Dr Chris Moughan

ACC Treatment Injury Centre

Wellington

Dr Brendan Cullen

ACC Treatment Injury Centre

Wellington

Treatment Injuries in Primary Care - Concurrent Workshop Repeated

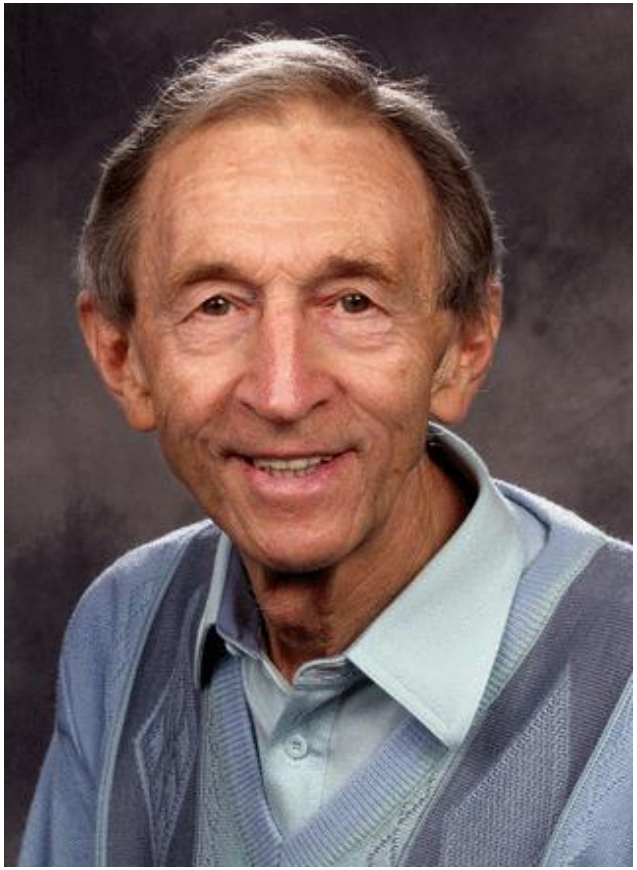
Saturday, 22 June 2013	Start 2:00pm	Duration: 55mins	Kandinsky
	Start 3:05pm	Duration: 55mins	Kandinsky

Treatment Injuries in Primary Care

Presenters:

Chris Moughan
MB ChB, FRNZCGP,
DipObst, DipOccMed

Brendan Cullen
BPhty, MSc



The Father of Family Medicine

Ian Renwick McWhinney 1926 - 2012

"*Over-investigation is perhaps the most common error in medicine today"*

" The prevalence of malpractice suits has a powerful influence on the search strategies of physicians, the effect being to encourage defensive medicine."

Agenda

- Who are we?
- NZ non-tort based legislation
  - Woodhousian principles
  - Who is ACC
- When and how to lodge a claim
- What's being lodged and covered
- Notifications of risk of harm to the public
  - Who, what and why
- General Practice vignettes

Woodhouse principles

USA Tort based	New Zealand – non-tort
Tort – medical negligence by act or omission - courts 15,000 and 19,000 malpractice suits per annum Awards in medical liability cases increased 43 percent in 1999, from $700,000 to $1,000,000 Low morale and widespread concern that ***defensive medicine*** will keep driving up the costs of healthcare in the future	1974 ACC scheme introduced 1992 Medical Misadventure. 2005 TI introduced = aligns with no fault intent of scheme 9,000 claims per annum (approx) **Focus : Client & injury** **Open Disclosure** **Needs Based entitlement**

Who is ACC

- National insurer – social insurance model
  - Net assets: $21,214 million (2012 Annual Report)
  - Outstanding claims liability (OCL): $28,396 million (2012)
  - TI account net assets: $1,779 million/OCL: $3,345 million
- Significant purchaser of health services: (First quarter 12/13)
  - 9% of total claims cost = hospital treatment
  - 17% of total claims cost = medical treatment
  - GP's 22% of total medical treatment costs – consultations down 2% and costs up 3%.
- 2012 1.7 million claims accepted
  - TI = 5,573 - <1% of ACC claims but 4% of long term claims pool
- 2012 claim payments totalled $2.6 billion
  - TI accounts for 4% of ACC spend and 11% of liability
  - ½ of TI liability social rehabilitation for serious injury

Defining Treatment Injury

- Section 32 Accident Compensation Act 2001:
  - **Personal injury** suffered by a person:
  - **seeking or receiving treatment from or at the direction** of 1 or more **registered health** professionals
  - **caused** by treatment
- Physical Injury
  - bodily damage
  - not just symptoms / signs

