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'Woe is me!': New Zealand's non-punitive regulatory environment

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“Given the absence of malpractice litigation in New Zealand, there is something rather self-indulgent in the response of the small minority of doctors who cry ‘Woe is me!’”¹

This statement, written in 2006 by the then Health and Disability Commissioner, implies that doctors are not justified in crying ‘woe in me’ in response to New Zealand’s regulatory system because it is somehow less woe-inducing, or less punishing, than malpractice litigation.

The New Zealand Medical Association has expressed a contrasting view:

“The New Zealand Medical Association is of the view that the medico-legal environment in New Zealand is a hostile one and constitutes a deterrent to good medical practice.”²

This policy statement was written in 2002 and the Association may since have changed its view because subsequent legislative reforms in the mid-2000s streamlined New Zealand’s professional accountability processes and removed error, or fault, from medical injury compensation eligibility criteria. Nevertheless, as the accountability processes themselves were largely unaffected by the reforms, it is likely that opposing views on the nature of New Zealand’s regulatory environment persist today.

The purpose of this essay is to explore these contrasting views and, in the words of John Steinbeck, to write to:

“Try to understand each other. You can’t hate men if you know them.”³

The systems approach to patient safety

The notion of punishment has particular relevance for patient safety. Patients who are harmed by health care rightly demand that those responsible be held to account and even punished.^{4–6} However, most patient safety experts today advocate a systems approach to patient safety which assumes that doctors are fallible and bound to make mistakes that might harm patients and so recommends systems and processes be put in place to prevent mistakes and minimise harm.^{7–10} Such an approach will only thrive in an environment where doctors can share information about error and adverse events, and learn, without fear of punishment. Many patient safety experts therefore advocate a low-blame or non-punitive approach to mistakes and adverse events.^{7,11–14}

The Institute of Medicine in its landmark report *To err is human* concluded:

“Preventing errors and improving safety for patients requires a systems approach in order to modify the conditions that contribute to errors ...

The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: Our guest ethicist and GP Katharine Wallis explores whether or not New Zealand’s regulatory environment for doctors is punitive in nature.

... health care organizations must develop a systems orientation to patient safety, rather than an orientation that finds and attaches blame to individuals. It would be hard to overestimate the underlying, critical importance of developing such a culture of safety to any efforts that are made to reduce error. The most important barrier to improving patient safety is lack of awareness of the extent to which errors occur daily in all health care settings and organizations. This lack of awareness exists because the vast majority of errors are not reported, and they are not reported because personnel fear they will be punished. Health care organizations should establish nonpunitive environments...¹⁵

It has been suggested that New Zealand's regulatory system is consistent with such an approach; that New Zealand is one of the safest places in the world to practise medicine,¹⁶ that New Zealand's regulatory system is non-punitive¹⁷ and has potential benefits for patient safety.^{9,18,19}

"In the words of Professor ..., New Zealand remains one of the safest places in the world to practise medicine."¹⁶

"... the non-punitive, rehabilitative focus of New Zealand's medical regulatory system."¹⁷

Does New Zealand have a non-punitive environment?

New Zealand's regulatory system might be considered non-punitive for two reasons. Firstly, because in New Zealand we have a no-fault compensation scheme, instead of a malpractice system, which provides compensation for injured patients without the need to prove negligence (or fault) and which, in exchange, bars patients from suing doctors for damages. Doctors in New Zealand are extremely unlikely to be sued for damages as a consequence. And, secondly, because the previous Commissioner claimed to favour the rehabilitative approach to complaints over the disciplinary approach.²⁰ The rehabilitative alternative to discipline was introduced into New Zealand in the mid-1990s, resulting in a drop in the number of (punitive) disciplinary proceedings and a corresponding rise in the number of (non-punitive) performance reviews and educational programmes.²¹ Doctors in New

Zealand are very unlikely to face disciplinary proceedings or even a review of their performance in their practising lifetime.

Doctors benefit from practising in such a (non-punitive) environment by paying low indemnity premiums compared to doctors in (more punitive) tort-based malpractice jurisdictions. They also benefit because, unlike typical doctor liability insurance schemes, under New Zealand's compensation scheme the cost of treatment injury compensation is spread among all tax payers (not just doctors).²²

Whether or not New Zealand's regulatory environment is non-punitive, however, surely depends on how one defines punitive. The *New Zealand Oxford Dictionary* defines punishment as:

"the act or an instance of punishing; the condition of being punished; the loss or suffering inflicted in this."²³

This definition suggests that punishment can be both that which is dealt (the penalty) and that which is felt (the suffering). Evidence suggests that New Zealand's accountability processes do make doctors suffer (do punish) irrespective of the outcome of these processes. Although the Commissioner (and sometimes also patients) might intend complaints be used for learning not lynching,²⁴ evidence suggests that the effect of complaints on doctors is more lynching than learning.²⁵⁻²⁷ Likewise, although the Medical Council's performance review process is intended to be rehabilitative rather than punitive, it is generally accepted that most doctors do suffer, or feel punished, when Council recommends their performance be reviewed. The process is the punishment.

