

Disclosure of treatment injury in New Zealand's no-fault compensation system

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Abstract

In July 2005 New Zealand became the first country to establish comprehensive no fault coverage for all treatment injury. This paper reports on a study of disclosure policies and practices related to treatment injury within the New Zealand hospital system. All 21 district health boards (DHBs), which provide publicly funded hospital services, were asked to complete a detailed questionnaire, with 90% responding. This was followed by an extended telephone interview with the chief clinical advisers and quality managers of 11 DHBs.

Most respondents reported that their boards had an established policy or were developing one. DHBs reported a high level of disclosure practice, even for preventable harm. All indicated that disclosure was now felt to be safer than non-disclosure, although this view was not shared by all grassroots clinicians. The New Zealand experience may point to ways of achieving fairer and accessible compensation for patients.

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DISCLOSURE TO PATIENTS of harm arising from their treatment is an important issue facing most health systems.^{1,2} Disclosure, leading to learning from failures, is a first step in building a quality culture.^{1,2} Action to promote disclosure is now being proposed in a number of countries. In the United States, following the Institute of Medicine

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What is known about the topic?

Disclosure to patients of harm arising from treatment is becoming recognised as a critical factor in providing fairer and prompter access to compensation. Few studies have explored policies and practices relating to disclosure.

What does this paper add?

This paper reports on policies and practices related to disclosure within New Zealand hospitals as reported by key clinical leaders of district health boards. Respondents reported a high level of disclosure and were almost universal in their belief that disclosure was safer than non-disclosure in avoiding patient complaints against individual practitioners and organisations.

What are the implications for practitioners?

The study highlights the opportunities of a non-litigious, no-fault compensation system in providing a safer learning environment for practitioners with prompter, fairer compensation for patients.

1999 report *To err is human*,³ the Joint Commission on Accreditation of Health Care Organizations introduced new patient safety standards including a requirement that all unanticipated outcomes of care be disclosed.⁴ An American survey in 2002 found that, although some progress was being made, policies and practices still fell short of expected standards. The study showed that fears of litigation from both hospitals and physicians were a major barrier to disclosure.⁴

New Zealand provides a unique environment for the study of disclosure. In 1974, the Accident Compensation Corporation (ACC) was established to provide a national no-fault universal system of compensation for injury by accident, but excluded injuries received from medical treatment. In 1992 the scheme was extended to cover "rare and severe" medical mishap, and medical error, the latter requiring fault to be determined before compensation could be claimed.⁵ In July

2005 the scheme was extended to cover all treatment injury, including minor injury, and provide access to compensation for patients on a fully no-fault basis.

Patients have no legal entitlement to sue for compensation. Hence medical indemnity premiums of \$1200 annually for all specialties are only a small fraction of those doctors are faced with in other countries, and are almost entirely to cover legal assistance to doctors in complaints by patients to the independent Office of the Health and Disability Commissioner (HDC).⁶ Fear of discipline arising from a small proportion of such complaints remains a major concern of doctors and is still felt to be a factor inhibiting disclosure.⁷

This study of disclosure and related issues was undertaken in New Zealand in 2004. Its aims were to determine district health board (DHB) policy and practice relating to treatment injury, consider these in the light of international experience of disclosure and discuss the implications of these for the development of a quality culture.

Progress towards quality improvement in New Zealand

Major efforts have been made to improve health care quality in New Zealand in recent years, with evidence of significant progress.⁸ These developments have been driven by studies that showed 12.9% of hospital admissions were associated with an adverse event.⁹ Other factors have been high profile clinical failings, sometimes associated with hostile media coverage, and increasing political and consumer expectations.¹⁰ Recent strategies are now focusing on the need to create safe, supportive systems of care and learning organisations.¹¹ Disclosure of treatment injury is increasingly seen to be a key factor in quality improvement initiatives.

These initiatives have taken place at a number of levels and have been described elsewhere.¹⁰ Although there has been some national leadership,¹⁰⁻¹³ most progress has been made through the efforts of clinical leaders working within the 21 newly formed DHBs.¹⁰ These are statutory

organisations that receive a population-based allocation from the government to fund all health services in their area, including hospital services largely supplied by DHBs themselves.

