ANZ J. Surg. 2007; **77** (Suppl. 1) A50–A51

MEDICO-LEGAL SURGERY

ML01
COMPETENCE REVIEWS IN NEW ZEALAND AND THE AFTERMATH

R. Blair

Anglesea Clinic, Hamilton, New Zealand

The inquiry into allegations concerning the treatment of cervical cancer at National Womens Hospital in 1987 and 1988 was one of the most significant medical controversies of the 20th century in New Zealand. This event brought the legal and medical professions into close contact, and the legal profession has been involved with further developments in the assessment of medical competence.

Since the inquiry in 1988 the government in New Zealand has moved to provide "further protection to the community": The appointment of a Health and Disability Commissioner to act as an advocate for the community and changes in legislation. As a result, the self regulating privilege of the medical profession has been lost.

The profession was initially stunned by the outcomes of the National Womens Review, but on the positive side there has been a response by the profession to improve the standards of practice. The department of Continuing Professional Development in the RACS has been a major step forward.

Over the next two days the Medico-Legal Section will examine our response to competence reviews. The changes over the last twenty years have brought about considerable change in our professional status within the community, but we must continue to address those matters which have resulted in a loss of community trust.

ML02
INFORMED CONSENT FOR VASCULAR INTERVENTION IS IMPROVED BY DEPARTMENTAL AUDIT

D. R. Lewis, K. Carter, C. Frampton, T. M. Buckenham and J. A. Roake

Dept of Vascular Surgery, Christchurch Hospital, Christchurch, New Zealand

Aim To re-audit documentation of consent in patients undergoing vascular procedures.

Method A retrospective audit of elective vascular admissions from October 2005–2006 was undertaken to assess the impact of a previous audit (2005). Clinic letters, handwritten entries and consent forms were scrutinised and data collated on which doctors took consent, when consent was obtained, what details of the consent process were documented and whether additional information was made available.

Results 99 notes were reviewed. For patients undergoing vascular surgery the consent form was signed by a consultant in 16 (32%) cases compared to 2 (4%) in the previous audit ($p < 0.013$). Significantly more vascular radiological consent forms were signed by a consultant (43) compared with surgical consent forms (16) ($p < 0.001$). Documentation that the risks of surgery had been discussed with the patient was present in 31 (62%) surgical notes. For radiological consent documentation, 34 (69.4%) patient notes recorded procedural risk. 22 (44.9%) of the vascular radiological patients had such risks documented in their outpatient notes by a vascular surgeon compared with 1 (2%) ($p < 0.001$) in the previous audit. Additional written information was given to 7 (14%) of the vascular surgical patients which was similar to the previous audit.

Conclusions Significant improvements have been made since the previous audit with more surgical consultants signing the consent forms and increased documentation of the nature of radiological procedures and risks discussed in outpatient clinics. From the current audit provision of additional written information (patient information sheets) was an area identified for future improvement.

ML03
WORK INJURIES – NOT ALWAYS WHAT THEY SEEM

C. Strack

RACP College of Occupational Medicine, Australia

We all know that work can be associated with health risks and injuries. Assessing whether a patient has a work related injury can be problematic at times, especially with conditions that are common in the general population. This is an area where common basic clinical assumptions and clinical "common sense" may sometimes be at odds with the epidemiological evidence.

Some times the extent to which a condition is reported as being due to work or injury may seem to have more to do with compensation and legal issues rather than work or injury related factors.

Two common conditions, carpal tunnel syndrome and lumbar spondylosis, will be discussed with respect to the extent to which they may, (or may not) be caused by work.

ML04
ASSESSING CHRONIC PAIN – IS IT INJURY RELATED?

J. S. Alchin

Pain Management Centre, Burwood Hospital, Christchurch, New Zealand

When asked to provide an opinion on whether a patient's chronic pain is accident related, how can we satisfy the medico legal exigencies, while also maintaining professional integrity? In this talk, I touch on 3 questions related to this:

1. Why do some people develop chronic pain, e.g. chronic post-operative pain? What are the risk factors?
2. Is there evidence relating trauma to chronic pain, e.g. chronic low back pain, whiplash neck pain?
3. Writing the medico legal report, including adopting universal precautions against legal fish-hooks.

The conclusion is that, medically, this issue is very problematic; but we should not be seduced into pretending to more certainty than is possible. It is for the medico legal process to deal with any residual medical uncertainties.

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ML05
WADDELL AND THE DECEIVING PATIENT – IS IT ALL INTENTIONAL?

A. D. Macleod

Pain Management Centre, Burwood Hospital, Christchurch, New Zealand

The intensity of pain perceived following physiological insult is unique to that individual. Pain, by IASP definition, is a subjective and psychological symptom. Circumstances, personality and psychiatric illness may amplify (and less commonly mute) volunteered pain scores. Most pain is organically initiated and then psychologically contaminated. The psychological and psychiatric factors influencing pain scores will be considered.

