First, do no harm

Misconduct aside, getting medical assistance may not always be good for you. Here is an outline of some recent publications on this topic.

Medical care: a high risk activity?

A report released by the Institute of Medicine of the National Academy of Sciences in the USA estimates that between 44,000 and 98,000 Americans die from medical errors each year – more than the number who die from motor vehicle accidents. According to Dr Kenneth Kizer, former head of the Veterans Administration, it is not surprising that errors occur, given the complexity of health care. 'What is surprising', he said, 'is that health care has lagged so far behind other high-risk activities in risk reduction'.

The authors of a commentary in *The Lancet* noted that errors in the execution of an act (slips of action or lapses of memory) are more likely to occur when people are tired, stressed, distracted or in unfamiliar surroundings – 'almost a caricature of medical life', they wrote.[1]

Training and education alone are unlikely to reduce the incidence of this type of error because they involve defects in unconscious processes (e.g. the unwitting departure from a new protocol to a more familiar one). The authors urged for changes and improvements in the way drugs are prescribed, dispensed and administered to remove some of the factors that impair performance or to detect errors before they cause harm. For example, similarities in drug names or packaging could be changed, and patients could be trained to check their own drugs.

Before any safeguards can be implemented, they wrote, it is essential to gain knowledge of exactly how the current systems work, where and how they may fail and the consequences of such failures. The authors suggested adapting methods of quality control from industry and putting into place effective means for reporting errors and systematically classifying them. In the USA, there is proposed legislation for making the reporting of errors mandatory. The authors proposed that voluntary schemes for detecting and reporting errors be set up without delay.

In an accompanying feature article,[2] Dr Richard Cook, an anaesthetist at the University of Chicago, explained that medical errors are best understood by piecing together the 'second story' – the story that emerges after the 'first story' has faded. First stories are virtually useless when trying to decide how to make a system safer; they focus on cause-and-effect and human error. Second stories reveal subtle weaknesses, invisible on superficial examination, and the steps that human components of a system have taken to cope with those weaknesses.

The article likened the healthcare system to an inverted pyramid. At the broad blunt end are the people who set the policies and enforce the rules. Errors of judgement by these people lie dormant before becoming visible. At the sharp end of the pyramid are doctors and nurses. Their mistakes have immediate consequences but must be viewed in context of the demands and constraints established by the people at the blunt end. All too often, a culprit at the sharp end is found, without examination of the complexities that actually led to the disaster. Dr Cook urges that medical students be taught how to perform new clinical tasks safely. The focus for future research should be not so much on how to prevent failure but on what it is that permits practitioners to be successful so much of the time, he concluded.

Series Editor's comment

While this study and similar ones (the Harvard Medical Malpractice Study, the Quality in Australian Health Care Study) have been criticised methodologically and statistically, especially in quoting whole population figures extrapolated from very small samples, there is a core message best summed up by a phrase originally introduced in the UK's NHS – Clinical Governance. Until recently 'Quality Assurance' has been seen to be a medical or clinical issue whereas 'Risk Management' was seen to be an administrative task. The reality is that they are simply two sides of the same coin and both 'getting it right' (quality assurance) and 'not getting it wrong' (risk management) are clinical responsibilities.

Whiplash: how healthcare providers and lawyers can delay recovery

An insurance system in which financial compensation is determined by the continued presence of pain and suffering provides barriers to recovery. So wrote the authors of a study published recently in *The New England Journal of Medicine*.[3] The authors examined the incidence and prognosis of whiplash

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injury in Saskatchewan, Canada, as that province changed from a tort-based system for compensation to a no-fault system for compensation for traffic injuries.

Under the tort-based system, people could sue for pain and suffering for injuries arising from a motor vehicle accident. Under the no-fault system, claimants are given immediate access to medical care and other benefits without being required to substantiate their injuries. Therefore, there is no financial incentive to delay recovery.

After adjusting for age, sex and initial intensity of pain, the authors found that the prognosis of a whiplash injury could be affected by whether or not a lawyer was involved, and the type of healthcare initially provided. Under both systems of compensation, the involvement of a lawyer was associated with a delay in the time taken for a claim to be closed. According to the authors, time to closure of a claim is a common proxy for recovery in studies of insurance claims for traffic injuries and workers' compensation. Under the tort system, the closure of claims was longer for people who initially consulted a healthcare provider (medical doctor, physical therapist and/or a chiropractor) than for those who did not consult a healthcare provider. Claimants who saw only a physician closed their claims faster than people who consulted a physical therapist or chiropractor – practitioners more likely to intervene. This supports other findings that minimal intervention in the acute period aids recovery, the authors stated.

The authors concluded that a no-fault compensation system for traffic injuries decreases the incidence and improves the prognosis of whiplash injury.

Series Editor's comment

Many would see these results as self-evident, motivated by a general mood in the community focused on fixing the blame (and seeking compensation) rather than fixing the problem. A plaintiff's lawyer of my acquaintance was known to caution all new workers' compensation clients 'Nothing I do for you will achieve any better result – financially and in terms of your life generally – than getting better, and returning to work, as soon as possible.' However, there are perverse incentives in almost all compensation systems. If the claim is challenged, the claimant has a vested interest to maintain the injury and disability until the legal challenge is resolved. Further, in the course of testing a claim, a claimant may be assessed repeatedly by a range of different medical examiners. This repetition first creates and then imbeds ill-health behaviour.

No-one has yet devised a system which has no perverse incentives, but one which does reduce the number of medical examinations is now used in a number of States whereby a medical panel, a quasi-tribunal, determines medical issues, thereby resolving medical disputes. This reduces court time and legal costs, but more importantly reduces the number of times the claimant goes through a medical assessment.

As Convenor of Medical Panels in Victoria's WorkCover system, I am responsible for such a system and can attest to its efficiency, fairness and modest costs. MT

References

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