

Fulfilling the Legacy of Cartwright

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Health and Disability Commissioner

The Groundwork

By the time I took office in October 1994, four years had passed since the Cartwright Report recommended the establishment of an independent health commissioner and a law to enforce patient rights. During this time the Act under which I was appointed had progressed through the legislative process and the health sector had been given a major overhaul. Even at this early stage there was doubt about the Health and Disability Commissioner Act's ability to function as originally envisaged. There was concern that the decision not to place HDC under the wing of the Human Rights Commission would make it vulnerable to pressure from the professions, that the separation of the advocates from the office would impair their effectiveness and that, through the Commissioner's powers of referral, the consumer could lose control of their own complaint. My challenge, in the face of this criticism, was to show how fifty-five pages of black type could be transformed into a powerful tool for consumers of health and disability services.

The process started with the development of the Code of Health and Disability Services Consumers' Rights. Two public consultation rounds attracted over 900 submissions from which the Code was distilled and refined. The Code had its own detractors. The exclusion of the right to free care, or care full stop, was controversial and remains a focus for the critics of the regulation.

In February 1996, the Act and Code received their first major trial by fire when I decided to examine the standard of service at Christchurch Hospital. My decision to investigate was vehemently opposed and indicated even the policy-makers did not understand the enormous breadth of the legislation Parliament had passed. The subsequent judicial review confirmed the Commissioner's ability to act without a specific complaint, to take pre-1 July 1996 events into account if they impacted on a post-1 July complaint, to

look at systems issues and to report on the outcome of an investigation even when I do not find a breach of the Code. The experience of this investigation has taught me to welcome legal challenges. While this High Court decision strongly reinforced the broad scope and considerable power of the Commissioner's legislation, the outcome of any judicial review will develop jurisprudence giving an interpretation and understanding of the Act and its place within the scheme of various protection legislation. The final report on Christchurch Hospital in itself broadened the understanding of the Commissioner's powers to make public comment on any matter affecting the rights of health and disability service consumers and is now being used to examine the overall quality processes and risk management in hospitals throughout the country. It has also been used as a resource by working parties developing new strategies for the sector.

Sector Change and the Code

Over the past eight years we have seen a shift from health as a vocation to health as a business. With this shift has come an increased emphasis on quality service and risk management. This has in some ways opened a perfect opportunity to sell the Code to providers as a quality improvement tool, a blueprint for customer service, and encourage them to incorporate its principles into training programmes and codes of practice. Despite the fact that providers are legally required to inform consumers of their rights and enable them to exercise them, partnership is essential to the ongoing effectiveness of the Code.

Historically, the sector (particularly registered health professionals) was somewhat numbed by the 'big stick' disciplinary approach. It is taking time for providers, both individual health professionals and managers, to realise that they must now be aware of a range of issues when dealing with patients, not just the ones which led

to disciplinary action in the past. In the pre-Code of Rights era, if a professional came under scrutiny from a regulatory body the focus would be on whether or not the service met appropriate standards. This is only one of ten equally important aspects of service delivery demanded by the Code. Complaints such as "the doctor was rude to me" are valid within the Code environment and must be taken seriously both by the professions and by me. Rudeness and arrogance are detrimental to outcomes, as consumers stop listening and participating in the service.

In addition, an investigation by the Health and Disability Commissioner is not simply a dress rehearsal for a professional body hearing. The Code establishes standards in its own right and the Commissioner's opinion (the result of a thorough and impartial fact gathering process) stands regardless of the outcome of any subsequent disciplinary action. To reinforce this, I have recently announced that I will be publishing investigation outcomes more extensively in the future - including names as necessary.

I have also been vocal about the need for similar openness in professional disciplinary proceedings. The Medical Practitioners Act unless otherwise ordered has been amended so that hearings are held in public and name suppression is the exception rather than the rule. However, other legislation needs to be changed, or interpreted in a manner that is appropriate in the new environment of accountability.

In a recent investigation I discovered that a health professional registered under the Nurses Act had been found guilty of professional misconduct on two counts in July 1997. One of the counts was on the grounds of negligence. The case was held in private, name suppression was granted, no case note was published and nothing has been learnt by the profession or public as a result.

New Zealanders need to know how

and why decisions for name suppression are made and, at the very least, the hearings themselves must be in public. The Nursing Council is pushing for its Act to be changed. However, this is not a priority on the government's agenda and, in the meantime, it is my view that public hearings are possible under the current legislation. I am currently pursuing this matter in the High Court to establish an interpretation.

