this can create tension with the no fault principle.
<ul style="list-style-type: none">• Potential to use “systems” based approach (see Reason 2000).	<ul style="list-style-type: none">• In practice tends to be focused “person” approach as described by Reason (2000) or avoidability without any investigations into whether or not the system needs addressing.

In general, a no-fault system is consistent with the social democratic principle of state intervention in the market, so that the whole community shares the costs of social services. Such a system is open to an expansion of claims.

Bovbjerg & Sloan (1998, pp. 71-72) argue the deterrence of injury and the promotion of quality should be improved through the use of no-fault schemes. One of the reasons given for this is that larger schemes allow the administering agency or insurer to develop epidemiological data about medical injuries and about what practices tend to reduce injuries, thereby providing a basis for encouraging changes in medical practice or referring a provider for discipline.

A further reason as to why no-fault schemes may improve injury prevention initiatives is that they tend to encourage more claims to be made and this, in turn, provides more information that can be used to help in developing injury prevention initiatives. Health professionals can lodge claims without fear of reprisal (particularly if the scheme is focused on avoidability rather than finding an individual at fault). Patients may also have more incentive to lodge claims as they are more likely to obtain compensation under a no-fault scheme than through tort. Though tort generally provides for more generous compensation, it also tends to focus only on compensating injuries at the severe end of the scale (Bovbjerg & Sloan 1998).

No-fault schemes also have the potential to use a systems based approach as a tool for viewing medical error. Weiler (1993, p. 908) considers systemic failures the major cause of medical accidents. He considers therefore, a no-fault scheme should prod hospitals to pool their collective wisdom and devise procedures and technologies that minimise the ever-present risk of occasional human error, rather than simply blaming individuals. However, for maximum effectiveness in terms of reducing injury a more in depth analysis of the circumstances of the claim, (e.g. investigations would be required to give due consideration to the multi-layered system of defences). In order to effectively report on claim trends, special expertise may be required, for example, as in the field of epidemiology. Despite the scope to consider organisational factors, no-fault schemes tend to be based upon the person approach described by Reason (2000). This occurs even if the

intention of the scheme is not to find fault with the health professional, as occurs under the Finnish and New Zealand no-fault schemes. The literature did not produce any evidence of a scheme attempting to address explicitly injury prevention relating to organisational or latent aspects of the medical treatment.

Despite having the potential to implement injury prevention initiatives many no-fault schemes have been criticised for doing little to reduce both the number of accidents that occur and the human costs of these accidents (Capstick, Edwards & Mason 1991, p. 231). The ACC (2002c) carried out an international comparative study on no-fault schemes in 2002 and although information on injury prevention was limited, the ACC found that some schemes do adopt injury prevention initiatives, for example, the Patient Insurance Scheme in Iceland reports all claims and activities to Iceland's Ministry of Health and makes a report available to the general public. Further, on a study tour of Sweden, Norway and Denmark, it was found that although these schemes make their claim decisions publicly available (in a form that does not identify individuals) disciplinary functions are kept entirely separate, (ACC 2002d). The Swedish scheme was established in 1975 and the Norwegian and Danish no-fault schemes followed the Swedish model in their development in 1998 and 1992 respectively (ACC 2002d). Danzon (1994, pp. 200-201) argues that the Swedish scheme was designed for the purpose of compensation rather than for deterrence. The scheme is funded by premiums paid primarily by Swedish Country Councils that provide medical care. The levy is a flat per capita amount unrelated to the number of claims lodged against each Council.

This separation between compensation and disciplinary systems in the Swedish, Norwegian and Danish systems is said to be necessary in order to obtain the co-operation of physicians in lodging and resolving claims (ACC 2002d). For example, in Sweden the disciplining of health professionals is handled by an entirely independent Medical Responsibility Board whose members are appointed by government. Patients can file claims and, following investigation, providers may be sanctioned by a reprimand, a warning, or a loss of license.

Critics have argued that there is no incentive to improve the accident record by taking measures (e.g. incident reporting, practice protocols, audits, and modern claims management techniques) open to hospitals to cut the cost of claims and to reduce the risk of accidents (Capstick, Edwards & Mason 1991, pp. 231-2).

However, given the international literature on the high frequency, and therefore the high cost to society, of medical error, this may help to create such an incentive. Towse & Danzon (1999) consider no-fault systems that sever all links between the compensation of the patient and professionals may result in relatively low accounting and overhead costs but instead invoke real social costs from the loss of deterrence. They consider the level of cost shifting is probably high and that it is not cost effective from a societal perspective to run such schemes.

No-fault schemes are funded in a variety of ways, for example, government funding or by drug manufacturers. No-fault schemes set up to compensate may be at odds with a focus on injury prevention, for example, injury prevention may not be high on a government's priorities. One method of funding that may have an impact on reducing injury is experience rating, however, there is no evidence in the literature of a no-fault scheme that experience rates registered health professionals (or organisations that provide medical care). 'Experience rating' in other areas may offer some insight into the likely outcome of experience rating health professionals. For example, 'experience-rating' of employers for work injuries has demonstrated that evidence for safer employment practices is, at best, equivocal (Birch 1991). Experience rating of registered health professionals is consistent with the neo-liberal goal of reducing costs and, if experience rating in other areas can provide lessons into experience rating of health professionals, the potential to assist the reduction of injury appears unlikely.

Brennen (2001) argues that an optimum system for injury prevention is possible under a no-fault scheme. He considers the optimal system for error prevention would:

- encourage healthcare providers to report errors, so that the data can be studied in order to understand the key structural determinants of common areas;
- send strong quality improvement signals;

- have systems in place to deal with practitioners who are incompetent;
- reinforce the honesty and openness of the patient/provider relationship – by creating a system that would encourage a provider to notify a patient of an injury sustained that could have been prevented.

4.9 Accident Rehabilitation and Compensation Insurance Act (1992) Compared To Other No-Fault Schemes in Terms of Injury Prevention

The Accident Rehabilitation and Compensation Insurance Act (1992) requires the reporting of a medical error when it is attributed to a registered health professional. However, it does not require reporting of general trends. Despite this, the ACC scheme under the Accident Rehabilitation and Compensation Insurance Act (1992) appears to be more advanced than many schemes in terms of injury prevention because of the requirement to report medical error findings to professional bodies. The potential for disciplinary action does not fit easily with the ACC scheme's founding principles, perhaps because a no-fault scheme was never intended to hold anyone accountable. However, a wider definition of accountability could include the 'public safety' aspect of accountability which would fall naturally into the ACC scheme's founding principle of community responsibility. Though reporting has not always been a statutory requirement, the public interest argument does provide a strong incentive to report.

The Accident Rehabilitation and Compensation Insurance Act (1992) is based on finding fault with regard to the actions of a registered health professional. This may provide a disincentive for the lodgment of claims. McGregor Vennell (1993, p. 29) questioned whether the requirement to report medical error may create an 'adversarial' stance being taken by the health professional and cause health professionals to keep things 'close to their chest' and cause them to fail their responsibility to patients. Other no-fault schemes such as the Swedish Insurance Scheme, which avoid a focus on individual blame by focussing on the concept of avoidability, may provide greater incentive for the lodgment of claims.

Although the potential to activate a premium to fund medical misadventure claims was introduced with the Accident Rehabilitation and Compensation Insurance Act 1992, the medical misadventure account is currently jointly funded by Earners and non-Earners Accounts. The former is funded by earners to cover the cost of earners non-work accidents and the latter is funded by Government from general taxation to cover the cost of non-earners' accidents (Gaskins 2000, p. 223). No other mechanism has been used to provide incentives for health professionals to reduce the number of claims made against them. As already noted it does seem unjust to collect premiums for medical mishap where injuries arise from treatment properly given, for example an allergic reaction to a drug. The argument against collecting premiums is that with such a low number of error claims it is inefficient to collect premiums and, any additional costs to health professionals would likely only be passed on to patients.

4.10 Conclusion

While not all adverse events are preventable, for maximum benefit in terms of injury prevention a scheme should:

- focus on avoidable injury to provide incentives for more claims to be lodged which in turn provides more data to inform injury prevention initiatives;
- ensure both person and systems based approaches considered (to ensure that both active and latent conditions are detected);
- use the data for injury prevention purposes with regard to both individual claims as well as general trends;
- use a criteria that does not focus on fault to help provide a greater incentive for the provider and claimant to lodge claims.

The implications for the ACC scheme are that an optimal scheme in terms of injury prevention would not focus on medical error as a criteria for cover and would move away from focussing on fault of an individual.

Chapter Five - Methodology

5.1 Introduction

In this thesis I am seeking to evaluate issues arising from the reporting process under the Accident Rehabilitation and Compensation Insurance Act (1992) and the impact of that process on the prevention of injury. Research commissioned by the ACC indicated that when people lodge claims many have expectations for lodging their claim (e.g. disciplinary action for the registered health professional) that are not met even when their claim is accepted (CM Research 1996). The previous chapter highlighted the high frequency of medical error both nationally and internationally. A comprehensive model of injury prevention was discussed and the advantages and disadvantages of the tort and no-fault schemes in terms of injury prevention were also outlined.

In this chapter the process of data collection, analysis, and the determination of key findings are outlined. My research evaluated sixty claims accepted on the basis of medical error under the Accident Rehabilitation and Compensation Insurance Act (1992) that were randomly selected from approximately eight hundred and forty claims. The research is exploratory due to the small number of claims in the sample.

5.2 Research Design

This research is a 'formative evaluation' in that it seeks to improve the ACC's medical error reporting process under the Accident Rehabilitation and Compensation Insurance Act (1992). Patton (1990, p. 156) argues that formative evaluation is suited to research with a focus on a specific context where there is a desire to make improvements by examining the strengths and weaknesses of a programme. With formative evaluation there is no attempt to generalise the findings beyond the specific context that is being considered. Thus the research examines the strengths and weaknesses of the outcome of the ACC's reporting process under the Accident Rehabilitation and Compensation Insurance Act (1992) with regard to injury prevention.

The research considers:

- (a) whether the legislation is consistent with 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.

5.3 Research Method and Process

Two methods are used in this research: document research and case studies. Once I had written my draft proposal and formulated my research questions, I met with the Health and Disability Commissioner to discuss the research topic and the feasibility of obtaining data from the HDC for research purposes. The Commissioner indicated his support for the research proposal and his willingness to assist in providing the necessary data within the auspices of the Official Information Act (1982) and the Privacy Act (1993). The Manager responsible for privacy issues within the ACC informed me that the data I wished to access was readily obtainable under the auspices of the Privacy Act (1993) and that as an ACC staff member I was bound by the 'statement of confidentiality' I had signed on commencing employment with the ACC. The Manager advised me to forward my ethics proposal application in the first instance to the General Manager, responsible for the Medical Misadventure Unit.

I approached the Assistant Registrar of the Medical Council in order to obtain permission to access information on the outcome of their investigations into medical error claims which had been reported to them by the ACC. I was advised that the information that I was seeking could not be provided under the Official Information Act (1982) as the Medical Council did not come under its jurisdiction. I was, however, advised that approval could be considered if I were to send a written proposal to the members of the Council who were due to meet two months later. Membership of the Medical Council is established under the Medical Practitioners Act (1995) and includes members elected by both medical practitioners and those appointed by the Minister of Health (Medical Council 2000). After due consideration, and given time constraints, I decided not to follow this process.

I considered that for those few claims that were under professional body jurisdiction, I could rely on information contained on the ACC copy file to provide me with the outcome of such investigations. Where the ACC reported a medical error to a professional body, the particular body concerned was requested to then advise the ACC of the outcome of their investigations. For this reason, I anticipated that for any claims with a date of injury prior to 1 July 1996 the information (i.e. correspondence on the outcome of their investigations), would be readily accessible on the ACC copy files retained in the Medical Misadventure Unit.

Following on from this I further clarified my research issues. As this is the first research that has been undertaken on the effect of reporting the ACC's medical error claims, I decided that it would be useful to explore and describe the outcome of that reporting process. I particularly wished to explore the effect of such reporting in terms of its ability to assist in injury prevention initiatives such as risk reduction strategies.

Once I had defined and developed my research issues I prepared my application seeking approval from Massey University's Human Ethics Committee to undertake the research (see Appendix 1). My application was supported by the General Manager, Policy and Assurance, ACC and by the Health and Disability Commissioner.

Some concern was expressed about privacy issues to do with data matching between the ACC and the HDC. However, the issue was resolved by the ACC's legal department who advised that, in their opinion, my research topic did not contravene the Privacy Act (1993) as the information that was to be disclosed was not going to be in a form that could reasonably be expected to identify any individual. The ACC formally supported the research proposal and stated that I would not receive privileged access to data purely on the grounds of my employment status with the ACC (see Appendix 2). The Health and Disability Commissioner also formally indicated support for the research project (see Appendix 3).

On receipt of formal approval from Massey University's Human Ethics Committee, I sought and obtained information under the Official Information Act (1982) from the ACC and from the Health and Disability Commissioner.

5.4 Data Collection Techniques

In general, the ACC's Medical Misadventure Unit classifies claims according to the medical specialty of the registered health professional who is involved in the provision of treatment that is alleged to have caused the injury. For example, if the injury is caused by the treatment given by a registered General Surgeon, then the claim is classified as a general surgery claim. The ACC was asked to randomly select ten general surgery claims, from the entire sample of sixty claims. However, I was provided with a list of forty-four general surgery claims obtained from a random table generation. I then further selected the first ten claims on the list.

Initially I considered only ten of the sample, in order to analyse the data provided so that I could decide on whether I should focus on the specialist area of general surgery or consider taking a broader range of cases across the range of medical specialty areas. It seemed to me that there may be benefit in concentrating on general surgery claims so that I could perhaps compare similar incidences in order to determine if similar injury prevention initiatives had been taken.

Once I had received the relevant file numbers for my sample, I then requested the actual files from the Medical Misadventure Unit. The Medical Misadventure Unit's process was that once a claim was accepted on the basis of medical error, the file was then transferred to the claimant's local ACC branch in order to determine the claimant's eligibility to entitlements. Prior to the file being sent, a photocopy was taken and this copy file retained in the Unit for the purpose of further correspondence with the professional body or the HDC. However, due to the age of the files on which I undertook my research, most of the files had been archived. I had intended to use the copy file in order to cause the least disruption to the ACC staff at the local branches, however, when I requested the first ten

claims only two could be located at the Medical Misadventure Unit. This was unexpected. Nevertheless, I was able to obtain the other eight original files from the respective ACC branches. I explained to each of the ACC branches that the information I was requesting was required for research purposes and provided them with copies of my research proposal and the approval received from Massey University's Human Ethics Committee. Locating and obtaining the files took a great deal of time, caused a certain amount of disruption to the branches and proved to be unproductive as the files did not contain correspondence from the relevant professional bodies. The reason for this may have been that any correspondence from a professional body was likely to be addressed to the Medical Misadventure Unit and not to the ACC branch and therefore, may not have been forwarded to the local branch to be filed with the original claim.

