



Health practitioner experience of Health and Disability Commissioner investigations

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ABSTRACT

INTRODUCTION: The New Zealand Health and Disability Commissioner (HDC) Act 1994 was designed to protect the rights of consumers and provide a fair, simple, speedy, and efficient resolution to complaints. No recent studies have been published about the health practitioner experience of HDC investigations following a patient complaint, and none that include nurses and midwives.

AIM: To use a restorative inquiry framework to understand the impacts and needs of health practitioners arising from an event that led to an investigation by the HDC during the last 10 years.

METHODS: A descriptive qualitative approach was used with data collected using semi-structured interviews with doctors, nurses, and midwives ($n = 13$). The data were analysed using thematic analysis.

RESULTS: Participants worked in primary care, aged care, and services provided by public hospitals. The emotional impacts arising from the event and investigation were profound, with long-lasting effects on participants' sense of self, reputation, and how, or if, they continued to practice. Participants indicated a need for support from colleagues and employers, a fair and relational investigation process, and a meaningful way of connecting to put things right.

DISCUSSION: A shift to a restorative approach whereby people involved in a complaint come together to speak truthfully about what happened and its impact on their lives, offers hope for a process that repairs relationships and improves health services. Restorative approaches clarify accountabilities and could lead to more satisfactory outcomes for all parties. This study contributes to emerging thinking about the use of restorative approaches in health-care contexts.

KEYWORDS: Organisational culture; adverse events; occupational stress; medical error; patient safety; qualitative research.

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Introduction

The World Health Organization estimates that globally, one in ten patients will experience harm from the health care they receive.¹ The rate is higher (13%) for patients admitted to hospitals in New Zealand.² Although not all harm results in a complaint and poor practice may not result in harm, consumers of health and disability services are entitled to complain. Following the recommendations of the Cartwright Inquiry,³ the Health and Disability Commissioner (HDC) Act 1994

established a Commissioner who would protect the rights of consumers and provide a fair, simple, speedy, and efficient resolution of complaints. The Code of Health and Disability Services Consumers' Rights Regulations 1996 (the Code) outlined the 10 rights of consumers and the corresponding duties of service providers.

The process on receipt of a complaint is that the Commissioner makes a preliminary assessment to decide if a breach of the Code might have occurred

WHAT GAP THIS FILLS

What is already known: Health and Disability Commissioner investigations produce powerful, long-lasting negative emotions for doctors that lead to reduced clinical confidence, more defensive medicine, and damage to doctor–patient relationships. There appear to be few overall improvements to patient care.

What this study adds: Health practitioners need support and a fair and relational approach to investigations that lead to meaningful ways of putting things right. A relational approach to justice using restorative practices offers a process that clarifies accountabilities, with potentially more satisfactory outcomes for all parties, including positive improvements to health services.

and if further action will be taken. A range of options are available under the Act, including taking no action, referral to the relevant registration authority, calling for a mediation conference, and investigating the complaint further. The annual reports of the Commission show that investigations are initiated in a minority of complaints (5.6% in the year 2019–20) and that restorative approaches, as a type of mediation conference, were adopted in six cases since the performance measure was introduced in 2016.⁴

The procedure for a formal investigation involves notifying the provider and seeking a response, accessing the relevant clinical notes, and relaying the provider's response to the consumer for comment. The parties may be interviewed, expert clinical opinions are sought, and the Commissioner drafts a provisional opinion to which the consumer and provider(s) are invited to respond. If the provisional opinion is that the Code was breached, the provider is likely to respond with an opinion from their own expert to which the Commissioner's expert will comment. A final opinion by the Commissioner is then made on the written evidence submitted.^{5,6} The process may take ≥ 2 years.⁷

There is no criminal liability if a health practitioner is found in breach of the Code, but they may be required to comply with recommendations and ongoing monitoring of competence by the relevant registration authority. Or, at the discretion of the Commissioner, a health practitioner can be referred to the Director of Proceedings who decides if

charges will be laid before a Health Practitioners Disciplinary Tribunal, although this happens relatively rarely.⁴ The Tribunal may impose a fine and court costs, but compensation for patient injury arising from treatment can only be met by New Zealand's unique no-fault Accident Compensation Corporation (ACC) scheme.