The Medical Council of New Zealand, the registration and accreditation body for doctors, has recently taken a strong position on disclosure, stating that it is ethically, morally and professionally expected of clinicians. In 2004, the Council issued a policy statement on "Disclosure of harm"¹⁴ that states that open disclosure contributes to better doctor-patient relationships, is required under the HDC Code of Patients' Rights, contributes to public awareness about the reality of medical treatment, and provides an environment that enables doctors to learn from openly discussed mistakes.¹⁴

The changes to the ACC implemented in July 2005 are consistent with these wider moves towards promoting a culture of safety and learning rather than blame. The new legislation provides a comprehensive, completely no-fault system of cover for all treatment injury.⁵ It is designed to provide immediate, low-cost and fairer patient compensation, with disclosure being an important factor in ensuring access. This study was commissioned by the ACC to explore policies and practices within DHBs relevant to the reforms now being implemented and to provide a baseline for subsequent evaluation.¹⁵

Methods

A two-part methodology was used, comprising a questionnaire to chief medical officers/advisors (CMAs) and to quality managers (QMs) of DHBs, with follow-up interviews with respondents from selected DHBs. The questionnaire, based on that used by Lamb et al⁴ with their approval, was modified after consultation with a New Zealand reference group comprising senior clinical and quality managers. The term disclosure was defined as "honestly telling patients and/or their families about harm/injury that was not a result of the patient's illness or underlying condition".

The questionnaire comprised three areas; trends in disclosure policy and practice, and

I Responses from district health boards on policies and practices relating to disclosure

	No. (%)
Policies	
Established	9 (50%)
Under development	4 (22%)
None	4 (22%)
Practices	
Routinely disclose	8 (44%)
Sometimes disclose	10 (56%)
Do not disclose	0

likelihood of disclosure following certain types of events including four specific scenarios. Secondly, DHBs were asked about the following responses: giving an explanation; an apology; acknowledgement of harm; undertaking to investigate and sharing results; providing health care and support; referral to relevant agencies; and assisting with making a claim or complaint. The third part of the questionnaire considered the consequences of disclosure (including the risk of complaints and media exposure) and barriers to disclosure, including fear of complaints and exposure.

The questionnaire was emailed (December 2003) individually to CMAs and QMs in all 21 DHBs. A joint response on behalf of the DHB was invited. Non-responders were followed up by email and telephone.

The questionnaire was analysed by tabulating responses where possible, and categorising and summarising written comments. This was followed up with extended joint telephone interviews with CMAs and QMs in 11 selected DHBs in early 2004. The DHBs were chosen for follow-up on the basis that they represented the range of DHB circumstances: urban or rural, large or small populations, basic secondary or more sophisticated services. The follow-up interviews used the original questionnaire as a framework and sought both confirmation of the responses to the questionnaire and further elaboration of the issues through discussion. An overall response was

compiled for each DHB and returned for comment to both respondents at each DHB. Overall findings were drafted on the basis of the DHB reports as signed off by both respondents.

A combination of questionnaire and follow-up interview from respondents with high credibility was assessed as the most reliable way of gaining insight into issues that are not otherwise well documented. CMAs are senior clinical leaders within the DHBs and are expected, in their job descriptions, to be fully in touch with clinical issues and colleagues within their organisations. They usually have overall responsibility for clinical governance and quality. QMs, also often with a clinical background, have an overview of the management of adverse events and are instrumental in the development and monitoring of quality processes within their DHBs.

Key findings

Policies and trends

Questionnaire responses were received from 18 of 21 DHBs covering 95% of the country's population. Box 1 shows reported DHB policies and practices relating to disclosure. Established policy was present in 50% of DHBs and four stated that policies were under development. All DHBs stated that in practice they disclosed routinely or depending on the seriousness of the event. Most respondents confirmed that policies often arose alongside evolving clinical practice rather than entirely driving that practice. However, once in place, such policies provided support for further developments in disclosure.

In the follow-up interviews some DHBs reported that their policies had arisen out of painful experience in dealing with difficult cases. As discussed later, they had learnt that non-disclosure led to patients seeking information they felt had been denied to them through the often difficult formal complaints process. The effectiveness of policies was dependent upon a broad-based discussion process within the organisation with wide involvement of clinical staff. Culture was as important as a formal policy

document, although strong corporate support for disclosure through written policy was important in helping clinical staff to feel more secure. Disclosure practices were generally a partnership involving service managers and clinical directors.

