REPORT OF THE

INQUIRY INTO THE PROCEDURES

OF THE ACCIDENT COMPENSATION CORPORATION

By

PETER J TRAPSKI CBE

# CONTENTS

**Contents, contd....**

## BACKGROUND TO THE INQUIRY

On 11 September 1990 the New Zealand Medical Council wrote to the Accident Compensation Corporation (the Corporation) enclosing a copy of its findings after inquiring into charges against Dr L.K. Gluckman an Auckland psychiatrist. Those findings said:

> In the course of hearing the evidence in this case, we were concerned that patient information within ACC appeared to be treated with a material disregard for confidentiality. We find this quite unacceptable. The Medical Council draws the attention of the management of ACC to the need to ensure that reports containing intimate and sensitive details are treated as highly confidential, available only to senior officers required to make decisions.

The Corporation had not been a party to the Council's inquiry. It asked the Council to provide it with the information that had been considered when it made this statement. The Deputy Chairman of the Medical Council replied in this way:

> In the course of giving evidence several of the patients complained not only that the reports contained information of a detailed sexual nature but that it had come to their notice that these reports were attached to their files in such a way that they might be easily accessed by anyone in the office handling the file. Evidence given by a medical officer of the Corporation did not allay the strong feelings that reports whether specifically marked confidential by the doctor or not, could be seen and read by persons who had no need to...
>
> You will be aware that the NZMA has issued an instruction that a doctor reporting to a third party (Insurance Company or ACC, or similar) should address his report to the (Senior) Medical Officer of that organisation. The Medical Officer in receipt of a report containing intimate confidential medical detail should we believe place a notation on the file that such a report exists, but then place it in secure custody until such time as a senior officer charged with making a decision is considering the matter. This would avoid any possibility that other staff working on the file for other reasons could have the opportunity to read this material. The medical officer from your Corporation who was a witness at the hearing was

> unable to reassure the Medical Council that this was always done though he did say that it was "sometimes done"...
>
> The issue in the Gluckman case was the relevance of all this detail in the circumstances. There will undoubtedly be cases for example in cases where injury has followed a sexual attack that intimate confidential information is required for an adequate medical opinion to be given and must therefore be included in the report to justify that opinion.
>
> Release of such reports to the patient concerned or their accredited representative is of course a matter over which we have no concern as it is covered by other legislation.
>
> The Medical Council would I believe be re-assured if you were able to indicate that staff receiving reports of this nature had been reminded of the confidential treatment of the documents and that systems were in place and used to achieve this.

The Managing Director of the Corporation, on 9 October 1990 after the Council's findings had been made public, said:

> The Corporation has a difficulty in that it is required to disclose to any claimant, the information on which any decision is made. We are not in an adversary situation as say insurance companies are, and it is the Corporation's responsibility to ensure that injured persons receive the compensation to which they are entitled. Conversely of course, as trustees for funds compulsorily contributed by the levy payers, we have a responsibility to ensure that the injured person receives only that compensation to which he is entitled.
>
> Since the introduction of the scheme, the Corporation staff have always been conscious of the need for individual confidentiality and I am not aware of any case where that confidentiality has been breached. Despite this, the staff are reminded regularly of the need for treating personal information as being confidential and a further reminder is being included in the October Staff Briefing.
>
> If the Corporation were to show individual claimants copies of medical reports with certain parts blocked out, the suspicion would be that this information is detrimental to the stance the Corporation is taking, and is therefore being withheld. We are therefore in somewhat of a difficult situation.
>
> However, in train with a number of other things that are going on within the Corporation's development at the moment, we are introducing a system that will mean sensitive claims among others, will be handled by a select group of senior Claims' Handlers and the claim files will not be available to all members of the staff in any one office.
>
> Not all of our offices have full-time medical staff, so that there is some difficulty if the reports are addressed directly to the medical officer.
>
> I can assure you the Corporation is very concerned about the confidential aspects of these claims and trust that you will

> feel the steps being taken will do something to overcome many fears your council may have.

