Lifting the veil of secrecy in the health sector: the New Zealand experience

HQSC Transparency Open Forum, 10 March 2020
Ron Paterson, University of Auckland
MINISTRY OF HEALTH GIVE COVID-19 UPDATE
NEW ZEALAND'S THIRD COVID-19 CASE CONFIRMED
Roadmap

Cartwright and informed consent
Disclosure after an adverse event
Patient experience and health system quality
Complaints & discipline
Official Information Act and surgical mortality
Increasing transparency
How Cartwright changed it all...
Cervical Cancer Inquiry – 1988

The Report of the Cervical Cancer Inquiry
1988

Dame Silvia Cartwright
NUMBER OF MEDICAL MISTAKES SHAKES UP COUNTRY

DON'T WORRY... WE'VE DOUBLE-CHECKED EVERYTHING ABOUT YOUR OPERATION. THERE'LL BE NO MISTAKES TODAY, MR. COLLINS.

MY NAME'S SMITH!

STAYSkal
99 TAMPA TRIBUNE
Death tally understates problem

Figures cannot be used to compare hospitals because of differing procedures

by Martin Johnston health reporter

The landmark acknowledgement that preventable mistakes killed 40 public hospital patients in one year understates the problem and it may well be at least two years before a more reliable count can be made.

The Government-appointed Quality Improvement Committee yesterday released the first national tally of serious and sentinel events at district health boards, following requests by the Herald and other media for details of the harm to patient.

The responses of individual boards covering hundreds of cases over several years include the death of a newborn baby at Waikato Hospital after independent midwives allegedly failed to request medical help quickly enough, delayed cancer diagnosis at Auckland City Hospital, and the death of a Waitemata patient with low blood pressure after delayed diagnosis of a gastric ulcer.

The major preventable events reported by the committee for the past five years or actually harmed 162 patients and included 40 deaths. They were among more than 800,000 patients treated at public hospitals that year.

Revealing the figures, which show Auckland DHB had the most events, at 161, officials said they could not be used to compare hospitals, because boards defined and reported events differently and cared for patient populations with varying degrees of complexity.

Committee head and Auckland board chairman Pat Snedden said the figures did not show his DHB was the worst.

"It has one-fifth of all hospital activity nationally and it has the highest complexity. It has advanced reporting systems, and that contributes to your number of events."

He said it was hoped to have a standardised national system of reporting such events in place by July 2008.

HOSPITAL ERRORS

Some of the most serious mistakes made by district health boards

Northland

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>Suicide of discharged psychiatric patient.</td>
</tr>
<tr>
<td>2003/04</td>
<td>Suicide of psychiatric patient on leave.</td>
</tr>
</tbody>
</table>

Waiheke

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>Patient dies from brain bleed after fall from trolley.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Intensive care patient dies from underdosed respiratory disease.</td>
</tr>
</tbody>
</table>

Auckland

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>Elderly patient falls from bed, receives fatal head injury.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Patient prescribed wrong medication, dies.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Skull opening initially performed on wrong side. Patient OK.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Skull opening initially performed on wrong side. Patient OK.</td>
</tr>
</tbody>
</table>

Counts Manukau

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>Surgical forces left in patient after operation.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Best home resident admitted with bed clot on brain.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Diabetic with leg ulcers and cellulitis dies.</td>
</tr>
</tbody>
</table>

Waitakere

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/05</td>
<td>Heart patient (myocardial infarction) dies while on cardiac monitor.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Emergency department patient sent home, dies within 6 hours.</td>
</tr>
<tr>
<td>2003/05</td>
<td>Emergency department patient discharged, dies within 48 hours.</td>
</tr>
<tr>
<td>2003/06</td>
<td>Baby born in breach birth, died soon after.</td>
</tr>
</tbody>
</table>

Star-rating for hospitals could lift standards

League tables comparing the safety of hospitals are said to be a way of reducing the number of patients harmed through medical care. The idea is that hospitals will all strive for high ratings, and that they will push aside secondary interests.
DIRECT COMPARISONS BETWEEN DHBS ARE NOT MEANINGFUL DUE TO DIFFERENT CASE-MIX, CONTEXT AND SERVICES PROVIDED