All respondents claimed that in their DHBs disclosure over the last 2 years had increased, in some cases significantly. Most indicated that disclosure had reduced the risk of complaints to the HDC, in some cases significantly. A few DHBs were able to support these claims from their information systems. However, information systems on disclosure and reported treatment injury were still at an early stage of development.

Circumstances of disclosure

Box 2 shows the responses related to the usual circumstances of disclosure as assessed by our respondents. The majority (14) reported that their DHBs always disclosed an unanticipated death or serious injury. A larger majority (16) reported always or frequently disclosing an unanticipated event not causing permanent long-term harm. Surprisingly, all DHBs were reported as frequently or sometimes disclosing an unanticipated event which reaches the patient but of

which the patient would be unaware as there were no obvious changes in care.

Box 3 shows the responses regarding the extent to which DHBs would normally disclose harm in four different scenarios. These were preventable serious and minor harm, and non-preventable serious and minor harm. Respondents stated that they disclosed non-preventable to a higher extent than preventable harm. This is not surprising, as preventable harm is still seen as more likely to be subject to possible formal complaint.

Actions following disclosure

Box 4 shows reported elements of and actions following typical disclosure. All respondents reported that their DHBs provide patients with an explanation, an apology/expression of regret, an undertaking to investigate the event in order to prevent similar incidents and a promise to share investigation results with the patient and family. All DHBs indicated that they would provide the associated health care needed and assist the patient/relatives to make a claim to the ACC if appropriate.

Almost all respondents (17) indicated that their DHBs would provide details of outside support

2 District health boards' practices relating to disclosure by type of event

Type of injury	No. of district health boards (%)		
	Always	Frequently	Sometimes
Unanticipated death/serious injury	14 (78)	4 (22)	0
Unanticipated, not causing permanent harm but leading to additional treatment/longer stays	7 (39)	9 (50)	2 (11)
Unanticipated and patient unaware	0	11 (61)	7 (39)

3 Reported potential disclosure of scenarios

"Harm" scenarios	No. of district health boards (%)	
	Very likely to disclose	Somewhat likely to disclose
Scenario 1: preventable serious harm	15 (83%)	3 (17%)
Scenario 2: preventable minor harm	13 (72%)	5 (28%)
Scenario 3: non-preventable serious harm	18 (100%)	0
Scenario 4: non-preventable minor harm	18 (100%)	0

groups and refer the patient to the HDC advocacy service. A substantial minority (8) reported that they would provide additional support or make modest payments towards this.

Barriers to disclosure

When asked about barriers to disclosure, over half of the respondents reported that these included medical staff fears of complaints to the HDC and medical and nursing staff concerns about reputation. Although some DHBs had received negative media publicity about adverse events this was not reported as inhibiting disclosure. It was repeatedly stated by our respondents that disclosure was now much safer than non-disclosure in terms of reducing risk of complaints to the HDC, and to some extent claims to the ACC. On the other hand it was also recognised by most DHBs that “grassroots” clinicians were still fearful of the risk of disclosure as it was perceived to expose them to the complaints process. This was described by one clinical leader as paranoia. It was also repeatedly stated that complaints arose more from a failure of appropriate communication with the patient than from the technical quality of the care provided.

Discussion

As in many studies that analyse changing policy and practice, there are limitations with the available data. We were unable to access data on the reporting and disclosure of adverse events or the level of compensation claims for individual DHBs and so were reliant on the reporting of local practice by key informants, only some of whom had robust information available to them. As with Lamb et al,⁴ it can be argued that these informants had a vested interest in presenting their organisations in as good a light as possible and that our data are therefore suspect. However, we believe that the use of a questionnaire and then follow-up interviews to explore the responses in depth allowed us to appraise those responses critically. In our view, there was no indication that respondents were trying to put a good “gloss” on their situation. All appeared conscientiously, often in the absence of “hard” data, to provide a balanced view of the circumstances in their organisations.