A series of New Zealand publications report the impact of patient complaints and the complaints process on doctors during the early to mid-2000s.^{8–18} The emotional impacts reported were of anger, depression, shame, guilt, and loss of the 'joy of practice', and for one in ten, these feelings persisted for some time. The experience contributed to less trust of patients, less confidence, and more defensive medicine. The damage of a complaint to the doctor–patient relationship extended to other uninvolved patients, and overall led to what was felt to be few improvements to the delivery of patient care.⁸ Other surveys from New Zealand^{19–21} reiterate many of these findings. No research was found concerning nurses or midwives in New Zealand.

The international literature about clinicians following an adverse event reports a wide range of persistent negative psychological responses and feelings.^{22–28} Described as second victims in this literature, clinicians were concerned about their ability to work safely and effectively, how they were perceived by others, and were embarrassed about seeking psychological support.²⁹ Burnout was common, as were emotional outbursts and exhaustion, and avoiding areas of patient care after an error.²³ Difficulty sleeping was common, as was reduced job satisfaction,²⁵ absenteeism, contemplation about leaving the profession,³⁰ and even psychiatric illness and suicide.²² As 'second victims', a term coined to indicate the clinician is an additional victim to the patient,³¹ they were at increased risk of providing suboptimal care and committing further errors.²⁵

The literature about whether the needs of consumers are met through the complaints process in New Zealand is sparse, especially if the Commissioner exercises discretionary powers and discontinues a complaint, as happens in one-third of complaints received.⁴ Consumers want to be asked about their needs, to be heard, to find out what

happened from the people involved, to ensure that what happened is never repeated, that people responsible are held to account, and that there be some means of restoration for financial and non-economic losses.^{32,33} These findings resonate with reports of Australian consumer experiences of open disclosure following adverse events.³⁴

Consumer needs are remarkably similar to needs addressed in restorative approaches to justice. Similar to care provided in health settings, restorative practices are constituted by relationships and responsibilities that focus on addressing human needs.³⁴ A restorative approach holds equal concern for people harmed and people responsible, bringing the parties together for a facilitated dialogue that focuses on harms, needs and repair.³⁵

The focus of this research is not on consumers or their needs. The needs of consumers who have experienced harm are acknowledged and we also acknowledge that other than in extremely rare instances, health practitioners intend the very best care for their patients.³⁶ When things go wrong, they too suffer. Health practitioners' needs are the focus of this research. The aim was to use a restorative inquiry framework to understand the impacts and needs of health practitioners arising from an event that led to an investigation by the HDC. The restorative inquiry framework asked three questions: What happened?, What are the impacts? and What are the needs of clinicians? A recent application of the framework to a health context in New Zealand is the response to harm caused by surgical mesh.³⁷ In this article, a relational approach to justice is proposed, whereby people involved come together to speak truthfully about what happened and its impact on their lives, to clarify accountability, and to resolve together how best to repair relationships and prevent further harm.³⁵

Methods

The study design was qualitative and data were collected using semi-structured interviews conducted by the principal researcher (JW). Purposive sampling was used to recruit health practitioners who had been investigated by the HDC in the last 10 years. Advertisements were placed in newsletters published by professional organisations with a health practitioner readership. Interested readers

contacted the researchers directly for more information and before consenting to participate. Thirteen interviews lasting 60–90 min took place via Zoom or in person between June 2019 and April 2020. Transcripts were returned to participants for checking and to ensure de-identification amendments were adequate for protection of privacy. The data were analysed using the six-phase iterative thematic analysis technique described by Braun and Clarke³⁸ and aided by qualitative data analysis software (QSR NVivo 12). Research ethics approval was granted by the Human Ethics Committee of Victoria University of Wellington (#0000027518). The findings are organised to address the three questions commonly used in restorative processes: What happened?, What are the impacts? and What are the needs of clinicians?