However, after the publication of the Medical Council's findings, criticism of the Corporation and its practices shifted from disregard of confidentiality to more general matters. On 12 September 1990 Dr Rodney Harrison, the lawyer representing women who had filed medical disciplinary complaints against Dr Gluckman, called for a general investigation into the Corporation's procedures; in particular he sought a full inquiry into the referral of the Corporation's claimants to medical practitioners generally. The Corporation then announced that it would agree to review claims if claimants were concerned about Dr Gluckman's involvement in their cases. It said that although it monitored medical reports no one had spotted a problem, but with hindsight it admitted that the Corporation should have been alerted.

On 18 September 1990 Dr Harrison wrote to the then Minister of Health and the Minister in charge of the Corporation detailing his concerns and seeking a public inquiry.

As a result of the publicity given to these matters this inquiry was instituted.

## MY APPOINTMENT AND TERMS OF REFERENCE

I was appointed pursuant to section 8 of the Accident Compensation Corporation Act 1982 by warrant under seal of the Corporation to inquire into the Corporation's procedures in accordance with the terms of reference which are annexed to this report. That commission requires me to inquire into six separate areas, with particular reference to the Corporation's engagement of Dr Gluckman.

1. To inquire into the Corporation's procedures for obtaining reports, opinions and advice from'specialist medical practitioners. For that purpose I am to inquire whether the Corporation has:

    (a) adequate and appropriate procedures and criteria for the selection and referring of properly qualified and independent medical advisers to give it specialist opinions and additional medical advice;

    (b) whether there is adequate monitoring of the quality of performance of those medical advisers and the Corporation's procedures; and

    (c) if the procedures or the monitoring of performance are inadequate, what procedures are required.

2. To consider

    (a) whether claimants have complained to the Corporation about Dr Gluckman's consultations and reports;

    (b) whether the content of Dr Gluckman's reports also should have given rise to concern by the Corporation; and

    (c) whether action was or should have been taken on any such complaints or in response to the doctor's reports.

3. To consider whether anyone has suffered from having been referred to Dr Gluckman as medical adviser to the Corporation, and if so what action should be taken by the Corporation to remedy or redress the injury to the interests of those claimants.

4. To consider

(a) whether the Corporation has appropriate procedures in place for maintaining both the internal and external confidentiality of reports containing private information;

(b) the responsibilities of the Corporation when it receives reports with intimate details which appear to have no relevance to the claim being considered; and

(c) what action should be taken by the Corporation when such irrelevant information is received.

5. To report on what occasions and on what evidence the Corporation should report to the Medical Practitioners' Disciplinary Committee, or to the Medical Council, perceived breaches of professional obligations.

6. To inquire whether there is a need for institutional safeguards within the Corporation's system to protect the rights and interests of claimants.

The terms of my inquiry are essentially related to the Corporation's procedures rather than to the actions of Dr Gluckman. Even insofar as I am to inquire whether the interests of any claimants have suffered and what action should be taken by the Corporation to remedy or redress any injuries, my inquiry is directed at or to the Corporation rather than at the doctor.

## THE INQUIRY

### Statistics

I was initially approached by the Corporation about my commission in November 1990 and I commenced work on the inquiry's terms of reference then, but there were some delays in completing the formalities of my appointment. My Warrant of Appointment was sealed on 21 December 1990 and I received it in February 1991.

In January and February 1991, the Corporation at my request ascertained from their records who had been referred to Dr Gluckman. They reported that their inquiries showed that 82 claimants had been referred over a period of eight and a half years from May 1980 to February 1989. During March 1991 the Corporation wrote to each of these people seeking their approval for me to access and review their files with the Corporation, and their consent to being involved in the inquiry and to being interviewed. The consent of 68 claimants was received and their files were obtained and read. Some of these claimants had been dealing with the Corporation over a prolonged period and their files were extensive.