Another way I could access the ACC's files was through 'Pathway', an electronic filing system where information such as copies of letters written by the ACC to the claimant and professional bodies were recorded. The ACC's phone discussions with interested parties such as claimants and health professionals were also documented. I found, however, that Pathway did not contain copies of letters that had been written to the ACC, although in some cases, staff had noted that a letter had been received from an external source such as a professional body. Pathway had been introduced in late 1998. As most of the claims in the data set were managed by the ACC before Pathway had been introduced, there was very little information recorded on the claims that was useful to my research.

As each file arrived I recorded the data on an excel spreadsheet and checked for information contained on Pathway. Having recorded data on the first ten claims I had initially chosen, I then made the decision to select the remaining fifty file numbers for my sample from a range of medical specialties and not just from general surgery. When I had analysed the first ten claims I found that the general surgery incidences varied too greatly to provide any useful comparison in terms of injury prevention initiatives. So I decided to take a broader approach and consider claims across the entire range of medical specialties. I was also interested in seeing if there were any unusual patterns between specialty areas, for example, a higher incidence of injury prevention initiatives in a particular medical specialty.

As I analysed the first ten claims in the data set I discovered that there was only limited information about the outcome of investigations by professional bodies and so I requested a second data set be provided with a date of injury occurring on or after 1 July 1996. This would allow me to focus on claims under the HDC's jurisdiction.

Due to the Medical Misadventure Unit's other work priorities it took almost two months before I was able to obtain the further sample that had also been taken using a random table generation. When the file numbers were supplied to me I then had to request that the files be retrieved from the ACC's archives where they were stored. However, instead of being provided with the individual files as I had requested, I was sent all the boxes of files that were archived under the Accident Rehabilitation and Compensation Insurance Act (1992). It took some time to carefully search through each box as many of the files were not filed numerically. Interestingly, in the end, only sixteen of the fifty files were able to be located. Given time constraints, my not wishing to cause unnecessary disruption to the local branches, and the assumption that the original files were unlikely to contain correspondence from the professional bodies, I decided not to obtain the further thirty four original files from the local branches.

The second batch of file numbers which the ACC had provided did not include the date of birth of the claimant. Realising that this was probably essential in order for the HDC to identify a case, I searched through Pathway to establish dates of birth before I requested the data on the outcomes of the HDC's investigations from the HDC. The HDC required me to sign a 'statement of confidentiality' before releasing the data which was then provided to me within a month.

The first batch of data I received from the HDC included decisions taken in regard to each claim as to whether or not there had been a breach of the HDC Code of Rights (1994). The information I received however was not specific enough to address my research question, as it lacked information on whether an injury prevention initiative had been undertaken. Further, it was not always made clear as to whom had first reported the complaint to the HDC. As I entered the details

on an excel spreadsheet I discovered a large number of the claims had an ambiguous or unknown result.

I contacted the HDC and explained that the information that had been supplied to me did not sufficiently meet the requirements for my research as there was insufficient information regarding the injury prevention initiatives taken, and little information as to who was initially responsible for instigating the HDC investigation. The HDC agreed to provide me with more information in terms of injury prevention outcomes with details on whom had first raised the complaint with them. Within a month the HDC provided me with comprehensive and thorough data.

5.5 Data Management, Theory and Analysis

In any research, thought needs to be given as to how best to manage the data. As the files arrived I recorded the details on an excel spreadsheet noting the following details:

- the claimant's name, claim number, and date of birth (used for identification purposes only);
- the date the injury occurred;
- the medical specialty, for example, nursing or general surgery;
- the qualification of the registered health professional to whom the medical error had been attributed;
- a description of the injury sustained;
- the professional body or organisation to whom the claim was reported (if this had happened);
- whether the medical error reported to the HDC/professional body had first been referred to them by another interested party (for example, the consumer);
- the date the claim was reported to the HDC or the professional body;
- the date the claim was lodged with the ACC;
- information regarding injury prevention obtained from Pathway;
- information regarding injury prevention obtained from the physical file (including whether this was from the original or the copy file);

- information regarding injury prevention obtained from the HDC;
- whether there had been: an injury prevention outcome; no injury prevention outcome; ambiguous reporting or an unknown outcome.

The name, claim number and date of birth were required for identification purposes with the date of injury recorded in order to establish which body had jurisdiction for the medical error, for example, the HDC or the relevant professional body. The medical specialty involved was included to allow for comparisons between medical specialties and the registered health professional's qualification was included to allow for consideration of variations between the health professional groups.

I was interested to see if there was any difference in the type of injury prevention initiatives taken (or not taken) relative to the qualification of the registered health professional and a description of the injury was recorded to allow for consideration as to whether a particular injury prevention initiative taken appeared to be relative to the nature of the injury.

Details on whether the ACC had reported the medical error to the professional body or to the HDC were recorded so that I could establish whether any claims had failed to reach the HDC and professional body. To help me determine if there had been sufficient time for the injury prevention initiative to have taken place, details on whether the complaint had first been referred to the HDC/professional body by another interested party were included. In order to ensure that the body responsible for taking an injury prevention initiative was identified, detail on the date the ACC reported the medical error to the relevant body was included. I then recorded when the claim was lodged with the ACC so I could do time series comparisons in order to determine whether patterns emerged over time, for example, if the ACC's non-reporting of medical error was more prevalent during any particular period.

As there were three possible places where the file data could be stored at the ACC (e.g. Pathway, the original physical file, or the ACC copy file) I recorded the

relevant information separately to ensure that I could easily track the file data should I need to refer back to it for any reason. Details on who took the injury prevention initiatives, the ACC, the HDC or the relevant professional body were recorded so that I could determine where the responsibility for the outcome lay. I undertook an analysis of each case in order to determine whether there had been an injury prevention outcome and recorded the details.

Although I had intended to make a comparison between medical specialties, and consider variations between health professional groups, the sample I drew did not lend itself to such considerations. The depth of analysis on the research was also limited by time constraints. Some of the data I recorded, such as the qualification of the registered health professional, and whether there had been sufficient time for an injury prevention initiative to have taken place, was not explored across the greater sample. Instead consideration of such issues was restricted individual case studies. This process of analysing the data was informed by grounded theory.

Grounded theory is a method of generating theories from data. It is an approach to the conduct of field research where the problem itself emerges from the data (Polit & Hungler 1993, p. 332). A main feature of grounded research is that the data collection and analysis occur together. Grounded theory research is the constant comparative process in which every piece of data is compared with every other piece (Burns & Grove 1993, p. 69).

Grounded theory is not typical in evaluation research. However, I found the approach was helpful in encouraging me to be open in my approach to the data. I had no preconceived ideas on what the data might reveal, and I developed analytical categories, based on similarity of content, as I proceeded to read the files. Initially I established two categories, injury prevention initiative and non-injury prevention initiative, but, as I began the process of recording and analysing the data, it became apparent that another two further categories were required: ambiguous outcome and outcome unknown.

5.6 Values and Politics

Values and politics affect social research at all stages in choice of topic, the methods chosen, presentation, and the utilisation of results. According to Finch (1986, p. 197) the researcher should bring value premises out into the open, and this is particularly important in social policy research where there is a clear and direct relationship with the research participants. To avoid bringing value premises into the open can confuse values and facts, which may mean the research will be discounted.

Evaluation itself is a political process, as is setting the criteria for evaluation (Spicker 1995; Weiss 1987). The existence of legislation such as medical misadventure legislation, means that Government accepts that its citizens should not be left to bear the burden of medical misadventure without government support. In choosing formative evaluation to evaluate the Accident Rehabilitation and Compensation Insurance Act (1992) in terms of a 'no-fault' scheme, I am making a political statement about the appropriateness of such programmes. It presupposes the programme should exist. While acknowledging the political nature of setting the criteria, I have been explicit about my rationale for placing judgement where indicated.

My approach to the evaluation was informed by the evaluation research approach described by Spicker (1995, pp. 15-19), where he argues that in principle, the evaluation of a policy requires at least the following four steps:

- identification of the aims;
- operationalisation of the criteria (the identification of goals);
- identification of results or effects;
- comparison of effects with aims and goals.

The identification of aims includes both positive and negative aims. Positive aims include factors which have to be achieved. Positive aims tend to be easier to identify as they are often made explicit in policies (given their potential for measuring whether there has been an improvement in service). Negative aims are

those matters which need to be avoided and may therefore be implicit, rather than explicit, for example, a requirement that services should not be too costly.

Operationalisation of criteria described by Spicker (1995) requires translating aims into specific measures, for example, a 'crime rate'. Such measures however have to be constructed and developed and they may be in the form of indicators.

Indicators themselves are not value free. For example, a government's selection of indicators is likely to be one that serves the government's interests best.

Indicators that are represented in numbers can be useful but it is important not to assume they contain definitive arguments about or solutions to social problems.

For example, unemployment may not be the same problem for everyone.

Understanding an issue may well be dominated by the means by which we choose to measure it. Realising this I chose to focus on outcomes rather than indicators.

The effects of policy can be difficult to identify and decisions have to be made at the outset as to what is to be measured, for example, inputs, outputs or outcomes. If a programme is measured on its outcome, the distributive effectiveness of the policy may be missed. For example, an educational programme may be successful in providing benefits to a group of students. However, in terms of distributive outcome such services may demonstrate an ability to assist the middle class and failure to assist the lower class. Nevertheless, although this research is focused on outcomes, it is beyond the scope of this study to consider the distributive effects of the Accident Rehabilitation and Compensation Insurance Act (1992).

Once the aims, goals and research effects are identified a comparison between them can be made. This will be discussed in Chapter Seven.

5.7 Ethics

Ethical principles need to be interpreted before being applied to the specific social contexts of the research being conducted as these principles will vary depending on the methods and perspectives chosen. Ethical principles guiding research include, though are not necessarily confined to: informed consent; confidentiality;

minimising of harm; truthfulness; social sensitivity and the acknowledgment of cultural differences (Massey University Human Ethics Committee 2000).

As previously outlined, my research was based upon document research and case studies of claimant files. As this process did not involve getting any information directly from a claimant it was not necessary to obtain individual informed consent. The Privacy Act (1993) and the Health Information Privacy Code (1994) govern the circumstances in which government agencies, such as the ACC and the HDC can release information for research purposes. These include that the research must not, for instance, disclose any information in any form that could reasonably be expected to identify individuals. Care was taken throughout this research to ensure that no information was disclosed that could identify anyone. All identifying data was secured. No identifying data was reported, for example, the naming of a hospital or any other identifying data in which the medical error that occurred could potentially identify the claimant or health professional concerned. Also, in accordance with the Privacy Act (1993) and Health Information Privacy Code (1994) and the Massey University Human Ethics Committee requirements, all information has remained in a secure cabinet on ACC premises and on completion of my research, all files obtained from the ACC returned while records (e.g. copies, spreadsheets) were destroyed in the ACC's shredder.

The material contained in this research has the potential to be published or presented to individuals directly involved in the decision making processes at the ACC. The findings of this thesis will be of interest to, and may be of assistance to, those involved with the Medical Misadventure Unit and the prevention of medical error.

This chapter has explained the process of data collection, analysis and determination of key findings. The following chapter discusses the research findings and seeks to evaluate the medical error reporting process as under the Accident Rehabilitation and Compensation Insurance Act (1992). It also examines the impact of the reporting process with regard to the prevention of injury.

Chapter Six – Results

6.1 Introduction

My research involved a search and review of a random selection of sixty ACC claims lodged between 1992 and 2001 which had been accepted on the basis of medical error under the Accident Rehabilitation and Compensation Insurance Act (1992). The purpose of the review was to evaluate the medical error reporting process under this Act and examine the impact of the ACC's reporting process with regard to the prevention of injury.

This chapter outlines the results of each of the four injury prevention categories and presents a summary of the eight case studies that were selected in order to provide more in depth analysis. Completing the chapter will be a report on the number of the ACC copy files I could not locate in the Medical Misadventure Unit and the number of claims that were not reported to the HDC.

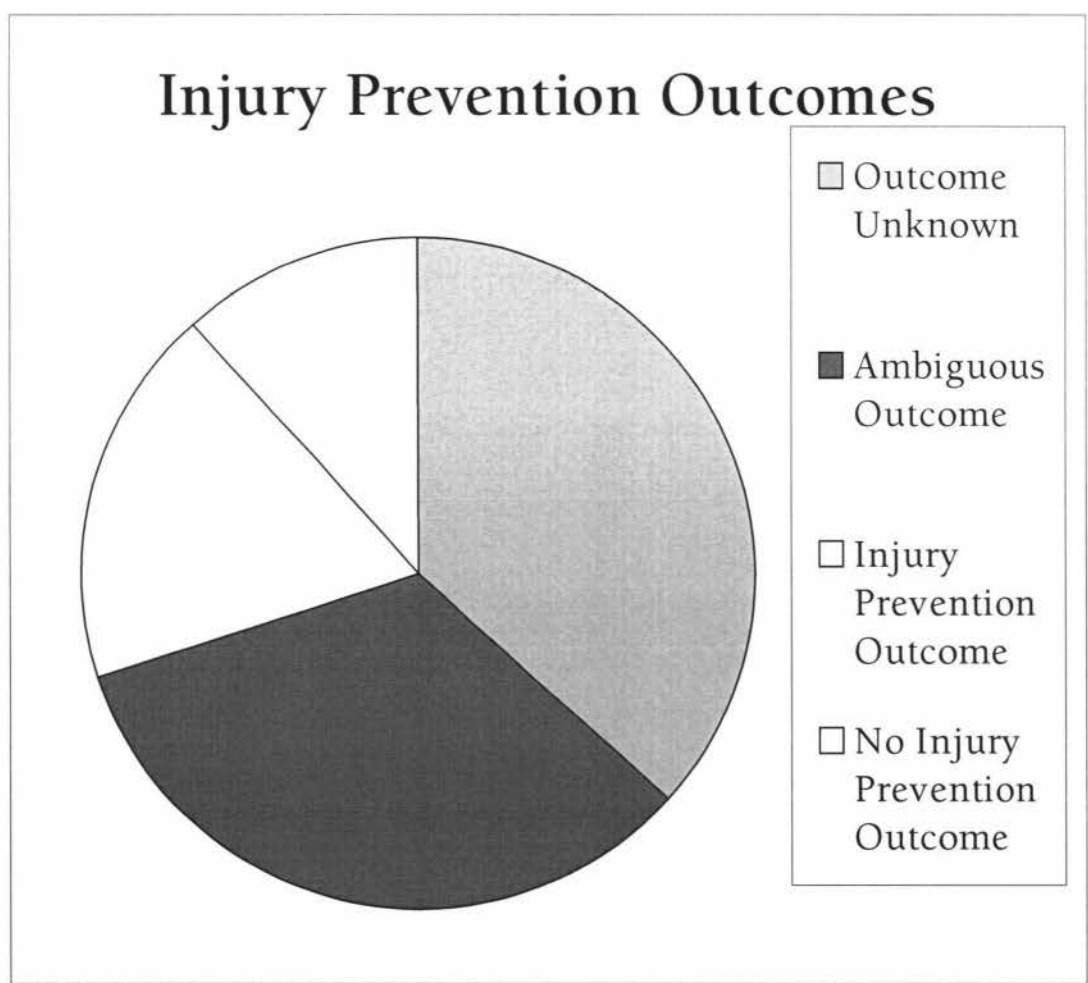
As the focus of my research is on the prevention of injuries arising from medical error, claims evaluated were coded according to whether or not there had been an injury prevention initiative taken as a result of the reporting process. I defined an injury prevention initiative as a pro-active action taken in an effort to minimise the possibility of the medical error reoccurring. I saw this as distinct from disciplinary action, the motivation for which was other than injury prevention.