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Accepted treatment injury claims</th>
<th>Number of discharges</th>
<th>Accepted claims per 10,000 discharges</th>
<th>Percentage of discharges accepted as treatment injury claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>564</td>
<td>142,485</td>
<td>39.50</td>
<td>0.40%</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>203</td>
<td>60,042</td>
<td>34.14</td>
<td>0.34%</td>
</tr>
<tr>
<td>Canterbury</td>
<td>440</td>
<td>121,991</td>
<td>36.07</td>
<td>0.36%</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>574</td>
<td>70,194</td>
<td>81.77</td>
<td>0.62%</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>533</td>
<td>118,341</td>
<td>45.04</td>
<td>0.45%</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>128</td>
<td>41,317</td>
<td>30.93</td>
<td>0.31%</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>322</td>
<td>37,536</td>
<td>85.78</td>
<td>0.86%</td>
</tr>
<tr>
<td>Lakes</td>
<td>92</td>
<td>29,036</td>
<td>31.68</td>
<td>0.32%</td>
</tr>
<tr>
<td>MidCentral</td>
<td>227</td>
<td>39,312</td>
<td>57.74</td>
<td>0.58%</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>268</td>
<td>31,456</td>
<td>85.20</td>
<td>0.85%</td>
</tr>
<tr>
<td>Northland</td>
<td>283</td>
<td>46,876</td>
<td>60.37</td>
<td>0.60%</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>115</td>
<td>14,510</td>
<td>79.26</td>
<td>0.79%</td>
</tr>
<tr>
<td>Southern</td>
<td>240</td>
<td>67,716</td>
<td>35.44</td>
<td>0.35%</td>
</tr>
<tr>
<td>Taranaki</td>
<td>65</td>
<td>11,269</td>
<td>57.63</td>
<td>0.58%</td>
</tr>
<tr>
<td>Taranaki</td>
<td>251</td>
<td>32,359</td>
<td>71.67</td>
<td>0.79%</td>
</tr>
<tr>
<td>Waikato</td>
<td>681</td>
<td>112,213</td>
<td>65.69</td>
<td>0.61%</td>
</tr>
<tr>
<td>Waikatoa</td>
<td>107</td>
<td>10,338</td>
<td>103.50</td>
<td>1.04%</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>390</td>
<td>126,466</td>
<td>30.64</td>
<td>0.31%</td>
</tr>
<tr>
<td>West Coast</td>
<td>29</td>
<td>7,158</td>
<td>40.51</td>
<td>0.41%</td>
</tr>
<tr>
<td>Whanganui</td>
<td>154</td>
<td>17,608</td>
<td>67.46</td>
<td>0.87%</td>
</tr>
</tbody>
</table>

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Dashboard of health system quality: New Zealand
Let's get real on medical complaints

In this country [doctors] are well-protected, possibly to a fault.

Safe health system depends on close scrutiny, openness

IN REPLY: Bill Garden says doctors must accept and acknowledge that their work will sometimes be subject to criticism.

Who would disagree with the need for responsible journalism? And, yes, when something goes wrong it does not always result in a failure by medical practitioners. As Health and Disability Commissioner Ron Paterson indicates, they, too, have feelings, and they, too, have to live with the outcomes of investigations.

But what caught my attention in Mr Paterson's article was his reference to this country facing a medical workforce shortage, and ‘hostile media publicity’ being a factor cited by doctors giving up practice.

He followed this up, however, by saying that most media reporting of health was positive. What, then, was his purpose in putting the medical profession in such a poor light, perhaps, seeking to manipulate?

Professional or other doctors have given up practising medicine because of hostile media publicity? It is just so easy to pull statements out of context, and then hang them there, waiting to do damage.

When members of the public go to the Health and Disability Commissioner or to the press they are entitled to be heard. For them, finding the support, the resources, the energy and the will to take on such a well-liked and respected professional body is the right thing to do.

The Press is, of course, the only place to go. For myself, approaching the media was a last resort. I had spent months trying to get the hospital to talk to me directly, and was told that the only contact possible from the Health and Disability Commissioner that my claims were untrue was through a complaint against me, which related to the death of my daughter Amanda at Middlemore Hospital in 1990, had been settling for a number of months.

I now find myself in the same position as before, but this time it is the media who turn a deaf ear and refuse to listen to the truth.

And, of course, should car salesman, politicians, lawyers or whoever not be given the same protection.

Bill Garden, of Takapuna, complained about the care of his 21-year-old daughter, Amanda, at Middlemore Hospital.

The Health and Disability Commissioner criticised South Auckland Health for the way the family were treated.

BILL GARDEN said his daughter became severely ill when she was involved in an accident. The Health and Disability Commissioner later found South Auckland Health had failed to maintain a high standard of care. His daughter died.

I am sure that the medical ethics codes of this country are tough against working where the environment is deemed unsafe because of inadequate resources, where people are knowingly practising in an unprofessional manner, where systems are not in place, or where there are no defined processes. In other words, the safety of the patient is deemed paramount.

That does not include doctors having done their absolute best, and the result being different from what they had expected to achieve.

Most of us are pretty reasoned, and where the medical profession is dealing with unreasonable people, safety barriers appear to be in place to ensure that doctors are protected. Where there are no barriers, the body of doctors, and more particularly the body of junior doctors, is placed in a most deplorable position.

And I can understand why doctors are sensitive when others do not have the same forethought about what to report and what not to report, and how long it is before the medical profession is interviewed about what is wrong.

And how does a political ideology fare in this environment? It is another important element because often the failure is not that of the practitioner but the ideology under which they have to work. Often clinicians are aware of this and the only way they can get to the public is through the media.

And, of course, should car salesman, politicians, lawyers or whoever not be given the same protection.
An elderly man was force-fed Milo by untrained caregivers. He later died after being left for four days with dangerously low blood sugar levels. The nurse responsible has not been named.

Why the secrecy?

The WATCHDOG charged with checking complaints against doctors has defended his office against claims it operates under unnecessary secrecy. Opposition MPs want the Health and Disability Commissioner (HDC) to publicly identify doctors, midwives and other health practitioners who he finds guilty of breaching the code of consumers' rights.