Inclusions or Exclusions

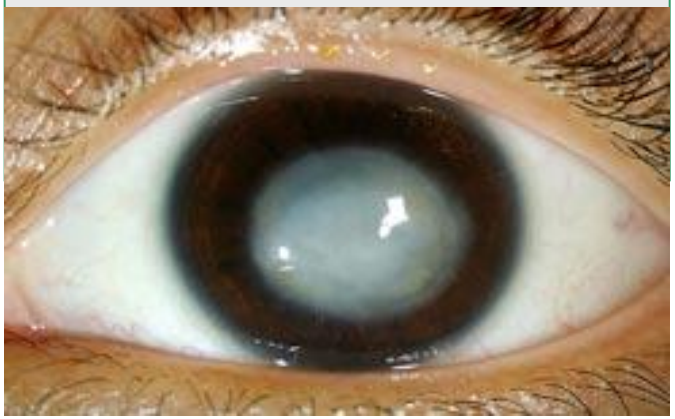
Treatment includes:	***TI Excludes:***
Giving of treatment	*Necessary part of treatment*
Failure / delay to diagnose or treat	*Ordinary consequence of treatment*
Obtaining informed consent	*Withholding / delaying consent*
Application of support systems	*Resource allocation*
Equipment, device or tool failure	*Desired results not achieved*

Process: Key Points

Why lodge claims ??

Fatal Treatment Injury
44 year old male
Failure to diagnose
Influenza A H1N1
-Survivors benefits
-Funeral costs

Drug Reaction
20 year old male
Drug reaction
Blind
- Education support
- Treatment