An injury prevention initiative could range from the simple action of writing to the registered health professional and advising them to think carefully in a similar situation in the future, or, at the other end of the spectrum, where the registered health professional was removed from the register and was thereby unable to practice. If the HDC had determined that the Code of Health and Disability Services Consumers' Rights Regulation had been breached, or there was a successful prosecution by the Director of Proceedings either of these was not in

itself considered an injury prevention initiative. A finding such as ‘conduct unbecoming’ from a professional body was similarly not defined as an injury prevention initiative.

Of the sixty cases considered, I found that in twenty-two cases the outcome of reporting in terms of whether or not an injury prevention initiative had taken place, was “unknown”. Twenty cases were classified as having an “ambiguous outcome”. In eleven cases there was clear evidence that an injury prevention initiative had occurred as a result of the ACC, and in seven cases there was no evidence that an injury prevention initiative had taken place (see Figures 9 and 10). Eight case samples were also examined in detail and highlighted a variety of outcomes.

Figure 9 – Graph Showing Injury Prevention Outcomes



Two other key findings that were reflected across the range of categories were that in forty two out of the sixty cases the ACC copy file was missing, and in at least eleven of the sixty cases the medical error findings were not reported to the HDC. I consider there may have been more information regarding the outcome of investigations from professional bodies had more of the ACC copy files been located. If more claims had been reported to the HDC it is likely that the number of claims with an injury prevention outcome may have been higher because the HDC was shown to be pro-active in taking injury prevention initiatives.

Figure 10 – Injury Prevention Outcomes

Outcome in Terms of Injury Prevention Initiative Taken	Number of Claims	Percentage of Claims
No outcome	7	11.7%
Clear outcome	11	18.3%
Ambiguous outcome (double reporting)	20	33.3%
Outcome unknown	22	36.7%
Total number of claims	60	100%

6.2 Unknown Outcome

The outcome of twenty-two of the sixty claims was unknown and this was the largest category of claims (see Figure 11).

To be categorised as outcome unknown, claims met one of five criteria:

- i. in eight cases, the ACC copy file could not be located. The HDC was able to confirm that the medical error finding had been reported to them by either the ACC or other interested parties (such as the consumer). However, it appeared that an injury prevention initiative had not taken place as a result of the findings. It is noted that while the possibility existed that a medical error finding had been reported to the professional body there was, however, no information to confirm whether or not this had occurred.
- ii. in six cases, neither the HDC nor the ACC had taken an injury prevention initiative. The medical error had been reported to the appropriate

- professional body but it was not known whether the professional body had undertaken any injury prevention initiative.
- iii. in five cases, the ACC copy file could not be located within the ACC. The HDC confirmed that the medical error had not been reported to them but it was not known if the medical error had been reported to the hospital or to a professional body.
 - iv. in two cases, the date of injury was prior to 1 July 1996 and the file was referred to the professional body. It was not known if any injury prevention initiative had occurred as a result.
 - v. in one case, the ACC had reported the medical error to the HDC. A confidential agreement was reached between the registered health professional and the consumer, in accord with resolutions available under the HDC Act (1994), but it was not known whether the agreement included an injury prevention initiative.

Figure 11 – Criteria for Falling into Category “Unknown Outcome”

Criteria for Establishing “outcome unknown”	Number of Claims
<ul style="list-style-type: none">• The ACC copy file not located.• HDC took no injury prevention initiative.• Unknown whether or not the ACC reported the medical error finding to the hospital or professional body.	8
<ul style="list-style-type: none">• The medical error was reported to the HDC and to the professional body.• HDC and the ACC took no injury prevention initiative.• Unknown whether the professional body’s investigations led to an injury prevention initiative.	6
<ul style="list-style-type: none">• The ACC copy file could not be located.• The HDC had no record of the medical error finding.• Unknown whether or not the ACC reported the medical error finding to the hospital or professional body.	5
<ul style="list-style-type: none">• The date of injury was prior to 1 July 1996.• The medical error was reported to the professional body but it was unknown if their investigations had led to an injury prevention initiative.	2
<ul style="list-style-type: none">• A confidential agreement was reached between the HDC and the consumer.	1
Total number of outcome unknown claims	22

6.3 Ambiguous Outcome

This was the second highest category of outcomes in terms of injury prevention with twenty of the sixty claims falling into this category. An injury prevention initiative had taken place for all claims falling into this category, however, the injury prevention initiatives could not be attributed to the ACC’s reporting process because it is likely the injury prevention initiatives would have occurred regardless of the ACC’s reporting process.

The ambiguous outcome claims met one (or more) four criteria. These are summarised in Figure 12 and discussed as follows.

- i. in nine cases, the HDC had undertaken an injury prevention initiative, however other interested parties such as the claimant, or family had

already referred the complaint to the HDC before the ACC had reported the medical error finding to the HDC.

- ii. in five cases, the registered health professional or the organisation responsible for the medical error, for example the medical centre or hospital, had already taken an injury prevention initiative, at the point in time when the ACC or the HDC's had office approached them with regard to the outcome of their respective investigations.
- iii. in two cases, both of the above occurred. The complaint had been referred to the HDC prior to the ACC's reporting of the medical error to the HDC. The registered health professional or organisation responsible for the treatment (such as the medical centre or hospital) had already taken an injury prevention initiative prior to being approached by the HDC.
- iv. in four cases, it is unknown if the ACC reported the medical error to the professional body or not. The professional body referred the complaint to the HDC who took an injury prevention initiative. It was unclear, however, whether the injury prevention initiative could be attributed to the ACC's reporting process or whether the professional body reported the complaint as a result of the complaint being raised by other interested parties such as the claimant.

Figure 12 – Criteria for Falling into Category “Ambiguous Outcome”

Criteria for Category “ambiguous outcome”	Number of Claims
<ul style="list-style-type: none"> HDC had already been advised of the complaint prior to the ACC’s reporting of the medical error finding. 	9
<ul style="list-style-type: none"> Injury prevention initiatives in place before the ACC or the HDC approached the registered health professional or hospital concerned. 	5
<ul style="list-style-type: none"> Mixture of both of the above. 	2
<ul style="list-style-type: none"> The Professional Body referred the complaint to the HDC. The HDC undertook an injury prevention initiative. Unknown whether the information passed on by the professional body to the HDC was due to the ACC reporting the medical error to them in the first instance or whether the professional body reporting would have occurred regardless of any ACC involvement in the reporting process. 	4
<ul style="list-style-type: none"> Total number of claims 	20

Injury prevention initiatives that occurred were varied and included (see Figure 13):

- a change in hospital protocol;
- a request for information on the outcome of the review of protocol, this may have been to establish a new protocol or review one that was in place prior to the incident occurring;
- a hospital using the incident as a case study for training staff;
- an article prepared for publication in an appropriate periodical (identifying details removed);
- an article placed on the HDC website (identifying details removed);
- an incident reported to the college responsible for training that particular registered health professional;
- a letter asking for a claimant’s permission to report an adverse reaction to medication so that a manufacturer who sought details of the incident could work towards reducing adverse reactions;
- implementing a refresher training programme for staff;

- a letter from the HDC to the provider advising them to take a particular action to prevent the incident from occurring again, e.g. to read the Code of Health and Disability Services Consumers Rights;
- discussing the issue at a Quality Assurance Meeting in a hospital;
- a letter to the Ministry of Health from the HDC requesting that the Ministry review its standards in the particular sector concerned.

The injury prevention initiatives were undertaken by hospitals and the office of the HDC (see Figure 14).

Figure 13 – Description of the Injury Prevention Initiatives Taken (nb in some cases more than one type of injury prevention initiative had taken place).

Injury Prevention Initiatives Taken	Number of Injury Prevention Initiatives
Hospital changed protocol.	10
Information requested on the outcome of a review of changed protocol.	4
Hospital used case study as an educational tool.	3
Article prepared for publication in appropriate periodical (with identifying details removed).	1
Article placed on the HDC website (with identifying details removed).	1
Incident reported to the college responsible for training the registered health professional involved.	1
Letter seeking claimant's permission to report an adverse reaction to the drug manufacturer.	1
Refresher training programme for staff.	4
HDC wrote to the provider and advised them to take a particular action to prevent the incident from occurring again.	5
Issue discussed at a Quality Assurance Meeting.	1
Letter sent to the Ministry of Health requesting that the Ministry review standards in the sector.	1
Total number of injury prevention initiatives taken	32

Figure 14 – Responsibility for Injury Prevention Initiative

Organisation Responsible for Taking the Injury Prevention Initiative	Number of Outcomes
Hospital	10
Office of HDC	8
Both	2
TOTAL	20

6.4 Injury Prevention Outcome

Eleven claims were classified as having resulted in an injury prevention outcome. The claims met the injury prevention criteria if there was clear evidence that an injury prevention initiative had been taken as a result of the ACC’s reporting process. The injury prevention initiatives included:

- writing to the registered health professional and advising the registered health professional to change current practice in a specific area. For example, one registered health professional was advised to read the Code of Health and Disability Services Consumers’ Rights to ensure that consumers were fully informed of all relevant treatment options for the named treatment in future;
- writing to the hospital or organisation concerned advising them to review their protocols;
- an article prepared for publication in an appropriate periodical (identifying details removed);
- an article placed on the HDC website (identifying details removed);
- reporting the incident to the college responsible for training the registered health professional;
- an overseas Medical Board notified of the complaint (for their information);
- a professional body notified and a request made for the Complaints Assessment Committee to be set up if the registered health professional concerned returned to New Zealand;

- the health professional required to complete an adverse event form and return it to the drug manufacturers.

Either the ACC or the HDC’s office was responsible for taking the injury prevention initiative in this category (see Figure 15). As described above a variety of injury prevention initiatives were found to have been taken (see Figure 16).

Figure 15 - Responsibility for Taking the Injury Prevention Initiative

Responsibility for the Injury Prevention Initiative	Number of Claims
ACC	2
The HDC	9
Total number of claims	11

Figure 16 – Description of the Injury Prevention Initiatives Taken (nb in some cases more than one type of injury prevention initiative had taken place).

Injury Prevention Initiatives Taken	Number of Injury Prevention Initiatives Taken
Letter to registered health professional advising the need to make a change in practice.	5
Letter to hospital advising the need to change protocol.	4
Article prepared for publication in appropriate periodical (identifying details removed).	2
Article placed on the HDC website (identifying details removed).	2
Incident reported to college responsible for training the registered health professional concerned.	1
Overseas medical board notified of the complaint (for their information).	1
Professional body notified and request for a Complaints Assessment Committee to be set up if the health professional should return to NZ.	1
Health professional required to complete adverse event form and return the form to drug manufacturers.	1
Total number of injury prevention initiatives	17

6.5 No Injury Prevention Initiative Outcome

This was the smallest category with only seven claims falling into this category. Claims in this category met one of the following two criteria (see Figure 17).

- i. in four cases the ACC copy file was located but the file had not been reported to a professional body or to the HDC. The HDC confirmed that the medical error had not been reported to them.
- ii. in the remaining three cases, the medical error had been reported to the HDC and to the professional body but there was evidence on file that an injury prevention initiative had not resulted.

Figure 17 – No Injury Prevention Initiative Undertaken

Criteria for Establishing No Injury Prevention Initiative Outcome	Number of claims
<ul style="list-style-type: none">File located but the medical error had not been reported to a professional body or to the HDC.	4
<ul style="list-style-type: none">The medical error finding was reported to the HDC and, in some cases, to the professional body as well.No injury prevention initiative had been undertaken.	3
Total number of claims	7

6.6 Eight Case Studies

As stated in Chapter Five I had planned to select six cases to analyse in further detail. In order to compare and contrast the process and outcomes from this pool of six cases I had planned to select three cases where there had been successful injury prevention initiatives and three cases where this had not been the case. I had not anticipated that rather than having just two categories, injury prevention and non-injury prevention outcomes, I would end up with four. However, in order to provide a more comprehensive analysis of the reporting process I chose to include one case study from each of the additional categories “outcome unknown” and “ambiguous outcome”.

Injury Prevention Outcomes: Of the eleven cases where there was an injury prevention outcome I selected three for further analysis: case studies One, Two and Three.

Case Study One

The claim was for failure to diagnose a gastric ulcer with peritonitis leading to exacerbation of the condition and ultimately the patient's death. This claim came to the fore because it was one of two in the injury prevention category where the ACC had taken an injury prevention initiative. The ACC determined that the medical error was a case of collective responsibility of the large number of health professionals involved in the patient's care and that it would be inappropriate to single out any particular health professional. The medical error was therefore not attributed to a particular registered health professional.

The claim had a date of injury post 1 July 1996 and the medical error was reported to the HDC. The HDC found no breach and did not take any injury prevention initiative.

The ACC also reported the claim to the General Manager of the hospital concerned, with the ACC's case notes citing awareness of an internal inquiry at the hospital following a formal complaint by the deceased's partner. The ACC's letter to the hospital recommended that if it had not been done already, the issue should be brought to the attention of all relevant staff so that they were aware of the fatal outcome for the patient. The ACC also recommended that appropriate protocols be put in place so as to minimise the risk of this sort of event occurring in the future.

A factor that may have prompted the ACC to write to the hospital was the seriousness of the case – the death of a patient. Another factor that may have influenced the decision to write to the hospital was the fact that as the medical error could not be attributed to a particular health professional it may have been difficult to identify the appropriate professional body to refer the claim to, for example, if both nurses and doctors had been involved.

Case Study Two

This claim appears to be for scarring following the removal of a wart. There is little information available about this claim as ACC's copy file could not be located and no details were recorded on the ACC's electronic database. It is also possible that the ACC could have undertaken an injury prevention initiative. The information that was available came from the HDC. The claim had come to the fore because it was one of two within the injury prevention category with the highest number of injury prevention initiatives taken. The Health and Disability Commissioner recommended that the registered health professional take the following actions:

- update himself and other staff on appropriate treatment for wart removal;
- conduct a review of all treatments that had been delegated to nursing staff;
- report the results of the review to the Commissioner;
- ensure that practices were consistent with current medical practice;
- ensure that appropriate mechanisms were put in place to ensure general practitioner intervention when necessary, e.g. during treatment delegated to nursing staff;
- ensure that consumers were fully informed of all wart treatment options;
- ensure that barrier cream is applied to prevent scarring if a specific procedure is used.