Results

Participants

Eleven women and two men participated in this research. All had considerable clinical experience. Their locations were geographically spread throughout New Zealand. Table 1 shows the type of health practitioner participants and their practice settings. Outcomes of the HDC investigations are shown in Figure 1. During or following the investigation, three chose not to renew their registration, and one was dismissed from their position 2 years before closure of the HDC investigation (this employer was also found in breach by the Commissioner).

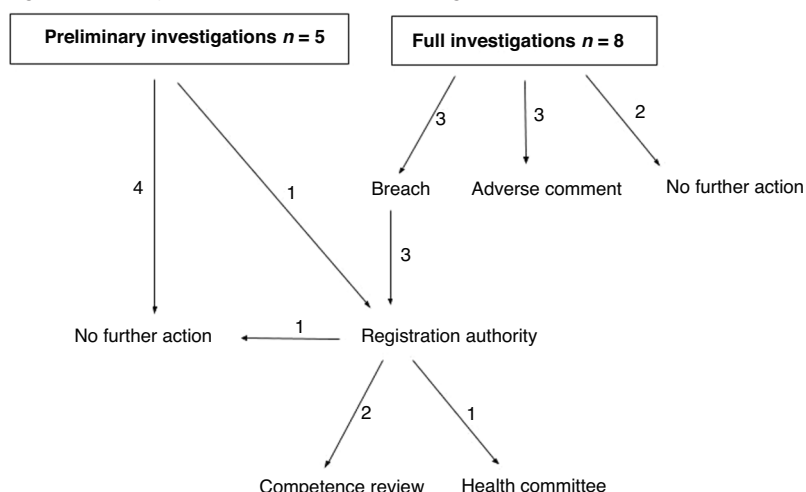
What happened?

All events leading to a consumer complaint to the HDC occurred within the previous 8 years. Preliminary investigations took 2–4 months and concerned five patient complaints largely related to administrative or communication matters. Full investigations took 2–8 years for completion and concerned one minor adverse clinical outcome and seven severe or major adverse clinical outcomes, although four of these were not directly related to the care provided. Issues highlighted by the Commissioner related broadly to patient assessment, documentation, and communication with the patient or team. Table 2 lists the events that led to a patient complaint.

Table 1. Participant characteristics: type and practice setting

Health practitioners	n	Practice setting	n
General practitioner (GP)	4	Primary care	5
Registered nurse (RN)	5	Aged care	1
Midwife (MW)	2	Public hospitals	
Medical specialist (SP)	2	Specialist clinic	1
TOTAL	13	Emergency Department	2
		Birth Unit	2
		Mental Health (community & inpatient)	2

Figure 1. Participant outcomes from HDC investigations.



What are the impacts?

Emotional impacts

The participants in this study were not immediately aware that patients they had treated were dissatisfied with their care or had experienced an adverse clinical outcome (an 'event'). News may have come informally over the next few days or weeks from police or coroner enquiries, or months or years later on receipt of a letter from the HDC about the complaint laid. Learning of a severe or major adverse clinical outcome for a patient in their care was devastating:

'I knew it was a terrible outcome whether he died or didn't die. And I was absolutely floored and mortified and devastated and stressed right from the minute I got that email from my colleague that night. It was awful, absolutely awful, just awful.' [specialist (SP) 2]

Irrespective of the magnitude of the event, these feelings were soon followed by self-doubt ('fertilising that seed of doubt in myself' [general practitioner (GP) 2]), vulnerability ('extremely vulnerable to anything that could possibly go wrong' [registered nurse (RN) 4]), and shame ('initially very embarrassed and ashamed' [GP1]). These emotions and others persisted for some participants for many years after the original event and well after the case had been closed by HDC. Four years after the investigation had closed, one participant said:

'I thought I'd dealt with it, but probably haven't. Well, I know I haven't, so it's made me realise that I need to go and seek some professional help about it.' [GP 2]

Table 2. Events that led to a patient complaint

Provision of information about a possible medical treatment
Referral following episodes of chest pain
Treatment of sinusitis
Refusal to prescribe a controlled drug
Provision of a vaccine
Failure to order an x-ray before treatment
Omission of a differential diagnosis
Assessment of a head injury
End-of-life care
Assessment of a mental health patient
Failure to assess a patient
Care of a pregnant woman
Communication with the team