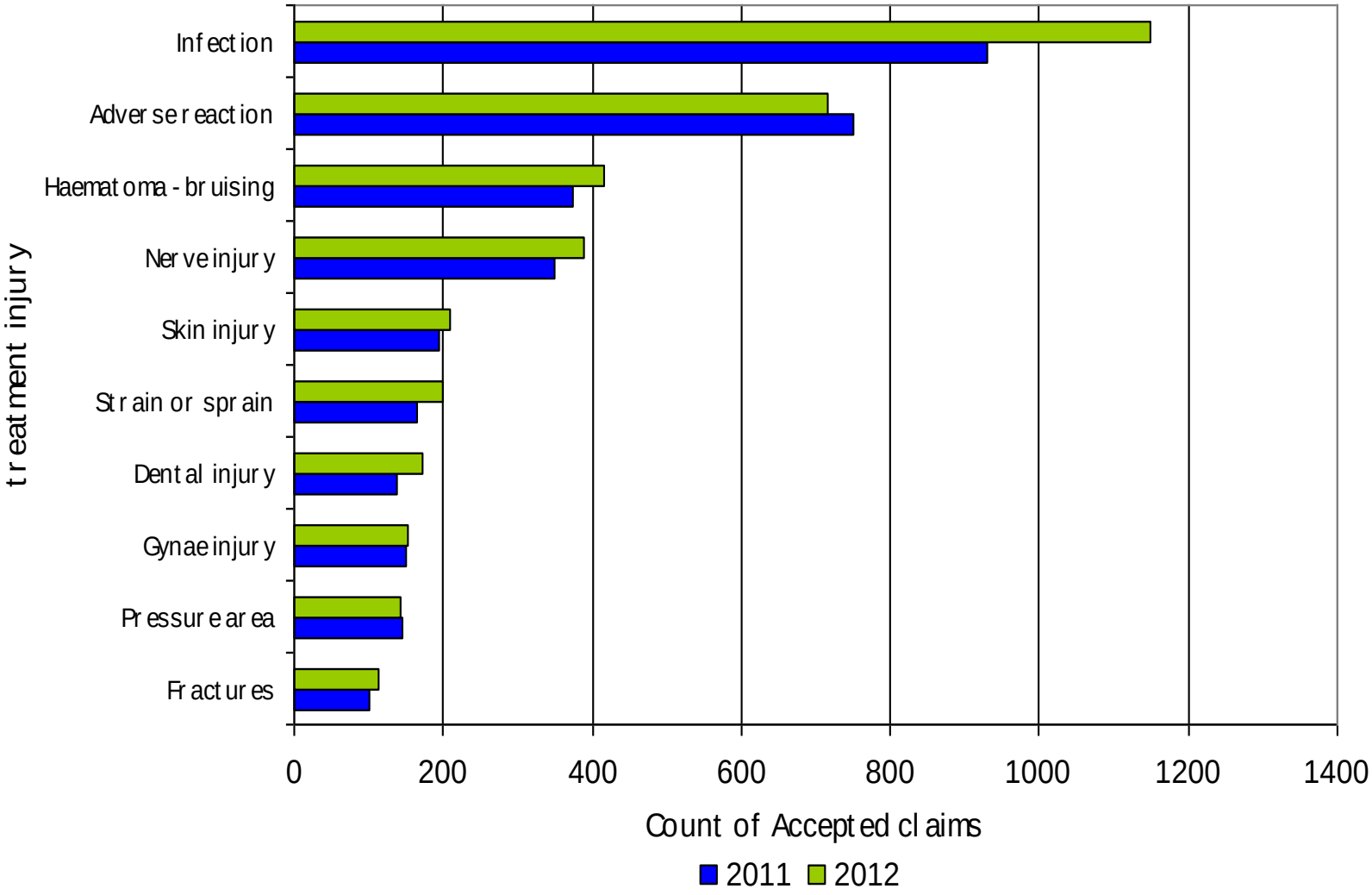


Data: Key Points

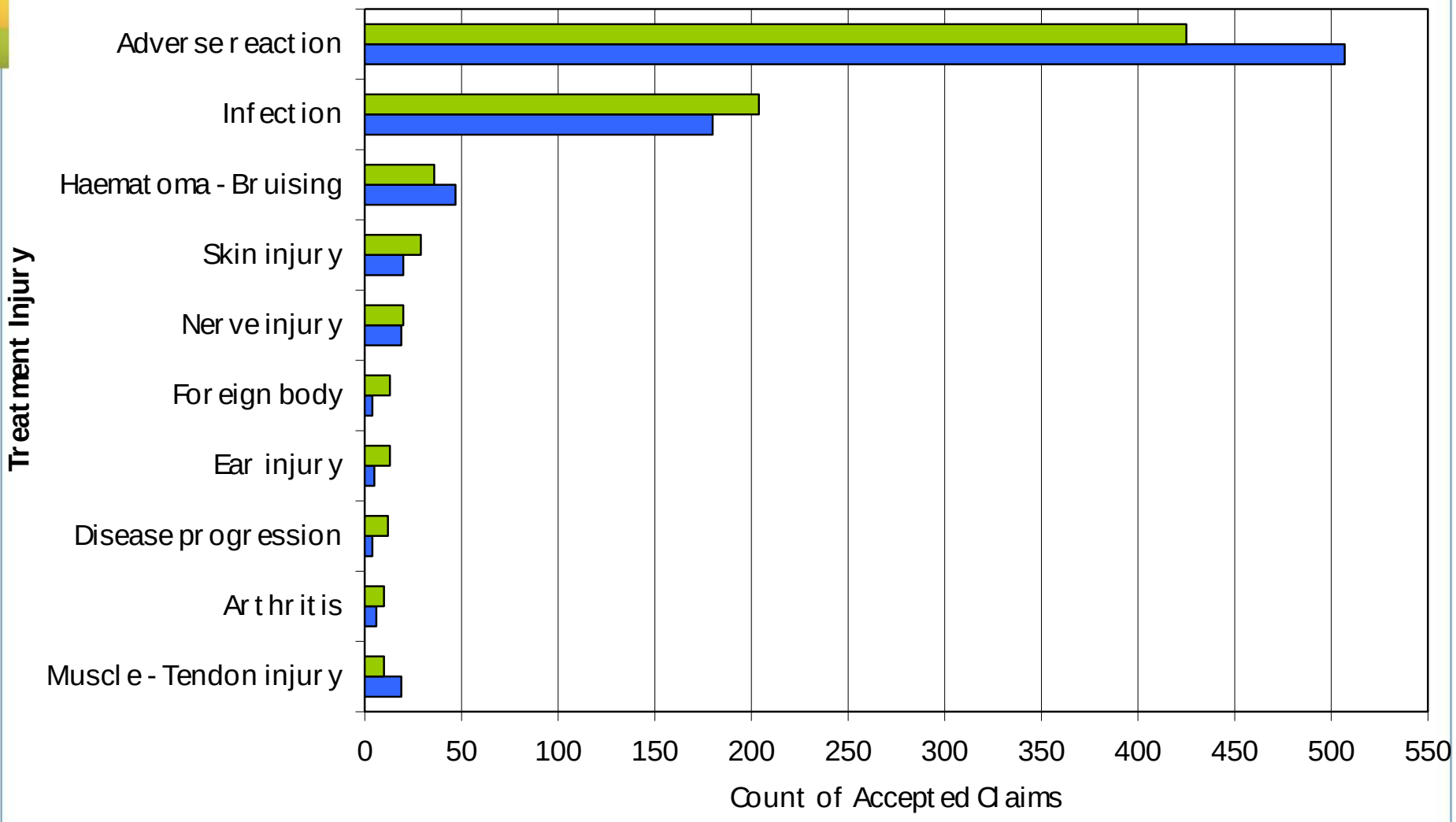
<u>Treatment Injury Data:</u>

- ✗ TI data is not an index for quality
- ✗ TI data only reflects claims lodged

2011 & 2012 National Top 10 Accepted Treatment Injuries