The Commissioner also recommended that an article on this case should be prepared for publication in the appropriate periodical.

Case Study Three

The claim was accepted on the basis of medical error because of failure to recognise and treat an injury to a woman which occurred at the time of the delivery of her baby. The claim came to the fore because it was one of two within the sample with the highest number of injury prevention initiatives taken within the injury prevention outcome category.

The Health and Disability Commissioner advised the registered health professional to take the following actions:

- read the Code of Health and Disability Services Consumers' Rights and confirm understanding of obligations should he return to New Zealand to practice;
- ensure that adequate anaesthesia is administered when forceps deliveries are contemplated, to allow for the repair of any resulting damage;
- ensure that oral preparations of medications are administered when that option is available.

The Commissioner also recommended that the following actions should take place:

- that a Complaints Assessment Committee should be set up if the particular registered health professional returns to New Zealand;
- that an overseas medical board be advised of the complaint against the registered professional.

No Injury Prevention Outcome: Of the nine cases where no injury prevention initiative had taken place I selected three for further analysis: case studies Four, Five and Six.

Case Study Four

The claim was accepted because of failure to excise a well-documented carcinomas lesion in the breast that was later confirmed to be carcinoma leading to additional surgery. The General Surgeon did not refer to the mammogram report and a lateral portion of the breast was removed instead of a medial portion. The medical error was realised immediately after the operation and surgery to remove the carcinoma was promptly rescheduled. The result was that the cancer did not develop further.

The injury covered by the ACC scheme was the original surgery which was seen to be unnecessary. ACC reported the medical error to the Medical Council who referred the case to the Medical Practitioners' Disciplinary Committee. The Medical Council then wrote to the ACC advising the action that had been taken

following the ACC's reporting of medical error. This claim came to the fore because it was one of the few claims that resulted in censorship and fines. The Medical Practitioners' Disciplinary Committee considered the circumstances of the claim and a charge of 'conduct unbecoming' was established against the registered health professional under Section 43 of the Medical Practitioners Act (1968). As a result, the registered health professional was censured, incurred a penalty of \$300 and was required to pay \$2709.98 which represented 30% of costs of, and incidental to, the inquiry. However, despite the finding of conduct unbecoming, no injury prevention initiative was taken. It was appropriate that the claim, which had a date of injury prior to 1 July 1996, was not referred to the HDC as the HDC has no jurisdiction to consider claims prior to this date.

Case Study Five

This claim was lodged because of complications following sebaceous cyst excision due to the failure of the registered health professional to observe a standard of care that was reasonable in the circumstances. The medical error was attributed to a Medical Registrar. The claim came to the fore because the ACC had made a deliberate decision not to report the medical error to the professional body concerned. The medical error finding was also not reported to the HDC. However, as the injury had occurred prior to 1 July 1996, it was appropriate that the error was not referred to the HDC.

The Medical Misadventure Advisory Committee was of the opinion that the supervising Registrar should have overseen the suturing by a fifth year medical student of the claimant's wound. The Committee determined this to be a generalised finding of medical error and recommended that the ACC should not refer the matter on to the Medical Practitioners' Disciplinary Committee⁵. The ACC made the final decision not to report the medical error. However, in this situation it would appear that the medical error could have been attributed to the

⁵. A generalised finding of medical error generally means that although the injury is as a result of a registered health professional's action the medical error cannot be attributed to a particular health professional.

supervising Registrar. Had the medical error been reported, an injury prevention initiative such as a change in protocol could possibly have been instigated.

Case Study Six

The claim was for facial palsy and deafness due to an inappropriate operating technique used by a visiting surgeon. The claim came to the fore because it was one where there appeared to be inter-agency confusion. The ACC had referred the medical error finding to the professional body, and the professional body had referred the claim to the HDC for investigation. However, despite five years elapsing since the ACC reported the claim, the HDC had no evidence of ever having received the complaint. As a result there was no opportunity for an injury prevention initiative to be developed and undertaken.

Case Study Seven - Unknown Outcome

This claim was lodged because of complications following an overdose of medication. The claimant attended her usual medical centre for her regular injection of medication. The Doctor, who was a Locum, inadvertently administered 60ml of medication instead of the usual 15ml. He stated that he was given the box with the vial of medication in it and unfortunately assumed that the whole vial was to be given. He stated that he proceeded to give the claimant the whole vial instead of her normal dose and only realised the medical error when the claimant requested the rest of her vial back.

The medical error was attributed to the Locum's failure to check the amount of medication contained in the vial and in not ascertaining the correct dosage of medication.

The claim came to the fore because it was an example of a claim that was halted by the HDC on the claimant's request. The circumstances of the overdose did lend themselves to the development of injury prevention initiatives such as a change in protocol in general practitioner practice, however, the HDC closed the file as the claimant did not wish to pursue the case. The claim was also referred to

the Medical Council. This claim comes under the category of “unknown outcome” because it is unknown whether the Medical Council took an injury prevention initiative. This case raises the question of whether claims should be investigated in the interests of public health even when an individual has chosen not to pursue the claim.

Case Study Eight - Ambiguous Outcome

The claim was for an intravenous caffeine burn to the dorsum of the hand and wrist. Medical error was attributed to two staff nurses. The ACC reported the file to the HDC. The HDC wrote to the claimant asking them to make contact so that the HDC could further investigate the complaint. The claimant did not respond. As a result the HDC closed the file and took no further action. The HDC was privy to a letter from the two nurses' Legal Counsel stating that initiatives had taken place since the incident. This may have been a factor in the HDC choosing not to take any further action.

The ACC copy file contained a copy of the letter from the nurses' Legal Counsel. The letter stated that the two nurses had been taken off the hospital's intravenous line Register for three months and were accepted back on to the Register when they again sat and passed the intravenous line test (both passed with 100%). The two nurses had also been involved in an educational exercise in the redevelopment of the hospital's protocols on drugs, which placed particular emphasis on drug calculations and fluid volumes. Since the incident, both nurses had received satisfactory performance appraisals and had not been involved in any other medical errors with regard to the administration of drugs.

This claim came to the fore because of the hospital's pro-active injury prevention initiatives as described above. This claim was classified as being ambiguous because, although there were injury prevention initiatives taken by the hospital, this was before the ACC had accepted the claim and reported the medical error. Therefore, the injury prevention outcome, could not be credited as being attributable to the ACC's medical error reporting process.

6.7 Missing Files

When the Medical Misadventure Unit accepts a claim on the basis of medical error the ACC then considers to which organisation it is appropriate to report the incident. For example, the professional body or the HDC. At that point, the original ACC file is referred to the local ACC branch for determination of whether or not the claimant is entitled to any payments, such as medical treatment costs, weekly compensation, independence allowance, home-help or attendant care. A copy of the claimant’s file is retained in the Medical Misadventure Unit for the purpose of future communication with the professional body or the HDC. However, I found that the practice varied considerably from the stated procedure and a large number of copy files could not be located (see Figure 18).

Figure 18 – ACC Copy Files That Could Not Be Located

ACC Copy Files	No of Claims	Percentage of Claims
Copy files located in the ACC archives	18	30%
Copy files not located in the ACC archives	42	70%
Total number of claims	60	100%

6.8 Claims Not Reported to the HDC

I am unable to provide specific data on the number of files that were reported to the professional bodies due to the large number of the ACC copy files that could not be located and, the fact that I could not get consent from the Medical Council to obtain the data directly from them.

The HDC was able to trace the outcome of their investigations on claims in the data set. Of the sixty claims, I found that eleven had not been appropriately reported to the HDC (see Figure 19). A further seven had not been reported to the HDC because their date of injury was pre 1 July 1996. The remaining forty-two claims had been reported to the HDC. It is noted, however, that other interested parties such as the claimant, family or professional body had raised complaints in

relation to some of these claims, so the ACC was not the first to report the complaint in all of these cases.

Figure 19 - Medical Error Findings Reported to the HDC

Result	Number of Claims	Percentage of Claims
Reported to the HDC	42	70%
Not reported to the HDC (and should have been)	11	18.3%
Not reported to the HDC (but appropriate as pre 1 July 1996)	7	11.7%
Total number of claims	60	100%

6.9 Conclusion

This chapter has outlined my findings. Claims were categorised into four types of injury prevention outcomes. Of the sixty cases analysed, I found that in twenty-two cases the outcome of reporting in terms of whether or not an injury prevention initiative had taken place was “unknown”. Twenty cases were classified as having an “ambiguous outcome”. In eleven cases there was clear evidence that an injury prevention initiative had occurred as a result of the ACC’s reporting process. In seven cases there was evidence that an injury prevention initiative had not taken place.

Eight sample cases were also examined in detail. These eight case studies highlighted a variety of outcomes:

- the ACC appeared pro-active in terms of a systems approach to injury prevention initiatives;
- the HDC appeared pro-active in undertaking injury prevention initiatives (including both person and systems approaches);
- the Medical Council appeared to be ineffective in taking injury prevention initiatives;

- the ACC had used its discretion to decide not to report a medical error where, on reflection, reporting may have been appropriate;
- there appeared to be inter-agency confusion in communications between the professional body concerned and the HDC;
- two claimants exercise their right not to pursue a complaint with the HDC which has implications in terms of providing an injury prevention outcome;
- hospitals appeared to be pro-active in undertaking injury prevention initiatives (including both person and systems approach).

Two other findings related to claims ranging across all four categories. One was the number of missing ACC copy files and the other was the number of medical error claims that were not reported to the HDC.

The next chapter presents an evaluation of the aims of the Accident Rehabilitation and Compensation Insurance Act (1992) and the process followed by the Medical Misadventure Unit. I also evaluate the four injury prevention categories, issues raised in the case studies, and the findings across the categories.

Chapter Seven – Discussion

7.1 Introduction

As outlined in Chapter One, the focus of this research was to investigate and evaluate the reporting process with regard to medical error as under the Accident Rehabilitation and Compensation Insurance Act (1992) and the impact of that process with regard to the prevention of injury. My research has involved a search and review of medical files from a random sample of sixty claims. These were claims made between 1992 and 2001, and which were accepted on the basis of medical error since the inception of the Accident Rehabilitation and Compensation Insurance Act (1992).

This chapter begins with an evaluation of the Accident Rehabilitation and Compensation Insurance Act (1992) in terms of injury prevention. The findings outlined in Chapter Six are then discussed in order to evaluate the reporting process as under the Accident Rehabilitation and Compensation Insurance Act (1992) and the impact of that process with regard to the prevention of injury. The evaluation is based on the findings relating to the four categories of injury prevention, eight case studies, and two issues that range across all four categories. The two issues are the number of missing ACC copy files and the high number of medical error findings that the ACC did not report to the HDC. In addition, the evaluation approach as described by Spicker (1995) involving the following four steps is considered in this chapter:

- identification of the aims;
- operationalisation of these criteria (the identification of goals);
- identification of results or effects;
- comparison of results or effects with aims and goals.

7.2 Legislative Intent

The extent to which the ACC's reporting process is successful in providing injury prevention outcomes may depend upon the emphasis which the legislation places

on the reporting of medical error for that purpose. As discussed in Chapter Three, the Accident Rehabilitation and Compensation Insurance Act (1992) required the ACC, if it was satisfied there may have been negligence or inappropriate action, to “report the circumstances to the appropriate body with a view to the institution of disciplinary proceedings, and to any other body that may be appropriate”.

Under the Act there was, in fact, no explicit purpose that the reporting mechanism should result in injury prevention initiatives. The focus was very much on the accountability and disciplining of registered health professionals.

The stated intention of the medical error reporting process was for accountability and discipline (Birch 1991). The prescriptive criteria for medical misadventure was to reduce the number of claims for the purpose of fiscal responsibility (Collins 1995). The goals of accountability and discipline are in line with the neo-liberal philosophy where the rights of the individual are seen as paramount. A goal of the reduction of the number of claims is also consistent with the neo-liberal goal of limited state involvement in the market. Under this approach the responsibility for services shifts from the government to the individual. Goals of limited state involvement are inconsistent with the social democratic values of a community responsibility that sees government having a role in assisting those who sustain injury through medical misadventure.

Accountability, especially in the form of discipline, does not fit neatly into a no-fault scheme which is designed to remove the requirement to determine fault. Accountability mechanisms for health professionals is one of the key arguments in favour of a tort system of compensation, as discussed in Chapter Four. Under a tort system injury prevention is left to the market. For example, the possibility of being sued is thought to constrain poor performance and the added possibility of economic burden helps to reinforce good medical practice. The assumption is that under market conditions registered health professionals who have a poor record of medical errors will not be able to attract consumers in the market. This approach assumes that the consumer has full knowledge of the product or service they are purchasing, and has a choice over which registered health professional. However, when purchasing health services, consumer knowledge and choice may be limited. For example, the consumer may not be privy to the information about

the health professional's poor record or may not be in a position to choose a provider⁶. Although it is argued that a tort system can provide incentives to reduce medical error others argue that tort has little effect on injury prevention (Runciman et al. 2001). A tort system is criticised for two main reasons: first in creating a climate where the medical error may be hidden for fear of retribution to the registered health professional and second that the threat of court action may not be sufficient to reduce medical errors. Therefore it is arguable that the focus on disciplinary action under the Accident Rehabilitation and Compensation Insurance Act (1992) is contradictory to injury prevention goals.

7.2.1 Rationale for Injury Prevention Goal

Cull (2001) raised the question as to whether an organisation such as the ACC, which is responsible for providing entitlements, should be involved in injury prevention initiatives at all. However, Vincent et al. (1993, p. 163) suggest that many people lodge claims and institute legal proceedings because they want an explanation, an acknowledgment that something has gone wrong, and an assurance that some action will be taken to prevent others suffering in the same way. Further, the international literature demonstrates that medical error comes at a high cost to society (Kohn et al. 2000; Davis et al, 2001). To many it would seem morally wrong if the ACC had access to information on medical error that could be used for injury prevention purposes but did not act on it. Clearly, with the focus on injury prevention under the Injury Prevention, Rehabilitation, and Compensation Act (2001), there appears to be the political will that injury prevention should occur.

Some other no-fault schemes, such as those in Sweden, Norway and Denmark, are based on the assumption that the compensation system should be completely separate from the disciplinary system so that there is no disincentive for health providers to lodge claims on behalf of their patients (ACC 2000d). The importance of providing a safe environment for providers to lodge claims is seen as paramount.

⁶ In the public system patients are usually not offered a choice of provider.