Patients with a propensity to somatise may elaborate and/or maintain 'organic' pain. This occurs 'unconsciously' (without awareness). This process deceives the patient (and often also the doctor). Intentional amplification of pain and the construction of pain behaviours for care-eliciting purpose (factitious disorder) or personal gain (malingering) deceives others. Though there are clinical clues to feigned pains able to be obtained from the history and signs such as those proposed by Waddell, it is notoriously difficult to differentiate partial malingering, conversion or somatoform pain and the pain signature of the particular patient. If the intent of symptom formation and its continuance is psychological, medicine has a diagnostic role. If the intent is for personal greed or is criminal, the diagnosis rests upon legal issues.

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ML06
CHRONIC PAIN AND GRADUAL PROCESS INJURY – ACC RESPONSIBILITIES

G. Walker

Workwise Christchurch, Accident Compenstation Corporation, Christchurch, New Zealand

The Accident Compensation Corporation (ACC) administers New Zealand's accident compensation scheme, which provides personal injury cover for all New Zealand citizens, residents and temporary visitors to New Zealand. In return people do not have the right to sue for personal injury, other than for exemplary damages.

Before a claim can be considered for cover under the current Act (IPRC Act 2001), it must first be established that the claimant has sustained an injury, and that this injury falls within the definition of 'personal injury'.

With respect to chronic pain, a person with chronic pain due to a personal injury may obtain cover for that personal injury through the ACC scheme in a variety of ways.

A personal injury caused by a work-related gradual process, disease, or infection (gradual process injury) is one way in which a person with chronic pain may obtain cover under the ACC scheme.

Specifically, ACC has accepted cover for chronic pain syndromes in circumstances such as follows:

1. The chronic pain syndrome is a plausible consequence of a person's work tasks or work environment (i.e. it meets the criteria for personal injury caused by a work-related gradual process, disease, or infection); or
2. The chronic pain syndrome is a plausible consequence of a covered personal injury (ie it meets the criteria for personal injury caused by a gradual process, disease, or infection that is consequential on a covered personal injury)

ML07
THE LEGAL PROBLEMS – WHERE THE ACC IS WRONG

G. Wakefield

Wakefield Associates, Christchurch, New Zealand

The role of chronic pain in the context of New Zealand's ACC legislation is unsettled. Its importance is likely to increase in coming years.

Legal problems associated with chronic pain include the difficulties in:

(a) identifying the cause of chronic pain.
(b) quantifying its effect.
(c) establishing a causal relationship to a personal injury by accident.

Currently ACC will only recognise chronic pain if it reaches the level of being 'clinically significant' in accordance with DSMIV and meets the diagnostic criteria.

ACC is likely to face challenges to its approach in the following areas:

(a) ACC's refusal to recognise chronic pain without a demonstrated physiological cause. This challenge will be based on medical and technical advances, and research (related in particular to the reduction of neocortical gray matter volume and density of chronic pain sufferers).
(b) ACC's refusal to cover elective surgery costs on the basis that there is no causal relationship between the original injury and the condition to be operated on (pre-existing conditions). There are currently frequent successful challenges to ACC for its failure to address temporal factors of which pain is an important aspect.
(c) ACC's failure to adequately consider chronic pain when addressing the amount of compensation to be paid under the current lump sum compensation payments (for impairment of bodily function). There are legal challenges currently underway addressing chronic pain that does not meet the DSMIV 'disorder' criteria.

ML08
CONDUCTING A REVIEW – THE IMPORTANCE OF PROCESS

A. F. Merry

Auckland, New Zealand

Reviews of practice tend to arise out of conflict between the person reviewed and the organisation requesting the review, usually after a failure of the two parties to resolve their differences at a lower level. It follows that legal challenges are likely, and this has been borne out by experience. Such challenges will generally be based on alleged failures in process. Furthermore, being reviewed is exceptionally stressful for any doctor and creates serious risks to his or her health and reputation. It is essential that these risks are minimized and that all parties emerge from the review believing that the process has been impartial, professional, confidential and fair.

The key is to engage a senior lawyer with appropriate experience and expressly charge him or her (in writing) with the responsibility for process. This lawyer must be independent (the reviewing organisation's own lawyers are not appropriate for this position), directly accountable to the chair of the review panel, and have unrestricted time for this task. He or she should be present at all meetings between the panel and the reviewed doctor and should revise all documents produced by the panel. The panel chair should assign the primary responsibility for reviewing the professional competence of the doctor to other panel members and should focus instead on 'chairing', on process, and on the wider (or 'big picture') issues which surround the review. Previous experience in reviews is essential for this role.

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