National Top 10 Accepted Treatment Injuries related to General Practice



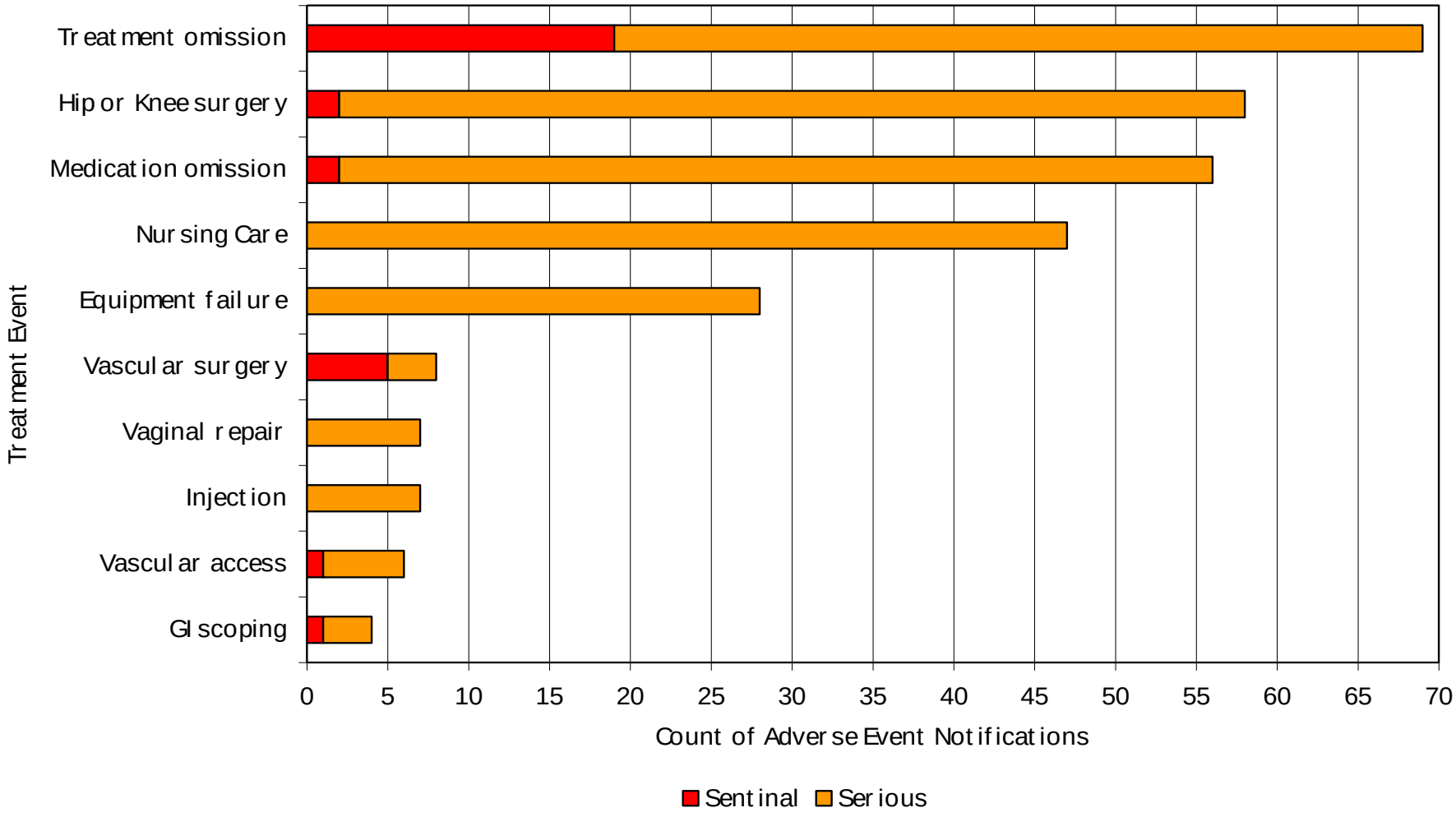
Reporting Belief of Risk of Harm

ACC Statutory Responsibility

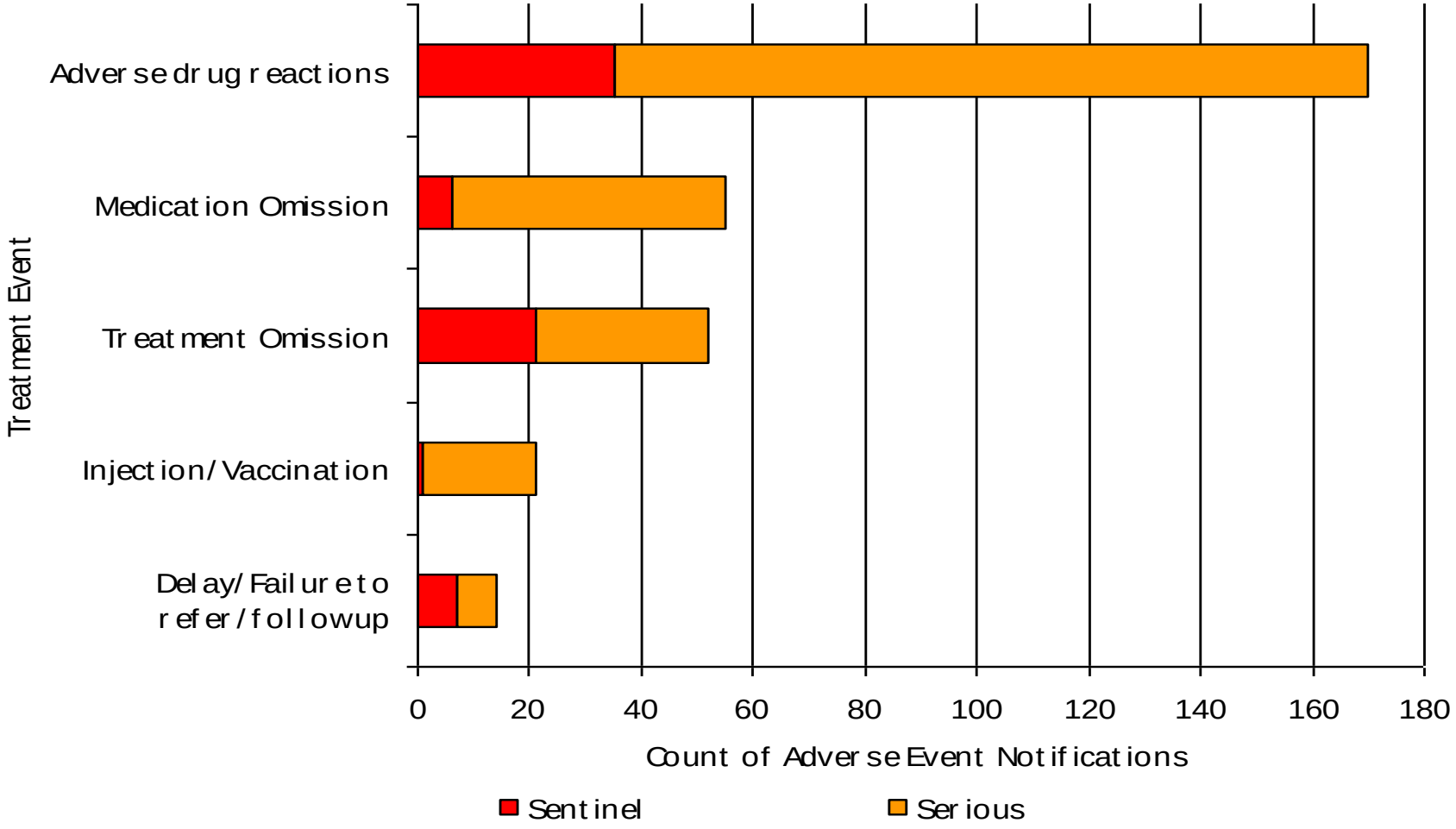
- Section 284: Reasonable belief of risk of harm
  - Use only cover information
  - Review accepted and declined claims
  - Notify Director General of Health (monthly)
    - Facility identifiers only
  - Registration authorities (extraordinary)
    - Must have peer advice
    - Peer advice must be critical of standards
- Sentinel and serious events may be notified