Table 3. Emotional impacts

Emotions experienced	Participant example
Avoidance	'I avoid thinking about it and I avoid looking at any information about it.' [RN 4]
Shame, self-doubt, lacking confidence	'You just don't feel as though you are a good clinician certainly, you feel like you are a bad clinician. That is the way that I was made to feel, very much so.' [RN 3] 'If I had been found in breach and had lost my registration... the shame. That... I actually can't think of anything worse. Yeah, everything about that ... that would have been terrible.' [RN 5]
Fear, anxiety, panic, sleep disturbance	'I didn't sleep; it just consumed me for a period of time.' [SP 1] 'I actually felt quite distressed and anxious about [doing the same procedure again] after I got this letter saying this is what you have done.' [RN 2]
Stress, anger	'Definitely makes you pretty stressed and grumpy... initially you're angry with yourself ... [you've] let yourself down.' [GP 1]
Self-recrimination, regret, rumination	'That to me was the very worst thing. It was like, oh my god, how can I do this job if I missed something so critical? I don't think we missed something but it leaves you thinking that we must have ... So, what did we miss? We may have missed something – but I don't know what it was – but maybe we didn't miss something. It kind of messes with your ability to trust your intuition or your instincts or your assessment process ... I think that's the thing; what did we miss?' [RN 4]
Misunderstood, alone	'I've written down: upset, threatened, shown up, accused, fearful ... angry, throw in the towel, give up, not understood, alone.' [GP 4] 'I was shocked and cried and couldn't believe what the patient had said about me... and I was going – it wasn't like that, no. No, it wasn't like that.' [MW 2]
Stigma, embarrassment	'There was this huge black mark all over my career.' [GP 2] '... at the end of the day, gossip and all that, it always moves with you and there'll always be people that will like to remind you of what happened and what you didn't do. And it's always in the back of my mind.' [RN 1]

Other examples of the emotional impacts reported are in Table 3.

Participants said that each time there was contact with the Commission about the investigation, they re-experienced the emotional impacts engendered by the event:

'I think the length of time that it takes means that you live in a space where you cannot stop thinking about it because at any moment that phone is going to ring or you are going to get an email, or someone is going to knock on your door and they are going to want to ask you another question. And then you are going to rehash the whole thing again.' [RN 5]

Preliminary investigations resulted in no further action, but the emotional impacts were nonetheless significant, also lasting for years in most cases.


Impacts on clinical practice

The outcome of an investigation is based on the written evidence received by HDC and involves

scrutiny of documentation in the patient's clinical record. Subsequent to the investigation, participants reported being more diligent about their documentation, particularly patient examination data, listing differential diagnoses, the rationale for the plan of treatment, and formal consent processes ('I have just become a lot more particular about all that sort of stuff' [SP 2]). Some noted valuable systemic changes that arose from an organisation's internal investigation. Another observed: 'it was quite a good experience in terms of looking at myself' [SP 1].

Other less desirable impacts were about having less trust in the practice of others in the team and repeating patient assessments others had already done ('you start to want to do everything yourself rather than trusting the rest of your team' [GP 1]), practicing more defensively by referring patients to tertiary services ('don't engage in any intellectual thinking or apply my knowledge or my assessment of anybody – just hand it over to somebody else to sort out' [GP 2]) and withdrawal of services ('We certainly decided that we wouldn't take any more young people' [RN 3]).

Table 4. Examples of the range of employer support

Good support 	'I was always made to feel like they believed me, and they always made me feel like they knew I wasn't lying or anything.' [RN 5]
	'I was given time off when it was needed on a few times when the HDC gave me just days to put some responses together. I was too overwhelmed and emotional at those times to be able to work well.' [MW 2]
	'I don't think my manager has ever considered it other than superficially and how it would affect him. I don't think there is any kind of genuine concern or protection at all.' [RN 4]
	'I was told by the director of nursing quite plainly that the service couldn't possibly accommodate or support me and that I was a burden.' [RN 1]
No support	'It was almost like I'd been dropped like a hot coal to be honest, never had any contact at all.' [MW 1]

Expertise was lost when participants left their profession or speciality area of practice. Midwives chose not to renew their midwifery registration; an RN chose to work as a health-care assistant; other RNs reduced the number of hours they worked or moved to completely different clinical speciality areas or types of organisations. A GP withdrew from clinical practice but remained in quality improvement.