7.2.2. Mandatory Reporting of Medical Error

The requirement to report medical misadventure attributable to ‘negligence or inappropriate action’ for the purposes of disciplinary action, rather than for medical error claims per se, arguably gave the ACC the discretion not to report in ‘all’ cases that were accepted on the basis of medical error under the Accident Rehabilitation and Compensation Insurance Act (1992). Although the Accident Rehabilitation and Compensation Insurance Act (1992) did not state explicitly that all claims accepted on the basis of medical error must be reported to an appropriate body with a view to the institution of disciplinary proceedings, this was arguably implicit in the Act as a finding of medical error infers that ‘negligence or inappropriate action’ has occurred. In comparison, medical mishap claims have arisen from treatment ‘properly given’ which implies that, by definition, medical mishap claims are not based on negligence or inappropriate action (Accident Rehabilitation and Compensation Insurance Act 1992). In my view mandatory reporting of ‘all’ medical error claims may provide better injury prevention outcomes.

The discretion not to report medical error for disciplinary purposes is illustrated in one case outlined in the previous chapter where there was a deliberate decision not to report the medical error to the professional body (see case study Five). This case has highlighted that decisions of this nature may be subjective, and that a mandatory requirement that every claim accepted on the basis of medical error be reported to the HDC may be more appropriate.

In addition to reporting to an ‘appropriate body with a view to the institution of disciplinary proceedings’ the Act also provides for the reporting of negligence or inappropriate action to ‘any other body that may be appropriate’ (Accident Rehabilitation and Compensation Insurance Act 1992). Although not stated specifically, this provision arguably allows the ACC to report medical error for purposes other than disciplinary action, such as injury prevention. Therefore the ACC could, if it chose, report to organisations such as hospitals asking them to make changes to their protocols or to teaching colleges. These organisations could use the information to alert trainees to the dangers and pitfalls in the

provision of certain treatments. The Injury Prevention, Rehabilitation, and Compensation Act (2001) does provide express reference to reporting for the purpose of injury prevention, and this may help to ensure that more medical error claims are reported to the appropriate body such as the HDC.

7.2.3 Reporting General Trends

The literature in Chapter Four outlined how the data held by no-fault schemes could be analysed and used for injury prevention purposes. Such data could then be used to provide a basis for encouraging changes in medical practice or for referring a provider for disciplinary action. The Accident Rehabilitation and Compensation Insurance Act (1992) does not specifically allow for reporting of general trends in relation to medical errors (or medical mishaps). However, under the Injury Prevention, Rehabilitation, and Compensation Act (2001) there is provision for reporting series and trends of incidences of medical error (and medical mishap) to the HDC and the relevant professional body, to the Director General of Health, or if appropriate, to the employer of a registered health professional.

7.2.4. Person and Systems Error

The Accident Compensation and Insurance Act (1992) has a focus on the person approach as described by Reason (2000). While it is important that active failures, mistakes of a person who is in direct contact with a patient, are recognised and addressed, this should not be at the expense of the systems approach to viewing medical error. Both are important.

The argument that many errors are not thought to be as a result of an individual's actions but rather as being systemic (Reason 2000) is borne out in a number of the sample claims where errors could not be attributed to an individual registered health professional's actions. However, in these cases the ACC had made a generalised finding of medical error. There had, for example, been a failure to diagnose a postoperative complication. As there had been a number of registered health professionals treating the patient, it was found that one registered health

professional could not be held responsible. The problem seemed more than likely to lie in the system, for example, with hospital protocols that did not require a mandatory check for that particular complication.

In order to provide the potential for maximum injury prevention potential, the legislation ideally should seek to understand ‘latent’ or systems issues. Although the Injury Prevention, Rehabilitation, and Compensation Act (2001) has introduced provision’s to attribute medical error to an organisation, there are limitations placed on the circumstances when this can happen. Given it is possible to attribute medical error to an organisation only if a registered health professional cannot ‘readily’ be identified (Injury Prevention, Rehabilitation, and Compensation Act 2001) it may be that fewer claims are investigated on the systems issue and therefore less emphasis is placed on the organisational aspect of injury prevention. This may mean that latent errors are not fully understood. A change in legislation to ensure full consideration systems errors would enhance the ACC’s potential to reduce the reoccurrence of medical error.

7.2.5. Fault Versus Avoidability Criteria

The ACC legislation has been criticised for its focus on finding fault with a registered health professional, because it endorses the ‘blame’ culture that is said to provide a disincentive for providers to lodge claims (Coates & McKenzie 2002). In such cases the opportunity to take injury prevention initiatives is reduced. Following the lead of the Swedish scheme, which uses terminology focussing on avoidability, may encourage increased claims and thereby increase the potential for preventing injury. A change to the ACC’s legislation may therefore be warranted in order to encourage maximum injury prevention potential.

7.3 Research Results

As outlined in Chapter Six the sixty sample claims were categorised into four outcomes which included “unknown”, “ambiguous”, “injury prevention” and “no injury prevention”. Eight case samples were also analysed in detail. In the

following sections each category is discussed in turn, along with the case studies, and consideration is given to the implications of my findings. The chapter concludes with a general discussion on missing ACC copy files and the medical error claims that were not reported to the HDC.

7.3.1 Outcome Unknown

The fact that twenty-two of the sample of sixty claims were categorised as having an “unknown outcome” demonstrates that the ACC’s medical error reporting process is not transparent. The key similarities across this category were:

- the ACC copy file did not show the medical error to have been reported to the professional body (or that the professional body had corresponded with the ACC in respect of the outcome of their investigation);
- there was no access to information that was with the professional body;
- the outcome was a confidential agreement reached by the registered health professional and the claimant.

One key reason for the difficulty in accessing information was the inability to obtain information from professional bodies under the Official Information Act (1982) as a non-government agency they are not subject to the official information regime.

Another issue involving both the ACC and the professional body was the apparent lack of coherence between agencies. When the ACC reported a medical error to the professional body the ACC asked that the body advise the ACC on the outcome of their investigations. However, the ACC copy files usually did not reflect compliance with this request. There was either a failure by the professional body in not advising the ACC or a failure by the ACC in not correctly filing the information.

In the case of a confidential settlement between the registered health professional and the claimant, the outcome was also kept confidential. The difficulty created by this could be overcome by ensuring a mechanism was in place so that when a confidential settlement is reached that there is provision to allow for injury prevention initiatives, and that such details are transparent.

7.3.2 Ambiguous Outcome

The second highest category of claims, “ambiguous outcome” (twenty claims), clearly demonstrated that there are a high number of injury prevention initiatives taking place without the ACC’s involvement in the medical error reporting process.

Hospitals were responsible for a high number of initiatives. This is illustrated by one case where hospital staff had written back to the ACC advising that ‘the matter was brought to the attention of all the medical staff, together with those of the specialty ward last year soon after the incident took place, and well in advance of MMC (sic Medical Misadventure Advisory Committee) deliberations’. This result appears ideal, as the hospital, through its own responsible reflection, is capable of initiating change in a much shorter time frame than the ACC and HDC (due to the more lengthy investigations conducted by the ACC and the HDC).

In another case, a complaint had already been lodged with the HDC before the ACC reported the medical error finding to the HDC. Again, rather than await the more lengthy investigation by the ACC before the HDC began its investigation, injury prevention initiatives were undertaken by the HDC in a more timely manner independent of the ACC’s involvement.

The pro-active action undertaken by the registered health professional, medical centre or hospital (or HDC as a result of a complaint from another interested party) is seen as a positive result. However, the research also demonstrated that injury prevention initiatives by other parties are not taken in all cases. This finding gives weight to the argument that the ACC does have a role in attempting to reduce the reoccurrence of medical error.

There was also an example of an injury prevention an injury prevention initiative taken outside the ACC and Health system. One claim in the “ambiguous outcome” category involved the HDC writing to the claimant and asking the them for permission to report the adverse drug reaction to the drug manufacturer. This was categorised as an injury prevention initiative taken by the HDC. It is

important to recognise that this was also an injury prevention initiative on the part of the drug manufacturers, in that they presumably wrote to the HDC initially to request that this process occur when a complaint is lodged in relation to a drug reaction. This was seen as a positive outcome.

7.3.3 Injury Prevention Outcome

This category of claims demonstrated that injury prevention initiatives have occurred solely as a result of the ACC's reporting process. This is seen as a positive outcome particularly given that the legislation was not designed with the aim of injury prevention. Although the aim of the medical error reporting process under the Accident Rehabilitation and Compensation Insurance Act (1992) was not for the explicit purpose of reducing error, the sample cases have shown that the ACC appears to have adopted a moral obligation to prevent injury. Another positive in the ACC's reporting process is the role of the HDC. The research has highlighted the HDC's pro-active role in undertaking injury prevention initiatives, where ACC had advised them of a medical error finding. The injury prevention outcomes in this category can be attributed to ACC's reporting process and this implies that the ACC scheme does have a role to play in the prevention of injury.

Injury prevention initiatives were sometimes aimed at the registered health professional, for example, letters had been written to the registered health professional advising them to read the Code of Health and Disability Services Consumers' Rights. At other times injury prevention initiatives were aimed at the hospital concerned where, for example, they were advised to change their protocols. Still other initiatives were aimed more generally at the medical professional generally. For example, by placing an article on the HDC website. Such an initiative has the potential to address both person and systems errors depending on who takes the opportunity to access and use the information provided.

The injury prevention outcomes were generally positive in terms of the ability to adopt Reason's (2000) systems approach despite the fact that the 1992 Act does

not address systems errors. Many of the injury prevention initiatives were aimed at systems issues such as changing the hospital protocols, rather than simply focussing on the individual. The implication is the legislation should be changed to reflect a systems approach as it is possible that the ACC's reporting process could be even more effective in addressing systems errors if this were the case.

7.3.4 No Injury Prevention Outcome

There were a large number of claims in this category where, the ACC did not report the medical error, but there was no evidence that the ACC had made a deliberate decision not to report. On the evidence available to me, it appeared that a high number of claims were simply not reported because of lax administration. The implication is that although the subsequent Injury Prevention, Rehabilitation, and Compensation Act (2001) now has a focus on injury prevention, simple administrative changes may also go towards improving outcomes in terms of injury prevention. Other claims in this category demonstrated that professional bodies did not take injury prevention initiatives. Further research in this area is required to determine the extent to which professional bodies respond the prevention of error.

My research demonstrates that although there are processes in place to institute injury prevention initiatives, such initiatives do not occur in all cases. However, if (as stated to be the case in the literature) medical errors are preventable by nature, then an injury prevention initiative should occur in every case that the ACC accepts on the basis of medical error.

7.3.5 Analysis of Eight Case Studies

The case studies provided further insight into issues relating to the reporting of medical error. Some are related to the specific categories to which they have been assigned, highlighting previous issues raised, and some relate to entirely new issues.

Case Study One – Injury Prevention Outcome

This claim was for failure to diagnose a medical condition leading to exacerbation of the claimant's condition and ultimately the patient's death. The medical error was considered to be the collective responsibility of a large number of registered health professionals involved in the claimant's care. The ACC did not consider it appropriate to attribute the medical error to a particular registered health professional, but instead accepted it as a generalised finding of medical error. The ACC wrote to the General Manager of the hospital concerned recommending that if it had not been done already, the issue should be brought to the attention of all relevant staff so that they were aware of the fatal outcome for the patient. The ACC also recommended that appropriate protocols be put in place so as to minimise the risk of this sort of event occurring in the future.

This claim illustrates what Reason (2000) describes in his "systems" approach that concentrates on the conditions under which an individual works and tries to develop strategies to reduce or prevent medical error in the entire organisation. The ACC's pro-active action to address a systemic issue can be seen as a positive aspect of the ACC's medical error reporting process, and illustrates that the ACC's reporting process can be effective in terms of the systems approach to medical error.

Case Study Two – Injury Prevention Outcome

This claim was for scarring following wart removal treatment. The ACC reported the medical error to the HDC. The recommendations made by the Health and Disability Commissioner were far-reaching in that they addressed both person and system issues. The recommendations with regard to the individual registered health professional concerned the requirement to undertake to update himself on appropriate treatment for wart removal and to ensure that his practice was consistent with current medical practice. Recommendations that were more systematic in nature included conducting a review of all treatment that had been delegated to nursing staff and reporting the results of the review to the Commissioner.

The Commissioner also recommended that an article on the case be published in the appropriate periodical. In terms of injury prevention, such an initiative would not only address the medical practice concerned but also other general practices more widely.

The HDC pro-active action to address both individual and systematic errors can be seen as a positive aspect of the ACC's medical error reporting process. A strong point was that the registered health professional was required to report the findings back to the HDC, helping to ensure that injury prevention initiatives were taken.

Case Study Three – Injury Prevention Outcome

This claim was for failure to recognise and treat an injury occurring at the time of childbirth resulting in an exacerbation of the injury. The medical error was reported to the HDC. The case was unusual in that the registered health professional concerned had subsequently left New Zealand. One of the Health and Disability Commissioner's recommendations was for a complaints assessment committee to set up if the registered health professional returned to New Zealand. The Commissioner also took the precaution of recommending that the overseas medical board be advised of the complaint.

This claim illustrates that it is beneficial for injury prevention initiatives to be considered in a global context when registered health professionals immigrate. Action taken by the HDC to advise an overseas medical board of the complaint can be clearly seen as a positive aspect of the ACC's reporting process in dealing with the issue.

Case Study Four - No Injury Prevention Outcome

The claim was for exacerbation of cancer caused by the failure to excise a well documented carcinomas lesion which was later confirmed to be carcinoma.

The ACC reported the medical error to the professional body as the claim had a date of injury prior to 1 July 1996. Although the professional body reported that they had made a finding of professional misconduct an injury prevention initiative did not occur. On reflection, however, it appears to be a case where an injury prevention initiative may have been appropriate. The implication is that when deliberating on disciplinary action, the professional body needs to give due to consideration to how they could prevent the error from reoccurring.

Case Study Five - No Injury Prevention Outcome

The claim was for complications following a sebaceous cyst excision which was considered to be due to a failure of the registered health professional to observe a standard of care that was reasonable in the circumstances. The claim was accepted on the basis that the Supervising Registrar should have overseen the medical student's suturing of the wound, as the treatment was given by a fifth year medical student. The medical error was said to be a generalised finding of medical error.

As the injury occurred before 1 July 1996 it was not appropriate to refer the medical error finding to the HDC because it was beyond the HDC's jurisdiction to investigate the claim. However, the ACC made a decision not to report the claim to the relevant professional body or to the hospital concerned.

It certainly appears that the events which surrounded this claim could have lent themselves to injury prevention initiatives such as a change in hospital protocol or a staff training programme. It could be that with deciding not to report the claim there is possibly a hint of patch protection. The non-reporting of the claim possibly favoured the Senior Registrar. This claim has demonstrated that decisions around whether or not to report a medical error to another body can be subjective. Mandatory reporting of medical error, as required under the subsequent Injury Prevention, Rehabilitation, and Compensation Act (2001), should resolve this issue.

Case Study Six – No Injury Prevention Outcome

The claim was accepted on the basis of facial palsy and deafness due to an inappropriate operating technique used by a visiting surgeon. This claim came to the fore as a no-injury prevention outcome because of what appeared to be inter-agency confusion. The professional body advised the ACC that it had referred the claim to the HDC. However, five years later the HDC had no record of ever having received the claim. This demonstrates a failure in inter-agency communication between the relevant organisations. Such a failure could be easily remedied, for example, if each agency provided a summary of claims received at the end of each quarter.