I interviewed 60 claimants, both men and women, over the period 13 May 1991 to 9 August 1991, 55 in personal interviews and five in telephone interviews. The files of a further five claimants were read but for various reasons personal interviews did not eventuate. In all, the claims history of some 65 claimants with the Corporation were reviewed in depth. The files of three of the 68 claimants who consented could not be located.

In addition to interviewing claimants I also interviewed an orthopaedic surgeon, a general medical practitioner for one of the claimants, two clinical psychiatrists, a psychiatrist attached to the University of Auckland School of Medicine, an anaesthetic specialist involved in a Pain Clinic in Auckland, and the Corporation's Auckland District Medical Officer.

The records supplied to me by the Corporation - and which I have cause to consider were incomplete - show that:

(a) in the six months from May -to October 1980 Dr Gluckman provided six reports to the Corporation in respect of two claimants;

(b) in 1981 one report was received (in respect of one of the previous claimants); and

(c) in each of the years 1982, 1983 and 1984 reports were received in respect of one further claimant. Thus, over the four and a half years from May 1980 until the beginning of 1985 the Corporation has records of receiving only ten reports from Dr Gluckman in respect of five claimants.

Thereafter the rate of referral increased. In 1985 twelve reports received pertaining to a further nine claimants. In 1986 there were seven reports about seven new claimants. In 1987 however, the increase was dramatic; it seems that 27 reports were received relating to 27 separate claimants. Through the months of April, May, June and July of that year reports were received almost weekly. This indicated a concerted effort to refer to Dr Gluckman all or most of the Auckland offices' long-term claimants who were suffering from chronic pain. I emphasise however, that I am not confident that these records are complete and it seems likely that further referrals were made. Nevertheless, the pattern which emerges over this period, from these statistics alone, is in my view significant.

In 1988 only two reports are recorded as having been received and in 1989 only one - concerning a woman who had been referred previously.

**Methodology**

From the beginning I was anxious to ensure that the inquiry be undertaken in a non-adversarial way. I suggested, and the Corporation agreed, that it should not have a representative present during my interviews with claimants. It was instead agreed that after I had completed the interviews I would take up with the Corporation any matters that had arisen which needed further explanation, investigation or comment. This process obviated cross-examination of the people being interviewed.

Where claimants indicated that they wished any other person to be present during the interview, I readily allowed that person or those people to be present and to be involved in whatever way they or the claimant desired. I did nothing to encourage the presence of legal counsel or advocates at the interviews.

Matters were discussed with each claimant in a non-threatening environment in the presence of my assistant - a mature woman qualified but not practising as a barrister and solicitor — and a female stenographer. With the claimant's prior consent each interview was recorded, on the understanding that the recording would be transcribed and then sent to the claimant for such correction, addition or amendment as they wished to make. It was only after that

process had been completed that I reviewed the transcript. The claimants were thereby able to discuss their experiences freely in what I believe was a non-threatening setting and, more particularly, they were able to communicate to me what they wanted to say - and it was this that was considered, rather than what they actually said in the course of the interview.

Prior to each interview I read the files pertaining to that claimant so that I was able to assist them through the historical narrative of their dealings with the Corporation and the handling of their claim. Interview time was thereby reduced to a minimum.

Many claimants have subsequently told me that they regarded the interview process, as therapeutic. But through this process I obtained very forthright views of how a reasonably large number of claimants saw the delivery of the Corporation's services in retrospect and I had the advantage of being able to review in some detail the files of these people, who I regarded in the main as a representative cross section of "ordinary" New Zealanders. I consider that I obtained a very clear view of the way in which the. Corporation operated in the Auckland area over the period in question. I discuss these perceptions when I deal with the handling of claims later in this report.