The findings of this research indicate that there is an increasing trend in New Zealand towards the disclosure of adverse events. A search of the literature has shown that relatively few studies of this kind have been undertaken to document

4 Elements of and actions following typical disclosure

Policy/practice	District health boards reporting, no. (%)
Elements of typical disclosure	
An explanation	18 (100%)
An apology/expression of regret	18 (100%)
An undertaking to investigate and prevent similar incidents	18 (100%)
A promise to share investigation results with the patient/family	16 (89%)
Actions following typical disclosure	
Provide the associated health care needed	18 (100%)
Provide/pay for additional support	8 (44%)
Provide details of outside support groups	15 (83%)
Provide details of relevant statutory agencies, eg HDC, ACC	17 (94%)
Refer to the HDC advocacy service	12 (67%)
Assist the patient/relatives to make a claim to ACC if appropriate	18 (100%)

HDC = Health and Disability Commissioner. ACC = Accident Compensation Corporation.

policies and practices regarding disclosure by organisations. The only comparable study found was the one by Lamb et al⁴ in 2002 of US hospitals, and on which our questionnaire is based. The Lamb et al study was based on responses from risk managers of a sample of 479 hospitals. Respondents (51% of the sample) indicated that their hospital's practice was to disclose harm, at least some of the time, although only one third had a board-approved policy in place. In our study, the response rate was much higher (90% of the organisations contacted, covering 95% of the population served) and was complemented by detailed interviews. Our results pointed to a higher level of communication with the patient/family of information, including an apology and providing support, than found in US hospitals surveyed by Lamb et al. These differences are most likely due to the differing policy, funding and regulatory environments in the two countries. Statutory provisions for claiming for treatment injury and the absence of the right to sue for compensation in New Zealand seemed to permit more openness in responding to the needs of patients/families following an adverse event.

Despite the lack of empirical research, there appears to be an unequivocal move in many countries towards disclosure.¹⁶⁻¹⁸ Apart from the actions of DHBs, the Medical Council of New Zealand has formally supported disclosure.¹⁴ In Australia, the Australian Council for Safety and Quality in Health Care (ACSQHC) is actively promoting disclosure with standards and educational and organisational support programs.¹⁹ A literature review undertaken by the Council found that there were many studies supporting the benefits to clinicians and patients of a frank and honest exchange of information when errors are made.¹⁹

Respondents in our study were, in general, convinced that disclosure reduced the risks of subsequent complaints to the HDC both for individuals and organisations. The literature on this issue is ambivalent. One of the few studies to show that disclosure reduces the risk of litigation reported on the extreme honesty policy at the Veterans Affairs Medical Center in Lexington,

Kentucky.²⁰ Most patients value and seek open disclosure and honesty.²¹ As Lamb states, "My experience has been that, when patients take their stories to the news media most of their anger is about how they were treated after the adverse event rather than the event itself".¹ Despite evidence that disclosure might result in fewer complaints or less litigation, our respondents acknowledged that their confidence in this respect was not fully shared by their "grassroots" clinician colleagues. A literature review undertaken by the ACSQHC found that loss of reputation was much more important than fear of litigation as a barrier to disclosure.¹⁹ It is clear that even where the threat of litigation is removed, as it is in New Zealand through the no-fault compensation system, disclosure may still be seen as leading to a highly professionally damaging complaints process.⁷

The tort system used in most countries to compensate patients for treatment injury is being increasingly seen as anachronistic and an obstacle to progress towards patient safety.²² It has been widely criticised as costly, slow, inequitable and blame oriented.^{23,24} There is little evidence that it acts as a deterrent to substandard care.²⁵ It tends to stifle open communication between provider and patient, thereby preventing the provision of the desired explanation and apology.^{2,25} The New Zealand experience of moving to a totally no-fault system may provide important insights into possible reform in other countries.

Conclusion

This study points to progress within public hospital services in New Zealand towards more open disclosure of treatment injury within what is an almost completely no-fault system. The main barrier to disclosure remains a fear of complaint and the consequent damage to professional status rather than litigation. Progress is likely to be enhanced through improved communication skills,²⁶ providing clinical support systems and promoting and extending existing mediation and advocacy services that assist the timely local resolution of complaints.