What are the needs of clinicians?

Support

Support was the most important need participants identified. Colleagues, some employers, lawyers, and to a lesser extent, family, provided support. Current or past colleagues, preferably from their own discipline, provided reassurance and perspective, especially if they had been involved in an investigation themselves.

Despite the shame participants associated with being investigated, some reported an overwhelming desire to talk about the event. There was a strong need for vindication from their colleagues about treatment decisions:

'I had to hear from multiple, multiple, multiple people that the decisions I made were the right decisions.' [SP 2]

Nurses and midwives described fewer collegial networks than the medical participants, and had less access to colleagues with knowledge about hospital and HDC investigation processes. Support from their employers varied widely (Table 4). Employer support assumed less importance for self-employed GP participants if they had supportive business partners.

Most participants appreciated the support they received from the legal counsel provided by their indemnity insurance. These lawyers helped to demystify the investigation process. Communication took place mostly by telephone or email.

Justice needs

Participants were generally unfamiliar with the HDC process, but expected it would be fair and that the principles of natural justice would be observed. They spoke, however, of having to prove their innocence ('you're guilty and you've got to prove yourself innocent' [GP 2]), of an HDC preference for the opinions provided by expert advisors ('the opinion of the expert was repeated over and over again without any attention being paid to my response in relation to her evidence, especially her contradictions' [Midwife (MW) 2], and of not being heard.

The written format of the participants' defence reinforced the sense that they were not heard. They found it hard to convey in writing the wider context of care provision, the attempts made to negotiate with patients or other staff, and the nuance of clinical encounter. For example, a RN laboured over hundreds of pages of written explanation about the dilemma she and her colleagues experienced as they navigated the tension between providing best practice care and respecting the wishes of a patient, yet still felt unheard and misunderstood:

'We worked really, really hard at ways we could keep him pain-free, but he was driving his care. We were really confident that that was the way he wanted it – and that is the bit they didn't seem to get.' [RN 3]

Participants were unprepared for the adversarial nature of the legal process, which most found more distressing than the event itself. Many were dismayed by the assumptions made about their intentions and character. There were few opportunities to clarify:

‘They said I was trying to cover it up ... they accused me of adjusting my notes and challenging me that I was trying to falsify the notes... [but] I had no idea that six months down the track this lady was going to put in a complaint about me, so why would I have done that?’ [MW 2]

Putting things right

As investigations come to an end, the Commissioner recommends that personal formal apologies (which were often already provided) be written by health practitioners to patients or their families. Some participants were eager to apologise, others were sceptical about its worth (‘I basically caused harm to this patient and was told to write a nice sorry letter’ [GP 1]); another thought a worthwhile apology should ‘convey emotion and feeling [but that is] quite difficult ... and not the sort of letter that gets written to HDC’ [GP2]; and another was irritated by the expectation:

‘I was really peeved that I was expected to apologise for something that [the Commissioner agreed] was clinically acceptable management.’ [GP 3]

Where real harm had occurred, and without personal contact, a written apology seemed an inadequate means to restore the relationship or put things right. Even when fault was not at question, any sense of human connection, understanding and forgiveness was lacking.