**Dr Gluckman's Involvement**

I did not see it as any part of my task to come to any conclusions about any complaints that claimants made about the way in which Dr

Gluckman had conducted his examinations. Rather, it seemed to me that my task was to inquire into the Corporation's procedures. My inquiry was vastly different from that of the Medical Practitioners' Disciplinary Committee or of the Medical Council. As I saw it any complaints made by claimants in the course of describing their examination by Dr Gluckman ought to be considered only as part of the background against which the Corporation's procedures were examined. I endeavoured to take every step possible to concentrate on the Corporation and on its procedures and not to deviate from that task.

However, I soon became aware that irrespective of whether the claimants' descriptions of the doctor's manner and methods were real or perceived, their perception of those events was in most cases traumatic and deeply distressing. I became acutely aware that this was particularly so for at least some of those women who had persisted with their complaints to the various medical disciplinary authorities. By the time I talked to them they had already been interviewed on a number of occasions and had had every detail of their evidence recorded in affidavit form, and six of them had been cross-examined in the presence of Dr Gluckman and his wife. I had no desire or intention to have them endure that process again and there seemed to be no point in having them do so. It was their perception of what had happened that was for me important, irrespective of whether or not their descriptions were accurate, or indeed fallacious, and Dr Gluckman's written reports seemed to be more pertinent to the purposes of my inquiry.

I was aware that Dr Gluckman had at all stages of the medical disciplinary inquiry denied the complaints that had been made against

him, through to the filing of an appeal against the eventual findings of the Medical Council, and of his thereafter continuing to maintain that he was innocent of any wrongdoing and that his conscience was completely clear.

For all these reasons I considered that it was neither necessary nor desirable for me to involve the doctor or his representative in the claimants' interviews, and I did not do so.

In April 1991 Dr Gluckman learned of my inquiry and at his request I informed him of my appointment and of my terms of reference. I provided him with a list of the claimants I was to interview. I also offered to make myself available to the doctor to discuss matters with him or with any other person he wished me to see. At his request I had my initial terms of reference amended by the Corporation so that my task was more clearly directed towards the goals to which I have referred. I received from Dr Gluckman a number of statements in the nature of character references, and at his request I read his affidavits and the series of character references which he had filed with the Medical Council in the course of its inquiry.

In addition I met with Dr Gluckman on 20 November 1991 in Auckland and listened to all that he wished to tell me. I did not however, disclose to him any information given to me in my interviews with claimants, and in accordance with the practice outlined above I excluded from that interview any representative of the Corporation or of any of the claimants - the only other persons present at the interview were Dr Gluckman's counsel and his wife - and I recorded

the interview. I had that recording transcribed and sent to Dr Gluckman for his amendment or correction and in return I received a good deal of additional material. In May 1994 I made available to the doctor's counsel in draft form those parts of this report which concern him more directly and I have received his comments.

**Interim Report**

On 7 August 1991, after I had completed my interviews with the claimants, I provided the Corporation with an interim report covering matters which had emerged to that time and my consideration of some 60 of Dr Gluckman's reports to the Corporation.

In my view it was important that the directors and senior executives of the Corporation had a picture of what I regarded as the seriousness of the matters involved in the inquiry, particularly as no representative of the Corporation had been present during the interviews. Throughout that interim report I emphasised that all the interviews had taken place in the absence of any representatives of the doctor or of the Corporation, and that none of the descriptions which had been given to me had ever been put to the doctor or to any member of the Corporation, and that they must be interpreted in that light.

I then reported, in an interim way, about:

**A. Referrals**

(i) I was concerned about an almost total absence of any evidence of consent having been given by injured persons {as the Corporation called them) to allow medical practitioners to supply information to the Corporation or to allow the Corporation to pass that information on. I said that the obtaining of that consent, if not necessary, would certainly be prudent and I said that I would at a later stage consider the adequacy of the Corporation's form C12 in providing "informed consent" in these "post-Cartwright" days. I discuss these matters more fully in this report.