Case Study Seven – Unknown Outcome

The claim was for complications following an overdose of medication. The claim came to the fore because it raised the issue of individual choice not to pursue a complaint against a registered health professional. The option of personal choice is consistent with neo-liberal philosophy which promotes individual choice. This is in contrast to the social democratic philosophy which states that governments have a responsibility to provide services to the community.

Case Study Eight – Ambiguous Outcome

The claim was for an intravenous caffeine burn to the dorsum of the hand and wrist. The medical error was attributed to two staff nurses. The claim came to the fore because of the hospital's pro-active initiatives. It was, however, another example of a claim where the issue of consumer choice not to have a claim investigated was raised. Nevertheless, a good outcome resulted because of the hospital's initiatives.

7.3.6 Number of Missing ACC Copy Files

As outlined in Chapter Five, when the Medical Misadventure Unit accepts a claim on the basis of medical error, letters are written to the professional body, the HDC

and to the hospital, as the Unit considers appropriate. The original file is then referred to the local ACC branch for determination as to whether or not the claimant is entitled to any payments, such as medical treatment costs, weekly compensation, an independence allowance, home-help and attendant care. A copy of the claimant's file is retained in the Medical Misadventure Unit for the purposes of future communications with the appropriate body regarding disciplinary action. I found that although this was the process, practice varied from policy. A key difficulty relating to accessibility of information was the high number of the ACC copy files that could not be located. Some information was able to be located on Pathway, the electronic file, and in some cases, the original file was located at the local branch.

I did an ordered search to see if there was a particular period during which the reporting had not occurred, but found that there was no pattern. The non-reporting appeared to be consistent over time and there was no indication that reporting had improved or worsened over time.

The recommendation is that ACC needs to improve its recording and management systems and in particular develop a more robust system of archiving in order to improve its performance in terms of the reduction of injury.

7.3.7 Number of Files Not Reported

My research illustrated that a high number of claims were not reported to the HDC. In all but one case, it is unclear why reporting did not occur. The one case was discussed earlier in this chapter (see case summary Five). Given that there were also a high number of claims which, for no apparent reason, were not reported to the HDC, it may well be that the requirement of mandatory reporting of every medical error claim may help to reduce administration error. In a process where it was mandatory to report *all* medical error claims, it may be that accidental failures to report the error would be less likely to occur.

7.4 Conclusion

The chapter began with an evaluation of the Accident Rehabilitation and Compensation Insurance Act (1992) in terms of injury prevention. The Act did not specify any injury prevention aim but instead focussed on providing disciplinary processes, the accountability of health professionals and measures to reduce the number of claims, which may be at odds with a focus on injury prevention. The goal of accountability and disciplinary action with regard to health professionals can be seen in the requirement to report medical error for the purposes of ‘disciplinary action’ and in the provision for the ACC to collect premiums from registered health professionals based on ‘experience-rating’. The measure to reduce the number of claims, and therefore less cost to the government, was a negative goal, evidenced by more prescriptive criteria where less claims were eligible for ACC cover compared to previous provisions under the Accident Compensation Act (1982). The goals of accountability and cost reduction are consistent with the neo-liberal approach, and which appear to be in contrast with injury prevention initiatives.

The ACC’s Accident Rehabilitation and Compensation Insurance Act (1992) would be enhanced if:

- there was a requirement for mandatory reporting of medical error;
- there was provision for reporting general trends;
- there was provision for a balanced investigation in terms to both a person and system approach to medical error;
- the fault criteria was removed and replaced by avoidability criteria akin to the Swedish scheme.

The findings outlined in Chapter Six were evaluated in terms of ACC’s reporting process and the impact of that process with regard to the prevention of injury. This forms the basis for identification of results or effects according to Spicker’s (1995) evaluation approach. In evaluating the twenty-two claims that fell into the “unknown outcome” category of claims it became apparent that the ACC’s reporting process is not transparent. The lack of transparency was in part due to

the difficulty in accessing information from the professional body under the Official Information Act (1982) and because of lack of inter-agency communication with the professional body. Other difficulties were the number of copy files that could not be located and the number of files that were not reported.

In evaluating the category of claims falling into “ambiguous outcome”, the second largest category with twenty claims, there was evidence that injury prevention initiatives can take place without the ACC’s involvement in the reporting process. The registered health professional, hospital, clinic, organisation and HDC all contributed to this result. While this was seen as a good result, it also highlighted the fact that injury prevention initiatives are not taken in every case, thus, supporting and promoting the ACC’s role in the reporting process where injury prevention initiatives have not already been undertaken.

In the injury prevention category there were eleven claims. The claims in this category demonstrated that the ACC had, at times, acted on a moral obligation to report the findings to hospitals for the purposes of injury prevention initiatives. Another positive outcome in terms of the reporting process was that of the HDC’s pro-active injury prevention initiatives. There was also evidence that both the HDC and the ACC took a systems based approach to injury prevention

The smallest category of claims, seven, was that of no injury prevention initiative. A number of the claims that fell into this category had a date of injury prior to 1 July 1996, and as such were only reported to the professional body. The lack of injury prevention initiatives taken by professional bodies was highlighted. Other claims in this category demonstrated a seemingly lax ACC administration system, where medical error claims were located but the error finding had not been reported and there was no detail on why this should be the case.

The eight case studies highlighted previous findings and raised other issues in relation to the ACC’s reporting process. The ACC and the HDC’s pro-active action in terms of injury prevention initiatives based upon both the person and systems approach to injury prevention were noted. One case highlighted what

injury prevention initiatives could be taken when a registered health professional immigrates. In this case, recommendations from the HDC included advising an overseas medical board for their information. This seemed an appropriate response. The professional body was shown not to have taken any injury prevention initiatives and the ACC's deliberate decision not to report one medical error appeared to be subjective. Other cases highlighted difficulties where claimants did not want their complaints investigated. While another case, demonstrated inter-agency confusion in that a file that a professional body reported to the HDC was not received by them although five years had elapsed. One final issue raised was the number of ACC's copy files that could not be located. I concluded that the ACC needs to have a better system of recording reported medical error claims. And a further related issue was the number of ACC claims that were not reported (as noted in the discussion on no injury prevention initiative taken). In all but one case, it was unclear why this reporting had not occurred. It is possible that the reason was lax administration. If this is the case, then it is recommended that the ACC take appropriate steps to ensure that such cases are reported in the future.

Spicker's evaluation approach includes the provision of a comparison of aims and goals, and results and effects. Surprisingly, despite the fact that the legislative intent was not one of injury prevention, my research has found that there was a number of injury prevention initiatives that did occur as a result of the ACC's reporting process. The number of claims falling into the ambiguous outcome demonstrated that although injury prevention initiatives occur without the ACC's involvement in the reporting process, this does not occur in all cases. It is therefore appropriate that the ACC be involved in taking injury prevention initiatives to reduce the incidence of medical error. A key negative was the number of claims for which an outcome was "unknown" and was largely due to my not being able to get sufficient information from professional bodies, and the fact that many of the ACC copy files could not be located.

My research has highlighted several gaps in the ACC's reporting of medical error. Further research focussing on the injury prevention initiatives taken by professional bodies would be useful and while, my research does not attempt to

quantify the actual outcome of the ACC's reporting of medical error, this would be an interesting area for further research.

Chapter Eight – Conclusion

8.1 The Research Process

The purpose of this research was to evaluate the medical error reporting process under the Accident Rehabilitation and Compensation Insurance Act (1992). This study began with an introductory chapter on the research aims and objectives, the philosophical basis of research and an overview of the thesis.

Chapter Two outlined the policy context, in which the ACC scheme evolved. This included a discussion on the international policy context, which highlighted the shift from social democracy policies to those informed by neo-liberal theory. Models of social policy in New Zealand and how the shifts in international policy impacted on New Zealand policy were then discussed. The impact of this policy shift in relation to both the Health and the ACC scheme reforms was then considered.

Chapter Three began with an exploration of the policy environment and outlined the ACC legislation as it relates to medical misadventure (and medical error) and the agencies impacted by the legislation. It concluded with a discussion on public inquiries, including the Cull Report, that have informed and continue to inform Health and ACC legislation.

In Chapter Four I reviewed the literature on medical error and adverse events. The chapter was divided into three sections: section one outlined the empirical research on the frequency of medical error; section two described the conceptual approaches to medical error; section three compared and contrasted the tort and no-fault systems in terms of injury prevention.

The design and methodological approach for my research was outlined in Chapter Five and included a discussion on process of data collection, analysis, and

determination of key findings. The research was based upon document research and case studies of sixty claims randomly selected from a total of approximately eight hundred and forty claims accepted on the basis of medical error under the Accident Rehabilitation and Compensation Insurance Act (1992). The evaluation is formative in that it does not seek to generalise beyond the context of the ACC scheme. As the number of files in the sample is small, the research is exploratory in nature.

The outcome of the findings of the ACC's reporting process were outlined in Chapter Six. Chapter Seven began with an evaluation of the Accident Rehabilitation and Compensation Insurance Act (1992) in terms of injury prevention based on the literature outlined in Chapters One to Four. The findings outlined in Chapter Six, and literature on medical error and no-fault schemes, was then discussed in order to evaluate the reporting process under the Accident Rehabilitation and Compensation Insurance Act (1992) and the impact of that process with regard to the prevention of injury.

8.2 Key Findings and Recommendations

A summary of the key findings and recommendations of the research is provided in the following sections.

8.2.1 Finding 1 – The Aims and Goals of the Accident Rehabilitation and Compensation Insurance Act (1992)

My research has found that the Accident Rehabilitation and Compensation Insurance Act (1992) had a negative aim of reducing the number of claims eligible for compensation with the goal of reducing government spending consistent with the neo-liberal goal of limited state involvement in the market. This is in contrast to the social democratic goal that sees government as having a greater role in the market and would therefore expect more claims. The emphasis on the reduction of government spending is also in contrast to the literature on injury prevention that highlights the need to encourage the reporting of medical error claims, so that the information that has been reported can be used

constructively, to prevent the reoccurrence of medical error (Coates & McKenzie 2002).

The research also found positive aims of the Accident Rehabilitation and Compensation Insurance Act (1992), accountability and disciplinary action, also consistent with neo-liberal philosophy. The goal of accountability and disciplinary action was to make registered health professionals more accountable for their actions through disciplinary measures. These aims and goals appear to be in contrast to the literature on injury prevention that highlights the need to remove any adversity, thus encouraging the lodgment of medical error claims, and professional reflection to improve practice (Coates & McKenzie 2002).

8.2.2 Finding 2 – Processes and Outcomes of the ACC’s Reporting Process in Terms of Injury Prevention

The findings relate to the four injury prevention outcome categories, eight case studies and two issues: the relatively high number of missing ACC copy files and the relatively high number of medical error findings that the ACC did not report to the HDC.

8.2.2.1 Unknown Outcome

The finding that there was an unknown outcome in 36.7 percent of cases in the sample indicated that the medical error reporting process was not transparent. This was a disappointing result. Recommendations detailed below in relation to legislative change and the need for a more transparent process should help to minimise the risk of claims falling into this category in future.

8.2.2.2 Ambiguous Outcome

Claims categorised into ambiguous outcome in 33.3 percent of cases were seen as having a positive outcome in they demonstrated that registered health professionals, hospitals and other agencies are taking injury prevention initiatives without the ACC’s involvement in the medical error reporting process. However,

at the same time, the research also demonstrates that the ACC does have a role to play in injury prevention given the fact that injury prevention initiatives were not taken by external agencies in every case.

8.2.2.3 Injury Prevention Outcome

Injury prevention initiatives were found to have been taken in 18.3 percent of cases in the sample. While this number may appear comparatively low it reflects a positive response overall given the fact that injury prevention initiatives occurred despite their being no legislative intent under the Accident Rehabilitation and Compensation Insurance Act (2001) for reporting to occur for the purpose of injury prevention. A positive outcome in this category was ACC's pro-active decision to report medical error for the purposes of injury prevention. The HDC's injury prevention initiatives and excellent record keeping was also a positive outcome of ACC's reporting process.

8.2.2.4 No Injury Prevention Outcome

In 11.7 percent of cases in the sample there was evidence that no injury prevention outcome occurred as a result of the ACC's medical error reporting process. Current ACC legislation has an overriding goal of minimising the overall incidence of injury in the community. This is reflected in the mandatory legislative requirement that all medical error claims are reported to the relevant professional body and the HDC. In my opinion, the ACC needs a more transparent reporting process to give effect to this goal and ensure that medical errors are reported. This category of claims also demonstrated that the disciplinary bodies appeared not to undertake injury prevention initiatives. Further research is required into the extent to which professional bodies undertake injury prevention initiatives.

8.2.2.5 Eight Case Studies

The eight case studies illustrated a variety of injury prevention outcomes including:

- the ACC's use of a systems approach to report on medical error;
- the HDC use of a systems approach when considering what injury prevention initiatives should be taken;
- the lack of injury prevention initiatives taken by a professional body;
- a hospital's use of a systems approach to prevent the error from reoccurring;
- the ACC is exercising its discretion of not to report a medical error claim, although it appeared appropriate that the claim be reported;
- inter-agency confusion, where a file that a professional body reported to the HDC never reached its intended destination;
- the claimant/consumer exercising the right not to pursue a claim/complaint with the ACC/HDC and the implications for injury prevention;
- the injury prevention initiatives taken to address circumstances where health professionals immigrate.

8.2.2.6 Missing ACC Copy Files

The issue of missing ACC copy files has implications across all four categories of claims considered, with seventy percent of the claims in the sample unable to be located. The ACC needs to ensure it adopts a better system to ensure information on its reporting processes are transparent.

8.2.2.7 Number of Claims Not Reported to the HDC

The issue of the number of ACC claims known not to have been reported to the HDC (at least 18.3 percent of cases) has implications across all four categories of claims considered. Although seventy percent of the claims in the sample were found to have been reported to the HDC, the ACC cannot take the credit for the reporting of all such claims, as some were reported by other interested parties such as the claimant's themselves or professional bodies. The ACC needs to have a better system to ensure all medical error claims are reported appropriately.

8.2.3 Finding 3 - Reflecting on Theoretical Material

8.2.3.1 Systems Error

The literature on medical error showed that both a person and systems approach are necessary to maximise injury prevention outcomes (Reason 2000). Despite the fact that there was no legislative intent to report for the aim of injury prevention, there was clear evidence that a number injury prevention initiatives were addressed at both the person and system levels. This result was seen as positive, however legislative amendments to recognise the systems approach to improving the incidence of systemic issues may improve injury prevention outcomes.

The systems approach is consistent with the social democratic goal of community responsibility and belief that the government has a positive role in helping to ensure the cost of medical injury to society is minimised.