Without adequate resolution, the emotion of past events remained present in the participants’ lives. Despite expressed trepidation, some participants indicated a desire to connect directly, in a facilitated meeting, which might bring closure for both parties. A GP participant thought a conversation with a patient might go something like this:

‘[I would] probably say that I could understand why she wrote the letter [to HDC] and why she was upset with me, and I have taken onboard that there were some things I could have done

better. But [to ask,] ‘How are you now?’ ... And in an ideal world she’d interact a bit rather than just saying, ‘See you later’. Yeah, that’d be good. And I wouldn’t be worried about a face-to-face if that was organised.’ [GP 4]

Discussion

Since the research undertaken in the early to mid-2000s about the impact of patient complaints and the complaints process on doctors in New Zealand,^{8–20} this is the first study to include nurses and midwives. Consistent with the impacts reported in earlier research and of the health practitioner experience of adverse events found in the international literature, the participants in this study reported the HDC investigation had profound, long-lasting emotional impacts on their sense of self, their reputation, and how, and even if, they continued to practice. Support, especially from colleagues, provided reassurance that they were trusted professionals^{11,13} and helped to restore their identity as healers.^{22,39,40} In contrast, employer protocols for immediate, ongoing and long-term support, including ways of addressing the sense of shame felt by practitioners for having failed to live up to the standards expected of them,¹⁷ were absent and likely contributed to a loss of workforce and clinical expertise.^{24,41}

Apology was the only formal means available to put things right, but participants generally thought it a meagre offering and were frustrated by the lack of personal connection with patients. New Zealand research about patient experiences following adverse events found that apologies should be tailored to the needs of patients.³³ They should be timely, contain an acceptance of responsibility, be offered in person, in a culturally appropriate way, after the provider has listened carefully to the patient’s story, their needs, and answered their questions. Written apologies should not replace verbal apologies.⁴²

Participants had anticipated their justice needs would be met through human connection – to be listened to and heard – but instead found the investigation focused on written facts, truth-finding and accusation. Notwithstanding the technical status of the Commissioner’s opinion being, for the most part, legally inconsequential,⁵ they placed high

importance on the authority of the decision due to potential disciplinary action and the impact on reputation and livelihood. Rather than an investigation of *the event* that led to a patient complaint, their experience was of being *personally* investigated, despite there being distinctly separate legal processes for that purpose.

Although this is a small qualitative study and would benefit from data about the consumer experience of the HDC investigation process, we suggest that the findings indicate the value of a shift to a relational approach to justice with a focus on addressing human needs.³⁵ Facilitated dialogue with patients was among the changes proposed to the complaints system in New Zealand >15 years ago¹⁰ and fit well with the restorative inquiry framework used in this research. The focus would change from: Which right has been breached?, who is responsible for the breach?, and what sanction will be applied? to: What happened?, what impacts have there been?, and what is now needed to repair the harms and prevent further harm? Such approaches have been reported as empowering for health practitioners because they help them to uncover and work to prevent systemic vulnerabilities.⁴³ They also provide the empathetic and supportive context necessary to relieve shame and restore self-respect. These processes are increasingly supported by the Health Quality Safety Commission in relation to adverse events⁴⁴ and could be incorporated into existing regulatory structures.

Conclusion

This study found there has been little change to the experience of being investigated by the HDC since research conducted >15 years ago. A relational approach to justice using restorative practices, whereby involved parties come together to speak truthfully about what happened and its impact on their lives, offers hope for a process that clarifies accountabilities, repairs relationships, and leads to potentially more satisfactory outcomes for all parties, including positive improvements to health services.

Competing interests

The authors declare no competing interests.

Data Availability Statement

The data that support this study cannot be publicly shared due to ethical or privacy reasons.