(ii) I was concerned that referrals had been made without the claimants knowing who they were to see or the purpose of their examination and that I had found little evidence of the assurance which had been given by the Corporation in the media on 14 September 1990 that "claimants are not forced into seeing specific specialists". I reported that I was consistently finding every indication to the contrary, and I enlarged on those findings. I concluded this section of my report by recommending that on the occasion of each referral:

(a) an injured person should be fully informed about the Corporation requirement for a report or an assessment from a particular nominated area of expertise;

(b) the injured person should be informed why that report or assessment was required; and

(c) the injured person should have the opportunity to choose or nominate a particular specialist within the required area of specialisation, especially if a practitioner suggested by the Corporation was unacceptable to the claimant.

These matters are covered more fully in this report despite my being told that this recommendation has been put into effect.

(iii) I was concerned that claimants had not been warned of the length of time their examination would take, and that the Corporation's referral letters were complicated and intimidating. I recommended that referral letters should state specifically and clearly

(a) that the opinion of a particular type of specialist was being sought;

(b) the reasons why such opinion was sought; and

(c) a request for the injured person to consent to the specialist reporting to the Corporation and to the Corporation supplying that specialist with the information it already held.

(iv) I was concerned that the Corporation's processes at least in the Auckland area at that time appeared to be confrontational and adversarial and that its officers appeared to be suspicious of everything a claimant said. These matters are covered in greater detail later in this report.

**B. Medical Involvement**

(i) I was concerned to find how little medical people were involved in referring claimants for specialist medical reports and assessments, especially as the scheme administered by the Corporation was essentially a medical insurance scheme. I pointed out that specialist medical practitioners preferred to receive their referrals from another doctor who would know precisely why that person was being referred and who could properly define the terms of the referral and provide the appropriate medical background. I suggested that loose referrals led to loose reports and invited unnecessary intrusion into the life or person of the claimant as well as providing a golden opportunity for a breakdown of confidentiality.

(ii) I was concerned about my conclusion that medical reports were not being dealt with in the confidential manner which they deserved.

(iii) I was concerned that much of the valuable information which had been obtained as a result of references to medical specialists remained on files unactioned, often to the detriment of the injured person's rehabilitation, simply because the report had not been referred on to a person of appropriate medical experience or knowledge.

I recommended a comprehensive system for ensuring greater medical involvement in the referral process and in dealing with subsequent reports in an appropriately confidential way. These matters still concern me. They are referred to in this report.

**C. Corporation Files**

I was concerned at the way the Corporation's files were kept and I recommended that something better be provided, particularly in these days of electronic data processing. I pointed to a very efficient system of electronic filing that I had seen in Australia, whereby an up-to-date, progressive picture of a claimant and the processing of their claim could be seen literally at a glance. I suggested that the use of such a scheme could well obviate any inclination towards mistakes or misinformation about a particular claimant and could help to prevent many of the problems I had noted in the course of my investigation. I also pointed to the simplicity and efficiency of such a system and I recommended its adoption.

## The Corporation's Involvement

In August 1991 I started to refer a series of questions to the Corporation concerning matters which had arisen in the course of a detailed consideration of my interviews with claimants and of their files. I selected ten claimants and worked my way through their files in a detailed manner and sought specific information on why specified actions were taken by the Corporation or taken in a particular way. So that my queries could be seen in context I provided the Corporation with a copy of the transcript of my interview with the particular claimant. At the same time I made it clear that the information which was supplied in those interviews was

confidential, or at the least sensitive and personal, and I insisted on it being treated as such.

I readily appreciate that it was difficult for the Corporation to supply the information I sought as the events went back many years, and most of it related to actions taken by officers who had long since left the Corporation. But nevertheless it did take an exceptionally long time to supply the information I sought. Finally, comprehensive and well considered replies to my queries were received from a very senior officer and I hasten to praise her dedication and candour in undertaking this work, in replying to very detailed questions and in subsequently assisting me in dealing with specific problems faced by three claimants in particular, but the initial replies I received from her in turn raised other issues which required further investigation. Overall the process became very protracted. Once the initial impetus had been lost it required intermittent attention through 1992 and then more detailed attention in 1993.