8.2.3.2 Fault Versus Avoidability Criteria

The literature on no-fault schemes suggested that a no-fault scheme based on avoidability criteria, similar to the Swedish no-fault scheme, may be more conducive to injury prevention outcomes (Coates & McKenzie 2002). Such a criteria is promoted for its ability to encourage an open atmosphere for reporting which is said to encourage health professionals to lodge claims on behalf of their patients. The more claims that are lodged the greater the potential for injury prevention initiatives to occur.

The literature has illustrated that the number of injuries that arise from medical treatment in New Zealand public hospitals is relatively high (Davis et al. 2001). If Coates & McKenzie (2002) are correct in their assertion that the ACC scheme's current legislative requirement to prove fault creates a disincentive to lodge claims, a change in legislation to avoidability criteria may encourage more claims. Such criteria is consistent with the social democratic approach that sees government with a role to play in assisting people with the cost of health services.

8.3 Recommendations

In considering the outcomes of the ACC's medical error reporting process and the literature on medical error, I make the following recommendations on how the ACC's medical error reporting process might be improved in order to maximise injury prevention.

I recommend that in future the ACC implement a more transparent reporting process for the reporting of medical error claims. Ideally this would include a regular audit to check that files have been reported to the HDC and professional bodies, and that any subsequent information received from the HDC or professional bodies is appropriately filed.

Inter-agency communication could be improved by, for example, quarterly audits to ensure the receiving agency has received the claim. A requirement that professional bodies report to the government on their injury prevention initiatives may also assist in providing a more transparent process.

The Accident Insurance Act (1998) repealed the Accident Rehabilitation and Compensation Insurance Act (1992) and removed the reporting mechanism. However, the Accident Insurance Act (1998) has been repealed by the Injury Prevention, Rehabilitation, and Compensation Act (2001) which has an overriding goal of 'minimising the overall incidence of injury in the community through establishing as a primary function for the ACC scheme, the promotion of measures to reduce the incidence and severity of personal injury' I support this goal and other changes made in respect of the reporting of medical error (and mishap) under the Accident Rehabilitation and Compensation Insurance Act (2001) including:

- mandatory reporting of medical error claims;
- provision for the reporting of medical error (and medical mishap) trends when the public interest requires that the incident be reported.

In addition to these changes, I recommend that future ACC legislative reviews consider:

- greater recognition of the systems approach to viewing medical error (see Reason (2000); and
- criteria that focuses on avoidability criteria instead of medical error (similar to the Swedish no-fault scheme).

8.4 Further Research Opportunities

I was unable to examine initiatives taken by the professional body in terms of injury prevention due, in a large part; to the inability to gain access to information, from professional bodies. My research has highlighted the deficiency of information with regard to injury prevention initiatives taken by professional bodies in relation to the medical error reporting process in terms of injury prevention. Such information is in the public interest and therefore a reporting process needs to be developed and need to be transparent. Research into establishing whether professional bodies have undertaken injury prevention initiatives is necessary.

My research has not attempted to quantify the response rate from any of the injury prevention initiatives taken by the ACC or the HDC. It would be interesting to analyse the rate of uptake of the injury prevention initiatives suggested.

Two other issues raised, that highlight the need for more research in relation to HDC's investigations of the ACC's medical error claims, and that also have implications for the ACC and other agencies involved in the ACC's reporting process are:

- managing injury prevention initiatives when the claimant wishes to use their right not to have their complaint investigated further;
- the extent to which global injury prevention initiatives should be undertaken if a registered health professional with a poor claims history immigrates.

References

- Accident Compensation Act 1972.
- Accident Compensation Act 1982.
- Accident Compensation Amendment Act 1974.
- Accident Insurance Act 1998.
- Accident Compensation Corporation 1976, *A brief description of the accident compensation scheme operating in New Zealand*, Accident Compensation Commission, Wellington.
- Accident Compensation Corporation 1999, *Annual report*, Accident Compensation Corporation, Wellington.
- Accident Compensation Corporation 2000, *Annual report*, Accident Compensation Corporation, Wellington.
- Accident Compensation Corporation 2002a, *Annual report*, Accident Compensation Corporation, Wellington.
- Accident Compensation Corporation 2002b, *Preliminary advice to the medical misadventure steering group*, Accident Compensation Corporation, Wellington, Unpublished Report.
- Accident Compensation Corporation 2002c, *Review of medical misadventure: ACC background papers*, Accident Compensation Corporation, Wellington, Unpublished Report.
- Accident Compensation Corporation 2002d, *Scandinavian patient insurance schemes, summary: Sweden, Norway and Denmark*, Accident Compensation Corporation, Wellington, Power Point Presentation.
- Accident Rehabilitation and Compensation Insurance Act 1992.
- Ashton, T. 1999, 'The health reforms: to market and back?', in J. Boston, P. Dalziel, & S. St John (eds), *Redesigning the welfare state in New Zealand, problems, policies, prospects*, Oxford University Press, Auckland, pp. 134-153.
- Ashton, T. 1992, 'Reform of the health services: weighing up the costs and benefits', in J. Boston & P. Dalziel (eds), *The decent society? Essays in response*

- to National's economic and social policies*, Oxford University Press, Auckland, pp. 146-168.
- Bell, C. & Newby, H. 1976, *Doing sociological research*, Routledge, London.
- Birch, W. F. 1991, *Accident compensation: a fairer scheme*, Government Printer, Wellington.
- Blank, R. 1994, 'New Zealand health policy: what future?' in R. Blank, *New Zealand health policy: a comparative study*, Oxford University Press, Auckland, pp. 121-152.
- Boston, J. 1992, 'Redesigning New Zealand's welfare state', in J. Boston, & P. Dalziel (eds), *The decent society? Essays in response to National's economic and social policies*, Oxford University Press, Auckland, pp. 1-18.
- Boston, J. & Dalziel, P. (eds) 1992, *The decent society? Essays in response to National's economic and social policies*, Oxford University Press, Auckland.
- Boston, J. 1999, 'New Zealand's welfare state in transition', in J. Boston, P. Dalziel, & S. St John (eds), *Redesigning the welfare state in New Zealand, problems, policies, prospects*, Oxford University Press, Auckland, pp. 3-19.
- Boston, J. Dalziel, P. & St John, S. (eds), 1999, *Redesigning the welfare state in New Zealand, problems, policies, prospects*, Oxford University Press, Auckland.
- Bovbjerg, R.R. & Sloan, F.A. 1998, 'No-fault for medical injury: theory and evidence', *University of Cincinnati Law Review*, vol. 67, pp. 53-123.
- Bowie, R. & Shirley, I. 1994, 'Political and economic perspectives on recent health policy' in J. Spicer, A. Trlin, & J. Walton (eds), *Social dimensions of health and disease - New Zealand perspectives*, Dunmore Press, Palmerston North, pp. 298-322.
- Bunkle, P. & Coney, S. 1987, 'An 'unfortunate experiment': at National Womens' Hospital', *Metro*, June Edition.
- Burns, N. & Grove, S. 1993, *The practice of nursing research – conduct, critique and utilization*, 2nd Edition, WB Saunders, Philadelphia.
- Campbell, I. 1996, *Compensation for personal injury in New Zealand: its rise and fall*, Auckland University Press, Auckland.

- Capstick, B. Edwards, P. & Mason, D. 1991, 'Compensation for medical accidents', *British Medical Journal*, vol 302, pp. 230-2.
- Cheyne, C. O' Brien, M. & Belgrave, M. 1998, *Social policy in Aotearoa New Zealand: a critical introduction*, 2nd Edition, Oxford University Press, Auckland.
- CM Research 1996 *Claimant satisfaction survey topline results (Draft Copy)*
Accident Compensation Corporation, Wellington, Unpublished Report.
- Coates, J. & McKenzie, L. 2002, 'Attributing medical errors to 'the system': the new accident compensation legislation', *New Zealand Medical Journal*, vol. 115, p. 142.
- Collins, D. B. 1992, *Medical law in New Zealand*, Brooker and Friend Limited, Wellington.
- Collins, T.A.Q. 1995, *Evaluating the policy making process behind Section 5 of the 1992 Accident Rehabilitation and Compensation Insurance Act: "policy making in action – a case study"*, Victoria University, Wellington, Unpublished Thesis.
- Corkill, B. 2002, *Medical misadventure – development of the statutory concept, and its place in the current medico-legal environment*, Accident Compensation Corporation, Unpublished Report.
- Cull, H. 2001, *Review of processes concerning adverse medical events*, Ministry of Health, Wellington.
- Davis, P. & Ashton, T. (eds), 2001, *Health and public policy in New Zealand*, Oxford Press, Auckland.
- Davis, P. Lay-Yee, R. Brait, R. Schug, S. Scott, A. Johnson, & S. Bingley, W. 2001, *Adverse events in New Zealand public hospitals: principle findings from a national survey*, Occasional Paper, Number 3, Ministry of Health, Wellington.
- Danzon, P.M. 1994, 'The Swedish patient compensation system: lessons for the United States', *The Journal of Legal Medicine*, vol. 15, pp. 199-247.
- Duffy, A.P. Barrett, D.K. & Duggan, M.A. 2001, *Gisborne cervical screening inquiry report of the ministerial inquiry into the under-reporting of cervical smear abnormalities in the Gisborne region*, Ministry of Health, Wellington.

- Finch, J. 1986, *Research and policy: the uses of qualitative methods in social and educational research*, The Falmer Press, Sussex, Brighton.
- Fitzjohn, J. & Studdert, D. 2001, 'A compensation perspective on error prevention: is the ACC medical misadventure scheme compensating the right sort of injury?', *New Zealand Medical Journal*, vol. 114, pp. 432-4.
- Furrow, B.R. 2001, 'The problem of medical misadventures: a review of E. Haavi Morreim's holding health care accountable', *Journal of Law, Medicine and Ethics*, vol. 29, pp. 381-393.
- Gorman, D. 2000, 'The Accident Insurance Act – A desirable reform or market madness?', *New Zealand Medical Journal*, vol. 113, pp.62-63.
- Gaskins, R. 2000, 'Recalling the future of ACC', in *Victoria University of Wellington Law Review*, Centennial Issue, April Edition, pp. 215-224.
- Health & Disability Commissioner 1999, *A review of the Health & Disability Commissioner Act 1994 and code of rights for consumers of health and disability services, a resource for public consultation*, Health and Disability Commissioner, Wellington.
- Health & Disability Commissioner 2002, *Annual report*, Health and Disability Commissioner, Wellington.
- Health and Disability Commissioner Act 1994.
- Health Information Privacy Code 1994.
- Health Professionals' Competency Assurance Bill 2002.
- Human Rights Act 1993.
- Injury Prevention, Rehabilitation, and Compensation Act 2001.
- Irvine, R. 1996, 'Losing patients: health care consumers, power and sociocultural change', in C. Grbich (ed), *Health in Australia: sociological concepts and issues*, Prentice-Hall, Sydney, pp. 191-214.
- Kelsey, J.1993, *Rolling back the state: privatisation of power in Aotearoa/New Zealand*, Bridget Williams Books Limited, Wellington.
- Kohn, L.T. Corrigan, J.M & Donaldson, M.S. (eds), 2000, *To err is human building a safer health system, committee on quality of health care in America*, Institute of Medicine, National Academy Press, Washington, DC.
- Leape, L.L. Woods, D.D. Hatlie, M.J. Kizer, K.W. Schroeder, S.A. Lundberg, G.D. (Editorial) 1998, 'Promoting patient safety by preventing medical error', *Journal of the American Medical Association*, vol. 280, no.16, p. 1444.

- Marchant, H. Wearing, B. 1986, *Gender reclaimed: women in social work*, Hall and Iremonger, Sydney.
- Massey University Human Ethics Committee Handbook 2000, *Code of ethical conduction for research and teaching in humanities subjects*, Massey University, Palmerston North, Unpublished Handbook.
- McGregor Vennell, Margaret A. 1993, 'Issues for women in claims for medical misadventure', in *Claiming the law: essays by New Zealand women in celebration of the 1993 suffrage centennial*, Victoria University of Wellington Law Review, Special Issue, Monograph 6, May 1993, vol 23:2, pp. 13-40.
- Medical Council of New Zealand 2000, *Annual report*, Medical Council of New Zealand, Wellington.
- Medical Practitioners Act 1968.
- Medical Practitioners Act 1995.
- Miller, R.S. 1993, 'An analysis and critique of the 1992 changes to New Zealand's accident compensation scheme', *Maryland Law Review*, vol. 52, pp. 1070-1092.
- Minister of Health 1991, *Your health and the public health: a statement of government health policy*, Ministry of Health, Wellington.
- Minster of Health 2002, *Memorandum to the cabinet committee on education and health*, Wellington.
- Nurses Act 1977.
- Nursing Council of New Zealand 2001, *Disciplinary provision of the Nurses Act 1977*, Wellington, Handout, Unpublished.
- Official Information Act 1982.
- Ombudsmen Act 1975.
- Paterson, R. 2001, 'Medico-legal myth and reality', *New Zealand GP*, 7 February Edition, p. 10.
- Patton, M.Q. 1990, *Qualitative evaluation and research methods*, 2nd Edition, Sage, London.
- Physiotherapist Act 1949.
- Polit, D. & Hungler, B. 1993, *Essentials of nursing research – methods, appraisal, and utilization*, 3rd Edition, Lippincoat, Philadelphia
- Privacy Act 1993.

- Reason, J. 1998, 'Achieving a safe culture', *Work and Stress*, vol. 12, no. 3, pp. 293-306.
- Reason, J. 2000, 'Human error: models and management', *British Medical Journal*, vol. 320, pp. 768-770.
- Runciman, B. Merry, A., & McCall Smith, A. 2001, 'Improving patients' safety by gathering information', *British Medical Journal*, vol. 323, p. 298.
- Social Security Act 1938.
- Spicker, P. 1995, 'Evaluating social policy', in *Social policy: themes and approaches*, Hemel Hempstead, Prentice Hall, Harvester Wheatsheaf.
- St George, I. (ed), 1999, *Cole's medical practice in New Zealand*, 3rd Edition, Medical Council, Wellington.
- St John, S. 1999, 'Accident compensation in New Zealand: a fairer scheme?', in J. Boston, P. Dalziel, S. St John (eds), *Redesigning the welfare state in New Zealand: problems, policies, prospects*, Oxford University Press, Auckland, pp. 154-176.
- Stritch, A. 1998, 'Competition and compensation: the privatisation of ACC', *Social Policy Journal of New Zealand*, issue 11, pp. 67-81.
- Studdert, D.M. & Brennan, T.A. 2001, 'No-fault compensation for medical injuries: the prospect for error prevention', *Health Law and Ethics: The Journal of the American Medical Association*, vol. 286, issue 2, p. 217.
- Studdert, D.M. Thomas, E.J. Zbar, B.I.W. Newhouse, J.P. Weiler, P.C. Bayuk, J. & Brennan, T.A. 1997, 'Can the United States afford a "no-fault" system of compensation for medical injury?' *Law and Contemporary Problems*, vol. 60, pp. 1-34.
- Towse, A. & Danzon, D. 1999, 'Medical negligence and the NHS: an economic analysis', *Health Economics*, vol. 8, pp. 93-101.
- Vincent, C. Ennis, M. & Audley, R.J. (eds), 1993, *Medical accidents*, Oxford University Press, United States.
- Vincent, C. Martin, T. & Ennis, M. 1991, 'Obstetric accidents: the patient's perspective', *British Journal of Obstetrics and Gynecology*, vol. 98, pp. 390-395.
- Vincent, C. Neale, G. & Woloshynowych, M. 2001, 'Adverse events in British hospitals: preliminary retrospective record review', *British Medical Journal*, vol. 322, issue 7285, p. 517-9.