Shouldn't be unknown to facility

National Adverse Event Notifications 2012

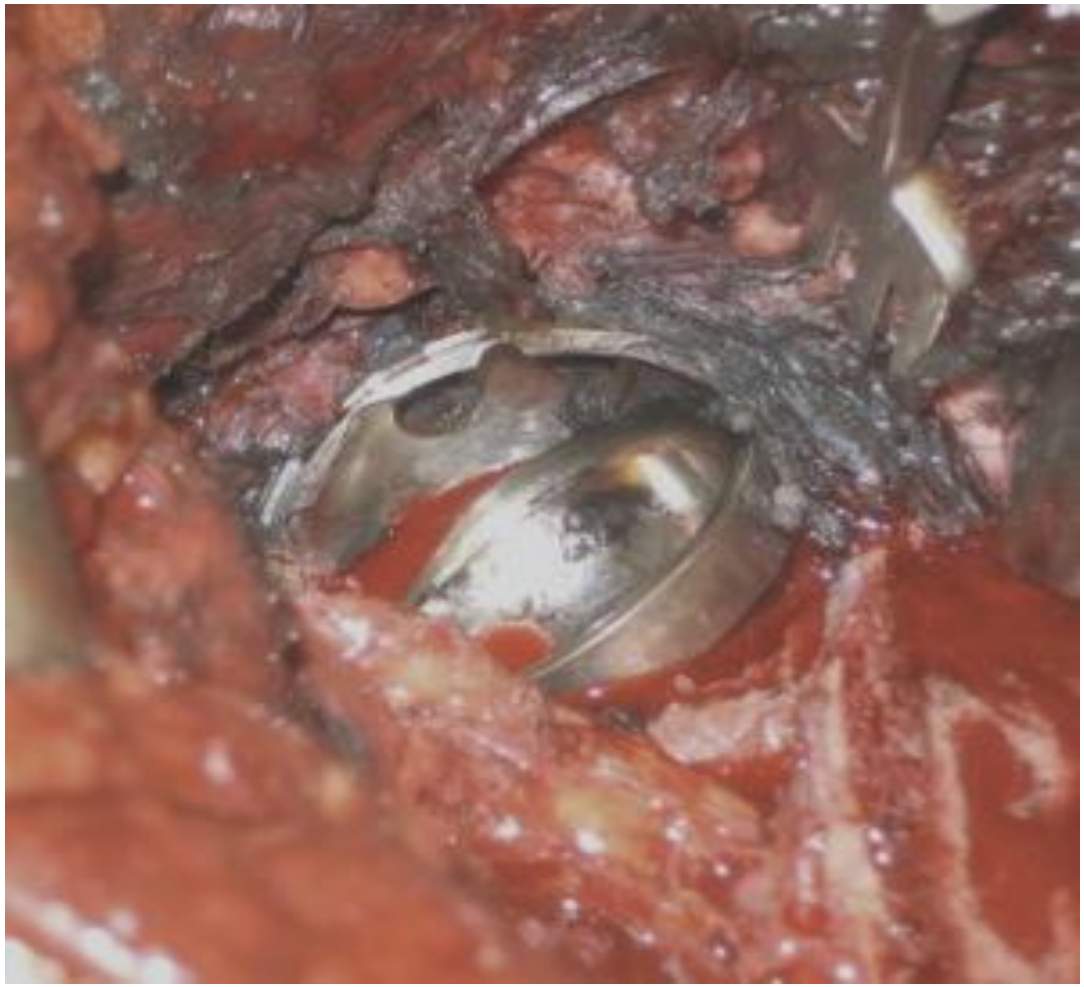


National Primary Care Top 5 AEN's 2005-2012



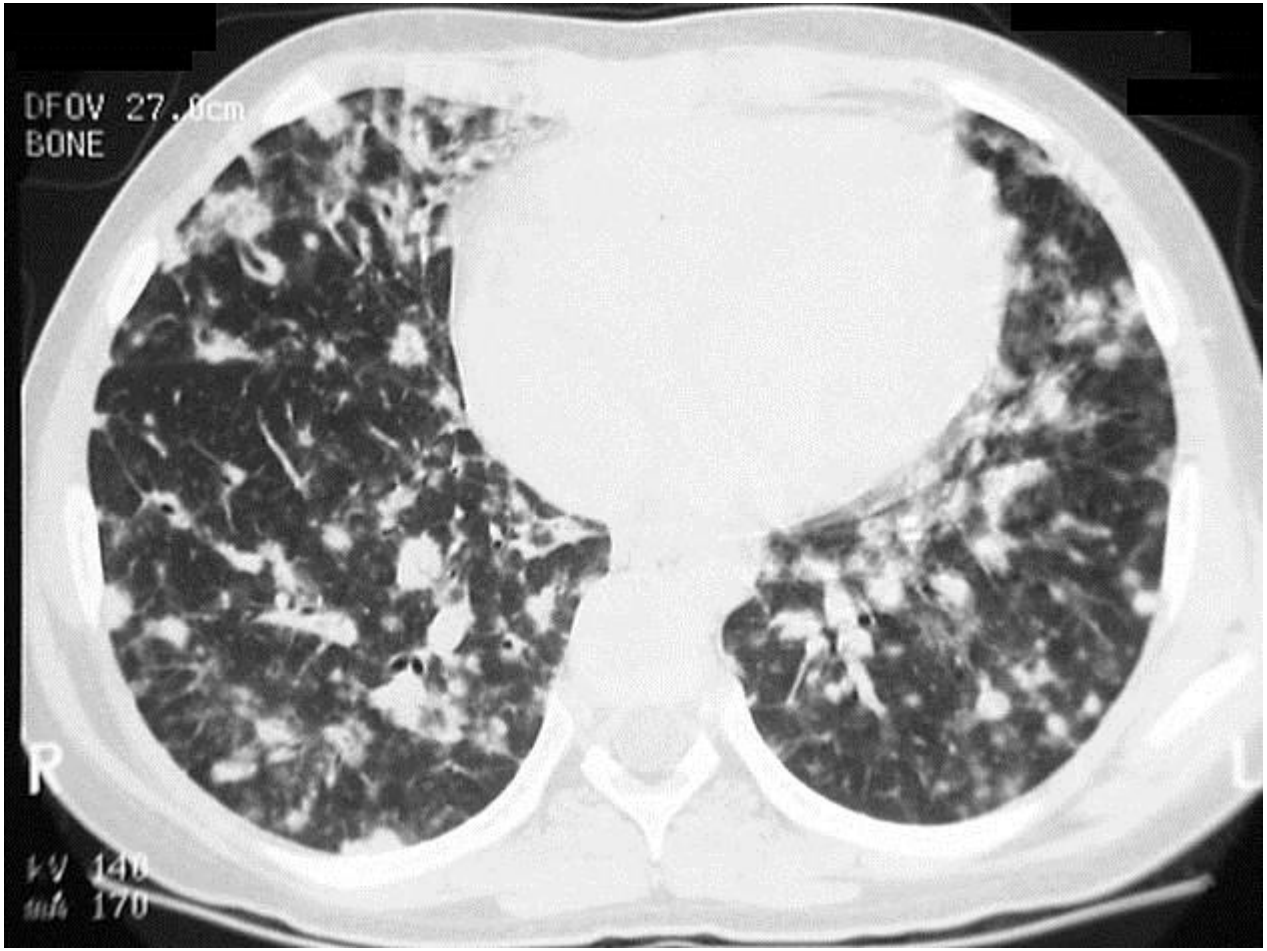
Case vignettes

Metallosis



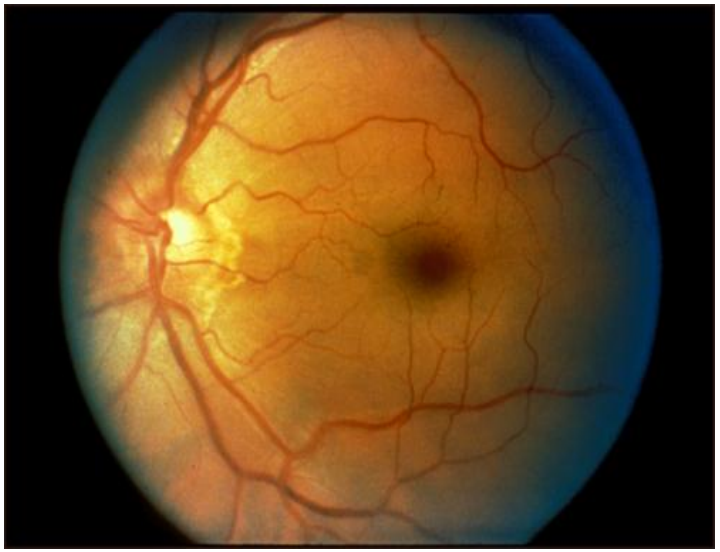
See case study 45 published June 2012

Nitrofurantoin lung disease

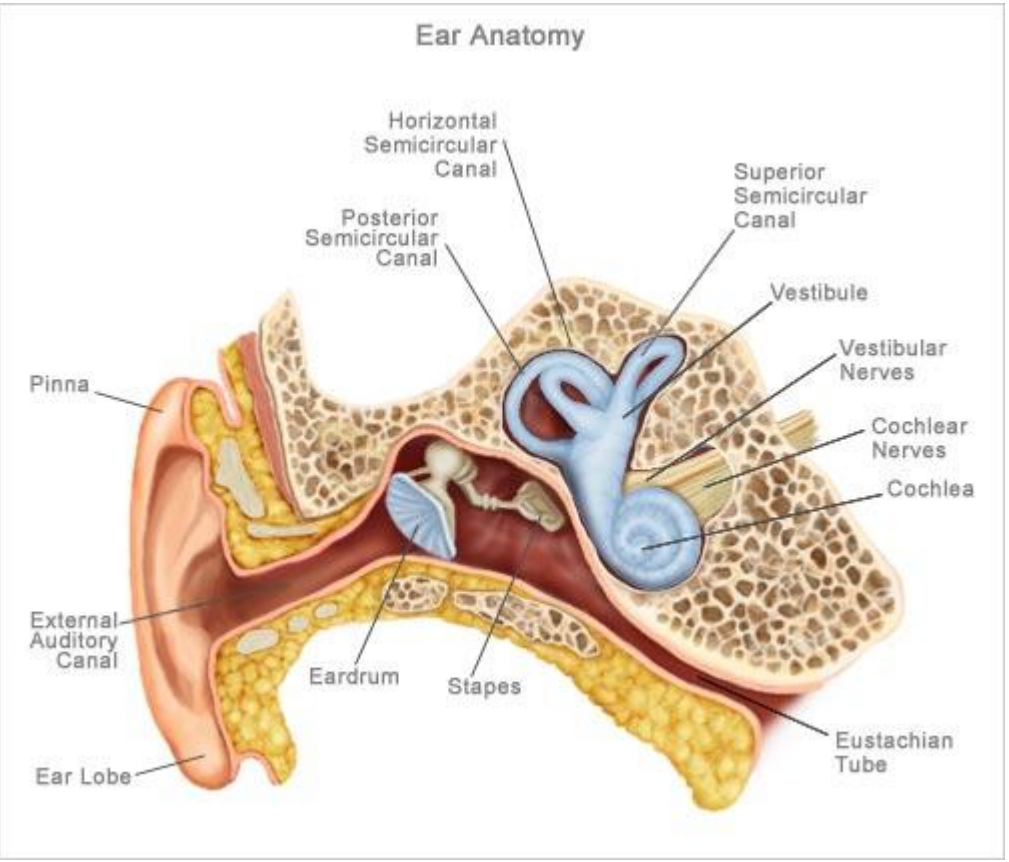


See case study 48 published September 2012

Temporal arteritis



Bobbing Oscillopsia



Bridging Anticoagulation

Appreciate your thoughts ?

Defensive Medicine ?

There is no need for defensive medicine in New Zealand today from a litigation perspective.

William Osler 1849 – 1919

" *I would urge upon you … to care more for the individual patient than for the special features of the disease*…"

(Osler cited by Ian McWhinney, Textbook of Family Medicine, OUP 2009)

And finally….

Providers
- Targeted & appropriate lodgement
- Consent

- ACC
  - Sharing information
  - TI.info@acc.co.nz
  - Case Studies
  - www.acc.co.nz > for providers > clinical best practice > treatment injury case studies

Feedback Welcome

Bio's

- Dr Chris Moughan is Medical Advisor to the Treatment Injury Centre, ACC Wellington. Chris graduated from Otago University in 1976. FRNZCGP 1988. GP and GP Obstetrician, in Hastings from 1980. Chris has also worked in Occupational Medicine from 2000, and has been Medical Advisor to the Treatment Injury Centre from 2007.
- Brendan Cullen graduated with a Bachelors degree from the University of Otago in 2000. After working at Wellington Hospital and in private practice for a few years, he returned to Dunedin and undertook a Masters degree through the Department of Anatomy and Structural Biology, graduating in 2006. He returned to Wellington and continued to work as a physiotherapist and was also involved in research and teaching roles. Brendan joined the ACC Treatment Injury Centre in 2011 as a Clinical Advisor.
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