Throughout this period I pursued the complaints and disappointments of many claimants who considered that they had been disadvantaged. These matters are referred to in a later section of this report under the heading of Remedial Action.

I then took a more general approach and sought the Corporation's response to each of the questions raised in my terms of reference. I received the answer to these queries in March 1994. Whilst I do not wish to place the whole of the blame for these delays on the

Corporation, it has indeed taken an exceptionally long time to bring me to the position of being able to provide a meaningful report.

And finally, before I report in detail on the results of my inquiry, I am deeply conscious that the various events which are the basis of this inquiry took place nearly 10 years ago so that there will be a natural inclination to react by saying that all of the systems and procedures which I now discuss were of that era, and have been overtaken by new and corrected systems, operated by new and more enthusiastic staff. Whilst I readily acknowledge that there have been changes, particularly over more recent months, I caution against the general reaction that all is well. Many, if not most of the matters I raise are I believe still current, at least to some degree, or to the extent that there needs to be a conscientious checking to see whether all these matters have in fact been attended to by the new system of Case Management and by the replacement of old staff.

## THE HANDLING OF CLAIMS

### Overview

I found a pervading impression among claimants and others who had dealings with the Corporation in the Auckland area at that time that complicated and serious claims were being handled by young, inexperienced and sometimes incompetent Claims Officers who had nothing more than clerical training. These people may well have been capable of handling the assessment and payment of compensation for clearly visible and identifiable injuries. However it was quite apparent to me after reviewing their work in some detail that they lacked the experience and training that would enable them to properly understand and deal with the medical and legal issues involved in processing and deciding upon complicated or continuing injuries.

### Staff Changes

The general impression of inexperience or immaturity in the Corporation's staff was fuelled by complaints frequently made by claimants, particularly when they were dealing with staff in the large metropolitan offices of the Corporation, that changes in the staff handling their file occurred too frequently; that staff changes occurred so often that claimants were never sure who their Client Officer was or who was actually handling their file at any particular time.

In one case a claimant reported that his file was handled by no less than twenty Claims Officers over a period of six months; an average of three different people each month. The perception was that they did not, and could not, know about him and his problems, and that they didn't care.

As an extension of this, claimants considered that they were dealing with a faceless organisation - always by correspondence; never on a personalised face-to-face basis - and that the Corporation "never knew me - I was just a file to them".

This led to the overall impression that most claimants had of the Corporation; that of an autocratic bureaucracy which declined to deal with them as fellow human beings with a problem. There was no impression of an organisation, or its staff caring for or being considerate of claimants and their personal and individual problems. I emphasise that this perception was consistently expressed by most of the people I interviewed.

By way of contrast, the claimant who told of twenty Claims Officers being involved in his affairs over six months then described moving to a new area serviced by a smaller office of the Corporation, where he was attended to on a personal, face-to-face basis with courtesy, compassion and understanding, and to his satisfaction.

## The Corporation's Adversarial Attitude To Its Claimants

There was an overall perception that the Corporation's staff in the Auckland area at that time, lacked empathy with the claimant, and on reviewing the Corporation's files I could see little evidence of any real understanding of the claimant[1]s position. There seemed to be no recognition of the fact that claimants were essentially people who were suffering the effects of suddenly imposed disabilities; that they were more often than not in a state of shock and bewilderment at least when they commenced dealing with the Corporation, and that they were people who were disadvantaged both physically and financially. In most cases claimants had been suddenly deprived of the ability and the opportunity to work and to earn the income they were used to. Their obligations, however, continued; they still had to meet their normal financial commitments for food, clothing, mortgage and hire purchase payments and all of the other necessities of life for themselves and for people who were dependent on them. They were, and felt, totally vulnerable.

Not only was there a lack of empathy with the claimants, there were repeated complaints by claimants of a confrontational and adversarial attitude towards them; they felt that staff doubted everything they said. Claimants said that right from the commencement of their dealings with the Corporation officers seemed to openly and consistently doubt their integrity and their honesty. It was as if through each stage of their dealings with the Corporation the answer would be "no", unless they could establish good reasons why that denial should be reversed.