- Wealleans, N. 1998, *The quest for consumer voice: an evaluation of the implementation and outcomes of the Health and Disability Commission Act 1994*, Massey University, Palmerston North, Unpublished Thesis.
- Weiler, P.C. 1993, 'The case for no fault liability', *Maryland Law Review*, vol. 52, pp. 908-950.
- Weiss, Carol 1987, 'Where politics and evaluation meet', in D. J. Palumbo (ed), *The politics of programme evaluation*, Sage Publications, Newbury Park, California, pp. 47-70.
- Woodhouse, J. 1967, *Report of the royal commission of inquiry, compensation for personal injury in New Zealand*, Government Printer, Wellington, New Zealand.

Appendix One – Ethical Proposal

Massey University Human Ethics Committee

To: Secretary, Human Ethics Committee
AT Principal’s Office Albany OR Equity & Ethics Old Main Building Turitea, Palmerston North OR Principal’s Office Wellington

Please send this original (1) application plus twelve (12) copies
Application should be double-sided and stapled Application due two (2) weeks prior to the meeting

APPLICATION FOR APPROVAL OF PROPOSED RESEARCH/TEACHING /EVALUATION PROCEDURES INVOLVING HUMAN SUBJECTS

SECTION A: GENERAL INFORMATION

1	Full Name of Staff Applicant	Lisa Tatiana Ralph		
	School/Department/ Institute/Section	School of Social Policy and Social Work		
	Region (mark one only)	Albany	<input type="checkbox"/>	Palmerston North <input checked="" type="checkbox"/>
		Wellington	<input type="checkbox"/>	
	Email Address	lisa.ralph@xtra.co.nz		
	Name of Employer	ACC		
2	Full Name of Supervisor(s)	Dr Jocelyn Quinnell, PHD, Senior Lecturer, School of Social Policy and Social Work, Palmerston North Campus Lesley Patterson, Lecturer, School of Social Policy and Social Work, Wellington Campus		
3	Project: Title	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.		
	Status:	Masterate		
	Funding Source:	Self-funded		
	Attachments:	Application form		
4	Signature (s) Applicant Supervisor			
	Date:			

1. Description

1.2 Justification

I am a policy analyst with the Accident Compensation Corporation (ACC) at Head Office, Wellington. In the course of my work I have become interested in the area of medical misadventure. Medical misadventure, defined in the Accident Rehabilitation and Compensation Insurance (ARCI) Act (1992), encompasses personal injury caused by medical error or medical mishap. Under this Act if ACC were satisfied that there may have been negligence or inappropriate action they were required to *'report the circumstances to the appropriate body with a view to the institution of disciplinary proceedings, and to any other body that may be appropriate'* Accident Rehabilitation and Compensation Insurance Act, (1992).

Six years later the ARCI Act was repealed and the new Act the Accident Insurance Act 1998 removed the reporting function. The Injury Prevention and Rehabilitation Bill 2000 which is currently under consideration has a major focus on injury prevention and proposes that the reporting function should be reintroduced. It is the reporting process and its outcomes with regard to prevention of injury which are of interest to me.

In order to fulfil the requirements to gain an M.A. in Social Policy I wish to evaluate the reporting process as under the ARCI Act 1992 and the impact of that process with regard to the prevention of injury.

1.2 Objectives

- To identify and describe the aims, processes and outcomes of ACC's reporting requirements with regard to 60 claims lodged under the ARCI Act 1992.
- To explore the extent to which 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.

- To make recommendations (if appropriate) on how the reporting processes of agencies might be improved by agencies in order to maximise injury prevention.

1.3 Procedures for Recruiting Participants and Obtaining Informed Consent

My research will involve a search and review of a selection of ACC medical files. ACC has indicated support for the research and has given its approval in principle subject to Massey University's Ethics Committee approval (see Appendix 1). I have discussed my research topic and methodology with the Health and Disability Commissioner who is supportive in principle (see Appendix 2).

1.4 Procedures in which Research Participants will be involved

My research will be based on a search of ACC's files. I will establish from a random sample of 60 claims made between 1992 and 2001 which have been accepted on the basis of medical error since the inception of the ARCI Act 1992.

Medical error is defined as a failure of a registered health professional to observe a standard of care and skill which could reasonably be expected in the particular circumstances.

Medical mishap is defined as a rare and severe outcome of treatment properly given by or at the direction of a registered health professional. As there was no requirement to report medical mishap claims under the ARCI Act 1992 the focus of my research will be on medical error claims.

Relevant selected details will be set out on an excel spreadsheet (see Appendix 3). From the spreadsheet I will then select 6 cases from a range of medical specialties, for example nursing and general surgery. These will provide further in-depth information on each case. In order to compare and contrast process and outcomes from this pool of 6 cases I will then select 3 cases where injury

prevention initiatives have had successful initiatives and 3 cases where this has not been the case.

Care will be taken when writing up the 6 cases and the circumstances of each claim, to avoid details which could identify individual claimants. Should the cases I select describe events which may lead to identification of particular claimants, these will be discarded and a further sample will be drawn. This process will be overseen by the General Manager, Planning, Policy and Purchasing, ACC.

I will provide the Health and Disability Commissioner's Office with a list of claims identified on the excel spreadsheet that have been referred to the Health and Disability Commissioner (HDC) for the purposes of reporting medical error. Under the Official Information Act 1982 I will request information on the outcome of the Health and Disability Commissioner's investigations into each case. All information supplied will be treated in accordance with my obligations as a researcher under the Privacy Act 1993 and the Health and Information Privacy Code 1994.

Professional bodies are not subject to the Official Information Act 1982 therefore information on the outcome of investigations is not available to me in the same way that it is with the Health and Disability Commissioner's Office. When reporting medical error ACC always asks the relevant professional body for details on the outcome of their investigations. Therefore in order to obtain information on the outcome of the investigations I will rely on letters which the relevant bodies have written to ACC with regard to these cases.

While I am interested in the reporting process and its effect on injury prevention, I am not interested in obtaining specific details of the individuals involved. However, I will require sufficient information in order for the HDC to be able to identify the relevant case.

1.5 Procedures for handling information and material produced in the course of research including raw data and final report(s)

I will write up an excel spreadsheet with the claim number, claimant's name, date the claim was accepted by ACC, the type of error claim and the date reported to the body for each of the 60 cases (as in Appendix 3).

With regard to the case of the professional bodies which are involved I will include the details of the outcome of their investigations with regard to each case, as obtained from their letters to ACC located on the ACC case files. The writing up of the claims will occur only on ACC premises and at all times the files will remain on ACC premises. My computer is password protected and this will ensure that only I have access to the information.

The HDC will be provided with a list of claims taken from the random sample of 60 claims that were referred to them under the ARCI Act 1992. They will be asked to complete the section on the outcome of their investigations. I will collect this material in person from the HDC. If I am unable to do so I will request that it be returned to me in a courier bag which I will supply.

Once I have received the completed list it will remain in a secure cabinet on ACC premises until the research is complete. On the completion of my thesis, this list and all data spreadsheets will be destroyed.

1.6 Procedures for sharing information with Research Participants

I will provide ACC and the HDC with a summary of my research findings. I will also provide a copy of my thesis to the ACC Library.

1.7 Arrangements for storage and security, return, disposal or destruction of data.

All raw data that may in any way identify an individual will be kept confidential. All research data gathered will be collated at ACC and kept in a locked cabinet on ACC premises. When the final report has been completed all information that may identify a case/individual will be destroyed in ACC's shredder.

2. Ethical Concerns

2.1 Access to Participants

This research involves access only to ACC case records but not direct access to any individual.

2.2 Informed Consent

As this research does not involve obtaining information directly from any individual but from ACC case notes informed consent will not be required (see 1.3).

2.3 Anonymity and Confidentially

Need to identify: Of the 60 random sample cases involved in my research, I intend to select 6 cases only. These will be identified within a level of broad categories. For the 6 case studies where I provide a brief synopsis of the event for the purposes of determining appropriate injury prevention initiatives, there will be no disclosure or use of any material which could identify and individual (see 1.4).

2.4 Potential Harm to Participants

In accordance with the Privacy Act 1993 and the Health Information Privacy Code 1994 potential harm to participants will be avoided by ensuring that all information presented in my thesis is written in such a way that no individual is able to be identified (see 1.4 and above 2.3).

I have discussed my research plans with ACC. The Manager of Privacy stated that he felt 'twice protected' as in addition to the above legislative requirements, I have as a member of ACC's staff also signed a privacy declaration stating that I will not disclose any confidential information.

2.5 Potential Harm to Researcher(s)

No foreseeable harm

2.6 Potential Harm to University

No foreseeable harm

2.7 Participant's Right to Decline to Take Part

As my research will be based on case notes to highlight matters of process and outcome, with no direct use of individual identifiers, this section does not apply.

2.8 Uses of the Information

The research findings have the potential to be used for policy development in the first instance by ACC, and also by any other agencies involved in reporting adverse medical incidents for the purpose of injury prevention. Its findings may also be useful with regard to the further development of policy and legislation. The research may also be published. On successful completion of the thesis it is likely that I would host a seminar for ACC and/or Massey University.

2.9 Conflict of Interest/Conflict of Roles

As an employee of ACC there may be potential for conflict of interest, given that discrepancies in the organisation's response to medical error claims may be found. Should such a situation occur I will discuss it with either, the ACC General Manager, Planning, Policy and Purchasing, and/or my thesis supervisors. I will be guided by their advice.

2.10 Other Ethical Concerns

No other ethical concerns are envisaged.

3. Legal Concerns

3.1 Legislation

3.1.1 Intellectual Property Legislation e.g. Copyright Act 1994

Not relevant.

3.1.2 Human Rights Act 1993

Not relevant as the focus of my research is on an overview of processes and outcomes.

3.1.3 Privacy Act 1993 and Health Information Privacy Code 1994

This legislation outlines limits on the use of personal information from agencies such as ACC. Information used for research purposes must be used in a form in which does not identify the individuals concerned and I have addressed this issue. Further, the research will not be published in a form that will lend itself to the identification of the specific individuals concerned. I have considered these matters in Sections 1.4, 2.3 and 2.4.

3.1.4 Health and Safety in Employment Act 1992

No specific issues with regard to this research need addressing.

3.1.5 Accident Insurance Act 1998

No specific issues need addressing.

3.1.6 Employment Relations Act 2000

This legislation outlines the steps to take to resolve employment disputes. It seems unlikely that any such issues will arise, however, should this happen they will be raised and discussed in the first instance with the General Manager, Planning, Policy and Purchasing, ACC.

3.1.7 Official Information Act 1982

ACC and the HDC are subject to the Official Information Act 1982. Unless there are withholding grounds as outlined in Section 9(2)(a) of the Act which allows information to be withheld if it is necessary to protect the privacy of an individual, all information is otherwise available to me. As outlined in section 1.4, 2.3, 2.4. and 3.1.3, my research will be written in a form that does not identify individuals. Care will be taken that any material published will not contain any personal identifiers.

Other Legal Issues

None envisaged.

4. Cultural Concerns

None foreseen which would require particular attention.

5. Other Ethical Bodies Relevant to this Research

5.1 Ethics Committee

Note: List other ethic committees to which you are referring this application

There are no other ethic committees to whom I am referring this application.

5.2 Professional Codes

Note: List all NZ professional codes to which this research is subject
I will use the Health Information Privacy Code 1994 as my ethical guide.

6. Other relevant issues

Note: List other issues you would like to discuss with the MUHEC

None

Signed

Date:

First Supervisor,

Jocelyn Quinnell, Ph.D. Senior Lecturer, School of Sociology, Social Policy and Social Work

Signed

Date:

Researcher

Lisa Ralph

References

1. Accident Compensation and Insurance Act 1992
2. Accident Insurance Act 1998
3. Injury Prevention and Rehabilitation Bill 2000

Note: Appendix 3 is supplied as part of the Massey University Human Ethics Committee Proposal (note Appendix 1 and Appendix 2 of the Ethics Proposal are provided as Appendix 2 and Appendix 3 respectively to the thesis.

Appendix 3 Excel Spreadsheet to record details of random sample of 60
- claims referred to professional body/HDC

Name	DOB	DOI	Accepted by ACC	Referred	Body	Error Type	Action
------	-----	-----	-----------------	----------	------	------------	--------

Appendix Two – ACC Support Letter

12 November 2001

Professor Sylvia V Rumball
Chairperson, Massey University
Human Ethics Committee
Palmerston North

Dear Professor Rumball

Re: Research undertaken by Lisa Tatiana Ralph, School of Social Policy and Social Work towards an MA (Social Policy)

Research Topic: Medical Misadventure – Legislation, Reporting and Injury Prevention: An evaluation of the outcomes of ACC's reporting of medical error findings in terms of injury prevention.

I have discussed Lisa Ralph's research plans and read the ethics committee proposal.

On the basis of this ACC agrees that:

- It supports the research in principle.
- It supports the research process as outlined in the application.
- To provide an over-seer in the process.
- To provide information (as outlined in the ethics proposal) in accordance with the Official Information Act 1982, Privacy Act 1993 and Health Information Code 1994.
- The researcher will not receive more privileged access to data purely on the grounds of her employment status with ACC.

Signed:

Date:

Over-seer for ACC
Cathy Scott
General Manager
Stakeholder Relations
Accident Compensation Corporation

Appendix Three – HDC Support Letter

4 July 2001

Professor Sylvia V Rumball
Chairperson
Human Ethics Committee
Massey University
Palmerston North

Dear Professor Rumball

Re: Research undertaken by Lisa Tatiana Ralph, School of Social Policy and Social Work, Massey University towards an MA (Social Policy).

Research Topic: Medical Misadventure – Legislation, Reporting and Injury Prevention: An evaluation of the outcomes of ACC's reporting of medical error findings in terms of injury prevention.

I have discussed the above research plans with Lisa Ralph and support the research in principle. Subject to Massey University Ethics Committee approval, and to time constraints, my Office will assist Lisa with her research in accordance with the Official Information Act 1982, Privacy Act 1993 and Health Information Code 1994.

Yours sincerely

Ron Paterson
Health and Disability Commissioner