For both registered practitioners and the raft of individual providers and organisations not subject to regulation, the Commissioner's ability to report on the outcome of investigations is an important route to public accountability and education. Any decision to publish the name of a health or disability professional will obviously be carefully weighed up considering the public's right to know, public safety, the individual circumstances of the consumer and provider, the seriousness of the matter and the educative value of publishing details. But the purposes of the Act must be the Commissioner's focus. The Act and the Code exist to protect health and disability consumers, not professionals, and I must do everything in my power to fulfil the purpose of the Act.

New Genies and Old Ghosts

Stretching the shrinking contents of the public purse to meet the increasing needs of New Zealand's ageing population will be a constant challenge for governments of the future. The exact direction our health system takes will depend upon how much of an inherited system successive governments decide (or can afford) to change. The current track is leading towards increased privatisation. Integrated care is being touted as a softer model of the American managed care system. In the States the rise of managed care has been accompanied by a growth in consumer rights movements and a push for associated legislation. In this respect, New Zealand is ahead of the play.

Critics of the Health and Disability Commissioner have stated that the legislation's effectiveness presumes the existence of a state-funded system where access to care is not an issue. True, the Code only applies to services given but it still provides an important 'buffer' against some of the harsher aspects of a commercialised medical environment. It demands that

consumers are provided with information about all the options available to them, not just those provided by a particular plan, which an insurer or practice management organisation believes is good value, or is supplied by a preferred contractor, or subsidised by a particular drug company. Its broad scope means consumers can access the Code's protection regardless of the system within which the service is delivered. Its ability to hold a vast array of health and disability professionals to account – not just those subject to registration – will be increasingly important if current trends towards de-regulation continue. And its clauses concerning continuity of care will guard against gaps in the network of public and private providers, and the barriers between competitors, however complex these interrelationships and tensions become.

Furthermore, while there are new developments which require vigilance, I believe it is a mistake to think that the old demons have disappeared. The fact that my office has received 15,780 enquiries and completed investigations into 1,324 complaints since the Code came into effect in July 1996 is testimony to the fact that most are alive and well. A recent tribunal decision on a case which resulted from one of my investigations also supports this view. The individual involved failed to obtain informed consent. The Tribunal had the option of finding them guilty of an act or omission that was, or was likely to be, detrimental to the patient's welfare, or the more serious charge of professional misconduct. The Director of Proceedings argued that informed consent was fundamental to health practice. Since the Cartwright Inquiry the phrase is well known and understood by the general public and should be permanently imprinted in the consciousness of the professions. It is such a basic concept that failure to obtain it should surely amount to misconduct. However, the Tribunal did not agree with this reasoning, found the professional guilty of the lesser charge and granted name suppression. Such decisions stress the need for consumer law which must incorporate full public reporting.

Even more importantly, the Commissioner is not intended as an auditor for the sector but a watchdog. Issues such as the decision to privatise ACC, policy moves to descriptive rather than prescriptive legislation, and ma-

ior restructuring within the sector, the Ministry, the HFA and providers tend to increase complaints to the Commissioner. The sector must be aware of the impact of process change on consumers and how this drives complaints. Certainly the Commissioner's funding is not sufficient to meet current demand let alone any increase. One way to destroy this legislation would be to inundate the Commissioner with individual complaints. This would limit the Commissioner's ability to undertake large systemic reviews and influence the sector overall.

Conclusion

In New Zealand we are extremely fortunate to have a regulation protecting consumer rights within the health and disability sector. At a recent international medico-legal conference in Europe, I discovered three other countries in the world have such rights in law. However, they were much more limited than ours and did not cover the disability sector. New Zealand's legislation is extremely comprehensive. It is significant that our legislation and expertise is being drawn upon to develop the US Federal Bill of Consumer Rights and Responsibilities.

In the immediate future, my next major task is to undertake a review of the Act and Code. When submissions were being accepted on the draft Code a number were received in relation to the Act. I do not want legal technicalities to prevent submissions from being taken into account, hence the decision for a joint review. It will be interesting to see what slant submissions take. During the original Code consultation process I was amazed at the homogenous nature of the comments received. Going through the anonymous quotes in the proposed draft Code document it is almost impossible to attribute them to a provider or consumer. I hope the experience of the Code in action has not polarised opinion and that the same will for continuing change is still present on both sides.