The call follows the case of a rest home nurse found guilty of professional misconduct after leaving a diabetics man to slowly die in the care of untrained staff.

The 69-year-old spent four days unconscious, unable to eat and generally in poor health with a dangerously low body temperature after a week of falling blood sugar levels. He died on September 24, 2003, three days after he was taken to hospital.

In a decision just released by the Health and Disability Commissioner, it was found the man could have been saved by an ambulance which was called even 45 minutes sooner.

Six days before his death, the man's blood sugar dropped below the dangerous hypoglycaemic level at which Diabetes New Zealand says patients need to be fed sweet food or drink immediately.

Untrained caregivers force-fed him Milo and repeatedly rang the local public hospital before being transferred by helicopter to the intensive care unit at a city hospital last day.

He never regained consciousness. The commissioner found the nurse was in breach of the medical code for failing to monitor the man's blood sugar levels for proper care. The nurse has been ordered to pay $10,000 in legal fees, apologise to the man's family and then only work under the supervision of another registered nurse.

Despite the man's death, Health and Disability Commissioner Ron Paterson said being found guilty of a breach did not necessarily mean a practitioner was bad at their job.

He believed they deserved to be able to protect their reputation without negative media publicity blowing their missionary out of proportion.

He said if he was forced to identify guilty practitioners, the system would become litigious and bogged down and "the community as a whole would suffer".

"This is not simply about bolstering or protecting doctors' reputations," he said. "It's actually a systems thing from which all benefit, where complaints will be properly aired and properly resolved and investigated."

The HDC investigated 172 complaints last year and found 71 breaches of the code.

For most breaches, the commissioner publishes a report but does not identify the practitioner, their employer, or the patient.

Significant breaches of the code, he said, are referred to the Director of Proceedings, who can then take action before a disciplinary tribunal or the Human Rights Review Tribunal.

At those hearings, the accused practitioner is usually identified, although the courts often grant name suppression.

Mr Paterson said automatically identifying practitioners who breached the code would not only be "out of kilter with the system" but also be inconsistent with international practice. But National Party health spokesman Tony Ryall said the public rightly expected the disclosure would be the norm.

Practitioners risked damaging their reputations if named, he said.

Act Party health spokeswoman Heather Roy said if the commissioner found a breach, the offender should be identified.

"The public has the right to know whether a practitioner is responsible for a breach they would actually choose to seek medical treatment from," she said.

But patient advocacy groups have been reluctant to criticise how the HDC operates.

Jo Fitzpatrick of Women's Health Action said "fingering one person in isolation within a system that's used to not help patients"

Dr Ross Boswell of the NZ Medical Association, the country's largest medical representative, said the assumption of anonymity made because the HDC was not chargeable with running "a justice system".

For lesser cases that did not need to go to tribunal level, it was reasonable for limited details to be public, he said.

"But it seems an unfair information on the practitioner to publicise their identity when there hasn’t been a public hearing or a thorough investigation, as is the case with most complaints, he said.

HAVE YOUR SAY

Should the names of doctors, midwives and other health practitioners found guilty of breaching the code of consumers' rights be publicly disclosed? We would like to hear your views on this issue.

Please email your opinions to health@nzherald.co.nz
“The affected health professionals ... can take solace from the fact that ... there is no finding by the Coroner that would remotely warrant negative publicity about them ... ‘it is the system not the individuals that require attention’.”

Whata J in Gravatt v Coroner’s Court [2013] HC 390
The Official Information Act 1982

Section 4    Purposes

... (a) to increase progressively the availability of official information for the people of New Zealand ... 

Section 5    Principle of availability

The question whether any official information is to be made available, where that question arises under this Act, shall be determined, except where this Act otherwise expressly requires, in accordance with the purposes of this Act and the principle that the information shall be made available unless there is good reason for withholding it.

“The Act plays a significant role in New Zealand’s constitutional and democratic arrangements. It is essential the Act's meaning and purpose is fully honoured by those required to consider the release of official information.”

Kelsey v Minister of Trade [2015] NZHC 2497 at [156]
Martin Johnston, health journalist
2015: New Zealand Herald OIA request

• Health journalist Martin Johnston made OIA request for data at individual surgeon level from five DHBs
• Also requested numbers of procedures, mortality, complications, raw numbers and rates
• Following refusal, he complained to the Ombudsman
DHBs required to report individual surgeon’s volume data but **not** outcomes (complications, readmissions and mortality data)

MoH and HQSC to provide publicly available, annual updates, from June 2017, on progress towards publication of meaningful quality of care measures (including outcomes data) across specialties by June 2021:

“selection, development and public reporting of quality of care measures (including outcomes data) that:

• **are meaningful to consumers**
• **are meaningful to the clinicians** who provide their care
• **are meaningfully attributable to the clinicians** or service providing that care, and
• **increase the availability of information** to the people of New Zealand.

Ombudsman opinion 402136
Health authorities told they must provide the public with surgical safety records.

Patients may be able to check their surgeons' safety records before going under the knife under new reporting systems to be put in place within five years.