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References

1. World Health Organization. Patient safety. Geneva: WHO; 2019. [cited 2021 February 10]. Available from: <http://www.emro.who.int/entity/patient-safety/index.html>
2. Davis P, Lay-Yee R, Briant R, et al. Adverse events in New Zealand public hospitals: occurrence and impact. *N Z Med J*. 2002;115(1167):U271.
3. Committee of Inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital and into other related matters. The report of the cervical cancer inquiry. Auckland: Government Printing Office; 1988. [cited 2021 February 10]. Available from: <https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/legislation/cervical-screening-inquiry-0>
4. Health and Disability Commissioner. Annual report for the year ended 30 June 2020. [cited 2021 May 27]. Available from: <https://www.hdc.org.nz/media/5696/hdc-annual-report-2020.pdf>
5. Skegg PDG. A fortunate experiment? New Zealand's experience with a legislated code of patients' rights. *Med Law Rev*. 2011;19(2):235–66. doi:10.1093/medlaw/fwr010
6. Paterson R. The patients' complaints system in New Zealand. *Health Aff*. 2002;21(3):70–9. doi:10.1377/hlthaff.21.3.70
7. Macdonald N. Complaints rise, two-year wait on health watchdog investigations. *Stuff* 2018, October 8. [cited 2021 February 10]. Available from: <https://www.stuff.co.nz/national/health/107635591/complaints-rise-twoyear-wait-on-health-watchdog-investigations>
8. Cunningham W. The immediate and long-term impact on New Zealand doctors who receive patient complaints. *N Z Med J*. 2004;117(1198):U972.
9. Cunningham W. New Zealand doctors' attitudes towards the complaints and disciplinary process. *N Z Med J*. 2004;117(1198):U973.
10. Cunningham W. The medical complaints and disciplinary process in New Zealand: doctors' suggestions for change. *N Z Med J*. 2004;117(1198):U974.
11. Cunningham W. The impact of complaints on medical professionalism in New Zealand. *N Z Med J*. 2005;118(1219):U1592.
12. Cunningham W, Crump R, Tomlin A. The characteristics of doctors receiving medical complaints: a cross-sectional survey of doctors in New Zealand. *N Z Med J*. 2003;116(1183):U625.
13. Cunningham W, Dovey S. The effect on medical practice of disciplinary complaints: potentially negative for patient care. *N Z Med J*. 2000;113(1121):464–7.