The idea that the process is the punishment is not new. Malcolm Feeley studied cases going through the lower courts in the US in the 1970s and published his landmark research in 1979 as *The Process is the Punishment*.²⁸ Feeley found that, for smaller scale crimes, the pre-trial process often served the function of punishing the defendant and, in many cases, exceeded the post-trial sanction or sentence imposed by the

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judge. Feeley's finding (that punishment was inflicted prior to a finding of guilt and by those other than the judge) went against the judicial ideal: a fair trial, a finding of guilt, and then the dealing out of punishment.²⁹ The complaints process, and the Council's rehabilitative processes, can work in a similar way: the process can punish, and often in excess of any sanction ultimately imposed.^{30,31}

New Zealand's regulatory system is punitive, then. Not only is it punitive, the punishment is not directed towards only those who deserve to suffer (and be punished). Although the Medical Council's performance review process might target only those who pose a risk of harm (although this is not established), research suggests that complaints, while not entirely arbitrary, are not directed towards only those who cause avoidable harm and who therefore, perhaps, ought to

it matter if New Zealand's regulatory system is punitive? Does it matter if doctors are justified, or self-indulgent, when they cry 'Woe is me'? It might matter if, as the Institute of Medicine believes, the fear of punishment is providing a barrier to patient safety and inhibiting doctors from sharing their mistakes and learning from each other.

To date, however, there is no evidence to suggest that New Zealand's punitive regulatory environment is inhibiting openness and learning or fostering a culture of blame in primary care settings. The culture in these settings has never been assessed. Furthermore, there are no tools designed to measure safety culture in these settings, although a UK safety culture tool has recently been adapted and tested in New Zealand general practices.³³ Although it is not possible to say definitively what the culture in primary care

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suffer and be punished.³² Complaints are directed towards both good and bad doctors and, regardless of a complaint, we all feel the presence of the complaints system. A general practitioner colleague of mine described feeling as if the Commissioner was "always there, sitting on my shoulder watching". While this might be a good thing, as the internalised presence of the Commissioner might motivate better performance and prevent unobserved doctors from lowering their level of care, the complaints system nevertheless asserts its disciplinary influence and takes its toll.

Does a punitive regulatory environment matter?

We must, of course, have processes in place to hold doctors to account. If these processes punish doctors and make them suffer, then so be it. Does

settings is, sociological research suggests there is more likely to be a culture of understanding and forgiveness than a culture of blame.³⁴⁻³⁸ Fox argues that the permanent uncertainty of medical practice and the necessary human fallibility (to err is human) leads to a shared sense of vulnerability among doctors (there but for the grace of God go I). This in turn leads to understanding and forgiveness rather than criticism, accusation and blame. Doctors might blame themselves, or even blame the patient, but they are likely to forgive their colleagues.³⁹

A punitive regulatory environment might not matter, then, if the alleged culture of blame (and fear of punishment) is not the barrier to patient safety. The barrier to patient safety might be something other, such as a stubborn attachment to atavistic superstitions:

“He tried to impose the latest ideas at Misericordia Hospital, but this was not as easy as it had seemed in his youthful enthusiasm, for the antiquated house of health was stubborn in its attachment to atavistic superstitions, such as standing beds in pots of water to prevent disease from climbing up the legs, or requiring evening wear and chamois gloves in the operating room because it was taken for granted that elegance was an essential condition for asepsis.”⁷⁴⁰

Although we might no longer believe that elegance is an essential condition for asepsis, we might hold a stubborn attachment to some other, as yet unrecognised, atavistic superstition. Who knows, even the belief that a ‘lack of awareness exists because... personnel fear they will be punished’ may one day prove to be such an atavistic superstition. Regardless, if we are not to be distracted from our common goal of improving patient safety, it will be necessary to come to a greater understanding of each other and to avoid belittling the suffering of others. While legal academics might consider punishment to be dealt (after a fair process to determine whether any suffering is due) and call our system non-punitive, doctors know that punishment, or suffering, is what they feel and so call the system punitive and cry ‘woe is me’.

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