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Competing interests

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References

- 1 Lamb R. Open disclosure: the only approach to medical error [editorial]. *Qual Saf Health Care* 2004; 13: 3-5.
- 2 Liang BA. A system of medical error disclosure. *Qual Saf Health Care* 2002; 11: 64-8.
- 3 Institute of Medicine. To err is human: building a safer health system. Washington, DC: National Academy Press, 2000.
- 4 Lamb RM, Studdert DM, Bohmer RM, et al. Hospital disclosure practices: results of a national survey. *Health Aff (Millwood)* 2003; 22: 73-83.
- 5 Accident Compensation Corporation. Changes to ACC medical misadventure. Wellington, New Zealand. Available at: http://www.acc.co.nz/wcm001/idc-p1g?IdcService=SS_GET_PAGE&ssDocName=WCMZ003409&ssSourceNodId=4249 (accessed Nov 2006)
- 6 Health and Disability Commissioner. Annual report for the year ended 30 June 2003. Auckland, New Zealand: HDC, 2003. Available at: <http://www.hdc.org.nz/page.php?&page=publications> (accessed Nov 2006).
- 7 Cunningham W. The immediate and long-term impact on New Zealand doctors who receive patient complaints. *N Z Med J* 2004; 117(1198): U972.
- 8 Blendon R, Schoen C, DesRoches C, et al. Inequities in health care: a five country study. *Health Affairs*; 2002; 21 (1): 182-91.
- 9 Davis P, Lay-Yee R, Briant R, et al. Adverse events in New Zealand public hospitals I: occurrence and impact. *N Z Med J* 2002; 115: U271.
- 10 Barnett P, Malcolm L, Wright L, Henry C. Professional leadership and organisational change: progress towards a quality culture in New Zealand's health system. *N Z Med J* 2004; 117: U978.
- 11 Ministry of Health. Improving quality (IQ): a systems approach for the New Zealand health and disability sector. Wellington, New Zealand: Ministry of Health 2003.
- 12 National Health Committee. Safe systems supporting safe care. Final report on health care quality improvement in New Zealand. Wellington: NHC, 2002.
- 13 Ministry of Health. Toward clinical excellence. A framework for the credentialing of senior medical officers in New Zealand, 2001, Wellington. Available at: [http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/85a5c6ade26c60facc256a10000a5d68/\\$FILE/Clinical.pdf](http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/85a5c6ade26c60facc256a10000a5d68/$FILE/Clinical.pdf) (accessed Nov 2006).
- 14 Medical Council of New Zealand. Disclosure of harm [discussion document]. Wellington, 2004. Available at: <http://www.mcnz.org.nz/Publications/Statements/tabid/81/Default.aspx> (accessed Nov 2006).
- 15 Malcolm L, Barnett P. Towards a more open culture of safety in managing patient complaints and claims for treatment injury. Report prepared for ACC related to the reform of medical misadventure. 2004. Available at: http://www.acc.co.nz/wcm001/groups/external_claims_care/documents/internet/wcmz002976.pdf (accessed Nov 2006).
- 16 Wu AW. Doctors are obliged to be honest with their patients. *BMJ* 2001; 322: 1238-9.
- 17 Leape LL. Reporting of medical errors: time for a reality check. *Qual Saf Health Care* 2000; 9: 144-5.
- 18 Pinker S. Quebec moves toward full disclosure of medical errors [editorial]. *CMAJ* 2002; 166: 800.
- 19 Clinical Practice Improvement Unit. Open Disclosure Project. Sydney: CPIU, 2003. Available at: http://www.nsh.nsw.gov.au/teachresearch/cpiu/open_disclosure.shtml#Literature20Review (accessed Nov 2006).
- 20 Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. *Ann Intern Med* 1999; 131: 963-7.
- 21 Mazor KM, Simon SR, Yood RA, et al. Health plan members' views about disclosure of medical errors. *Ann Intern Med* 2004; 140: 409-18.
- 22 Vincent C. Compensation as a duty of care: the case for "no fault". *Qual Saf Health Care* 2003; 12: 240-1.
- 23 Mello MM, Studdert DM, Brennan TA. The new medical malpractice crisis. *N Engl J Med* 2003; 348: 2281-4.
- 24 Studdert DM, Brennan TA. No-fault compensation systems for medical injuries. *JAMA* 2001; 286: 217-23.
- 25 Davis P, Lay-Yee R, Fitzjohn J, et al. Compensation for medical injury in New Zealand: does "no-fault" increase the level of claims making and reduce social and clinical selectivity? *J Health Polit Policy Law* 2002; 27: 833-54.
- 26 Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors: a review of the literature. *Arch Intern Med* 2004; 164: 1690-7.

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