14. Cunningham W, Dovey S. Defensive changes in medical practice and the complaints process: a qualitative study of New Zealand doctors. *N Z Med J*. 2006;119(1244):U2283.
15. Cunningham W, Tilyard M. The Queenstown report: proposals for change in the medical disciplinary complaints process. *N Z Med J*. 2003;116(1170):U358.
16. Cunningham W, Wilson H. Shame, guilt and the medical practitioner. *N Z Med J*. 2003;116(1183):U629.
17. Cunningham W, Wilson H. Complaints, shame and defensive medicine. *BMJ Qual Saf*. 2011;20(5):449. doi:10.1136/bmjqs.2011.051722
18. Cunningham W, Wilson H, Tilyard M. Mistakes, errors and wrongdoing. *N Z Med J*. 2001;114(1145):559.
19. Jarvis J, Frizelle F. Patients' complaints about doctors in surgical training. *N Z Med J*. 2006;119(1236):U2026.
20. Tapper R, Malcolm L, Frizelle F. Surgeons' experiences of complaints to the Health and Disability Commissioner. *N Z Med J*. 2004;117(1198):U975.
21. Stuart T, Cunningham W. The impact of patient's complaints on New Zealand dentists. *N Z Dent J*. 2015;111(1):25–9.
22. Kable A, Kelly B, Adams J. Effects of adverse events in health care on acute care nurses in an Australian context: a qualitative study. *Nurs Health Sci*. 2018;20(2):238–46. doi:10.1111/nhs.12409
23. Lewis EJ, Baernholdt M, Hamric AB. Nurses' experience of medical errors: an integrative literature review. *J Nurs Care Qual*. 2013;28:153–61. doi:10.1097/NCQ.0b013e31827e05d1
24. Mira JJ, Lorenzo S, Carrillo I, et al. Lessons learned for reducing the negative impact of adverse events on patients, health professionals and healthcare organizations. *Int J Qual Health Care*. 2017;29(4):450–60. doi:10.1093/intqhc/mzx056
25. Quillivan RR, Burlison JD, Browne EK, et al. Patient safety culture and the second victim phenomenon: connecting culture to staff distress in nurses. *Jt Comm J Qual Patient Saf*. 2016;42(8):377–86. doi:10.1016/S1553-7250(16)42053-2
26. Rinaldi C, Leigheb F, Vanhaecht K, et al. Becoming a "second victim" in health care: pathway of recovery after adverse event. *Rev Calid Asist*. 2016;31:11–9. doi:10.1016/j.cali.2016.05.001
27. Bourne T, De Cock B, Wynants L, et al. Doctors' perception of support and the processes involved in complaints investigations and how these relate to welfare and defensive practice: a cross-sectional survey of the UK physicians. *BMJ Open*. 2017;7(11):e017856. doi:10.1136/bmjopen-2017-017856
28. Bourne T, Vanderhaegen J, Vranken R, et al. Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data. *BMJ Open*. 2016;6(7):e011711. doi:10.1136/bmjopen-2016-011711
29. Joesten L, Cipparrone N, Okuno-Jones S, Dubose E. Assessing the perceived level of institutional support for the second victim after a patient safety event. *J Patient Saf*. 2015;11(2):73–8. doi:10.1097/PTS.0000000000000060
30. Edrees HH, Wu AW. Does one size fit all? Assessing the need for organizational second victim support programs. *J Patient Saf*. 2021;17:e247–e54. doi:10.1097/PTS.0000000000000321
31. Wu AW. Medical error: The second victim. The doctor who makes the mistake needs help too. *West J Med*. 2000;172(6):358. doi:10.1136/ewjm.172.6.358
32. Bismark M, Dauer E. Motivations for medico-legal action: lessons from New Zealand. *J Leg Med*. 2006;27:55–70. doi:10.1080/01947640500533317
33. Moore J, Mello MM. Improving reconciliation following medical injury: a qualitative study of responses to patient safety incidents in New Zealand. *BMJ Qual Saf*. 2017;26(10):788–98. doi:10.1136/bmjqs-2016-005804
34. Iedema R, Sorensen R, Manias E, et al. Patients' and family members' experiences of open disclosure following adverse events. *Int J Qual Health Care*. 2008;20(6):421–32. doi:10.1093/intqhc/mzn043
35. Marshall C. Justice as care. *Int J Rest Justice*. 2019;2(2):175–85. doi:10.5553/IJRJ/258908912019002002001
36. Ameratunga R, Klonin H, Vaughan J, et al. Criminalisation of unintentional error in healthcare in the UK: a perspective from New Zealand. *BMJ*. 2019;364:1706. doi:10.1136/bmj.1706
37. Wailling J, Marshall C, Wilkinson J. Hearing and responding to the stories of survivors of surgical mesh: Ngā korero a ngā mōrehu – he urupare (A report for the Ministry of Health). Wellington, New Zealand: The Diana Unwin Chair in Restorative Justice, Victoria University of Wellington; 2019. [cited 2021 May 27]. Available from: <https://www.health.govt.nz/publication/hearing-and-responding-stories-survivors-surgical-mesh>
38. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101. doi:10.1191/1478088706qp063oa
39. Berlinger N. Avoiding cheap grace: Medical harm, patient safety, and the culture(s) of forgiveness. *Hastings Cent Rep*. 2003;33(6):28. doi:10.2307/3527823
40. Berlinger N, Wu AW. Subtracting insult from injury: addressing cultural expectations in the disclosure of medical error. *J Med Ethics*. 2005;31(2):106–8. doi:10.1136/jme.2003.005538
41. Seys D, Scott S, Wu A, et al. Supporting involved health care professionals (second victims) following an adverse health event: a literature review. *Int J Nurs Stud*. 2012;50(5):678–87. doi:10.1016/j.ijnurstu.2012.07.006
42. Prothero MM, Morse JM. Eliciting the functional processes of apologizing for errors in health care: developing an explanatory model of apology. *Glob Qual Nurs Res*. 2017;4:1–9. doi:10.1177/2333393617696686
43. Dekker S, Breakey H. 'Just culture': improving safety by achieving substantive, procedural and restorative justice. *Saf Sci*. 2016;85(C):187–93. doi:10.1016/j.ssci.2016.01.018
44. Health Quality & Safety Commission [HQSC]. Learning from adverse events: adverse events reported to the Health Quality Safety Commission, 1 July 2018 to 30 June 2019. [cited 2021 February 10]. Available from: <https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Learning-from-adverse-events2019-web-final.pdf>