I commenced the role of Commissioner with a strong belief in the power this legislation gave to consumers to effectively have their say in ensuring they received quality health and disability services. However, I have never underestimated how hard this would be. When announcing the release of the draft Code I said "One of the most difficult things for me over

the next 12 months will be keeping consumers aware that all their expectations can't be met. People need to understand that the world can't change overnight. This is a method of doing it slowly through the system, rather than banging heads together to get quick responses which doesn't re-

ally create long term change." This statement is still relevant today. Attitudinal, long term change takes time. My office has been the focus of an enormous amount of expectation from individuals, interest groups and the media, both in terms of the issues I am able to address and the time and

resources it should take me to do so. Despite this pressure, the legislation is successfully fulfilling the legacy of the Cartwright inquiry - transforming individual tragedy into systemic change to ensure mistakes are not repeated and the lessons benefit all.

Article

Virtuous Doctors or Virtuous Patients?

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My title is deliberately provocative, and will at once raise questions in your minds about my sense of proportion. Isn't 'virtue' a very elitist word, suggesting somewhat smug people, who see themselves a cut above the ordinary mortal? And why expect doctors to be 'virtuous'? Isn't it enough that they are dutiful, conscientious in their care of patients? Even worse, how dare we impose the demand to be virtuous on the sick - isn't it hard enough just to be a patient, without having to be a virtuous one as well?

These questions are understandable reactions, but they represent a misunderstanding of the place of virtue in moral theory, and so in medical ethics. By paying attention to virtue we are shifting our attention from questions of right action to questions of enduring human character. Modern moral philosophy, influenced by the Judaeo-Christian tradition, has focused on the question: How should I act? But Virtue Ethics, in both its ancient and its modern forms, seeks answers to a different question: How should I *live*? In answering this latter question, virtue ethics has to describe specific human excellencies of character or behaviour to which individuals or social groups should aspire.

The modern revival of interest in such questions may be traced to Alasdair MacIntyre's *After Virtue* (1984). In this work MacIntyre argued that the post-Enlightenment project of achieving moral agreement through a shared set of rational principles is a manifest failure. Our supposed rationality is itself socially and historically determined and the liberal ideal of toleration,

rather than achieving consensus, has merely revealed the incompatible diversities of the modern age. As a result, what were formerly prized for themselves as human goods (for example, the seeking of knowledge for its own sake, or the practice of a craft for its inherent satisfaction) are now regarded as of value only if they bring results in market value terms, only if they have extrinsic value. It is unclear whether MacIntyre believes that a return to virtue is possible, but if it is to be achieved, then it has to be within the context of *practices*, which are shared human activities of acknowledged internal value. MacIntyre defines practices as:

... any coherent and complex form of socially established human activity through which goods integral to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.¹

Clearly, medicine may be seen as a 'practice' in this sense, and so one concern of medical ethics must be not just the *rightness* of medical decisions but the success or failure of modern medicine in enabling both doctors and patients to share in a common endeavour, which they both regard as of intrinsic value, as a fulfilment of themselves and of their aspirations in life. Another way we can express this is to use MacIntyre's term 'the narrative unity of human life'. Do the encounters between patients and health care professionals contribute to that sense

of continuity of lives of inherent worth? If not, then what needs to change in the ethos of health care to enable this to happen, at least some of the time?

Dangerous Myths

To consider this key question let us consider the dangerous myths about virtue that have clung to the delivery of health care for generations. These are myths both about what makes a 'good' doctor and what makes a 'good' patient.

The Doctor as God

The first myth is created by the fears which illness provokes. Faced with the uncertainties of human pain and fragility, doctors and patients alike are tempted to endue the profession with a godlike presence, an appearance of virtue which can shield them both from anxiety. We see this myth in the nineteenth-century admonition of the AMA about the appropriate bedside manner:

A physician should not only be ever ready to obey the calls of the sick, but his mind ought also to be imbued with the greatness of his mission. Physicians should, therefore, minister to the sick with due impressions of the importance of their office. They should study, also, in their deportment, so to unite tenderness with firmness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence.²

and it is wonderfully portrayed in Tolstoy's *The Death of Ivan Illych*:

... from the doctor's summing up Ivan Illych concluded that things looked bad,