One claimant said it was as if the staff were on some sort of bonus system. Another said that the overall impression he got was that the Corporation considered him to be a liar in every aspect of his life. Another woman said:

> "They forced me into an adversarial position; they didn't want to pay me so they went out of their way to prove that there was nothing wrong. Their actions and their disbelief cost me my health. My main problem was their confrontational attitude; the distrust and disbelief whilst I was trying to come to grips with chronic pain and disability."

Another woman said the ACC made her feel like a bludger - and then added plaintively, "But I'm not - I love work".

Another claimant described the Corporation as part of an enormous clobbering machine which had the objective of wearing people down so that they became submissive or gave up the fight.

As a further example of negative attitudes.. I was startled to read in one file a notation from a senior client officer:-

> "So my fears have been realised. She is now in the clutches of the pain clinic lot! Not much I can do now but monitor. The 'new woman' should be able to return to work some time after Christmas."

I would have thought that the objective of the whole scheme was to ensure that claimants did return to work. The reluctance to accept this as an objective, no matter how it was achieved, is almost unbelieveable, but it does put into perspective many of the decisions made by that particular officer - now left the employ of the Corporation.

The most frequent complaint was of a lack of communication; that throughout their dealings with the Corporation claimants never really knew what was happening; that nobody ever told them anything. Instead, they said, they had to ask continually in order to get any action and even then nobody ever explained what was being done or why. One claimant said:

> "We were dealt with as numbers or files rather than as people."

Complaints were consistently made about threats, sometimes implied but more often than not quite explicit, contained in correspondence or in telephone conversations. Letters requiring claimants to undertake an examination or treatment always it was said, ended with a sour or threatening note, and usually with a reference to some penal provision in the Act which claimants did not in any case understand. The form which advised claimants that an appointment had been made for them to have a medical examination said, for instance :-

> Failure to attend the examination without an acceptable reason will result in your being required to reimburse the Corporation for the cost of any fee charged by the specialist for your failure to attend.

Claimants complained that they had no intention of failing to attend, and they had given no impression that they would not attend. There was just no need for such an unfriendly or adversarial attitude.

In another case a woman was told

> I would like to draw your attention to section 87(3) of the Act. We therefore request that you attend the counselling sessions.
>
> Failure to do so will result in the suspension of your compensation.

She also said that there was no reason for the Corporation to write to her like that. She wanted to be rehabilitated and get back to work and if they had only spoken to her they would know how keen she was to do so, but no one bothered.

In some cases these threats were taken further. One woman told of receiving, out of the blue, a notification that she was required to see Dr Gluckman. She was bewildered. Why was she being sent to him, she asked. She phoned a named officer to inquire. He simply said, she reported, "If you don't go, you don't get paid." The reports of this being the standard response to any questions or queries - if you don't go, you won't get paid - were so prevalent and so consistent that I cannot reject or discount them. But even if these comments were not made in these exact terms, the repeated nature of these complaints reflects a perception of the Corporation which must in my view be remedied, rather than denied or ignored.

The Corporation ought not take an adversarial or confrontational attitude to its claimants. As was said by the then Managing Director of the Corporation in his letter to the Medical Council of 9 October 1990, that the Corporation was' not in an adversary situation. Unfortunately my investigations led me to the conclusion that the Corporation was totally adversarial in its attitude to claimants, in stark contrast to the attitude of insurance companies in similar areas of business which I discuss later in this report. The attitude of the staff of the insurance companies I consulted was clearly that they were attending to their client's business and that they wished to retain that business by ensuring that they performed in accordance with the client's expectations. There was a contrary attitude in the

Corporation's staff - that claimants, especially those who claimed to be unable to work because of the effects of chronic pain, were malingerers who were out to get money they were not entitled to in order to live the easy life.

I must emphasise that of the 60 people I interviewed I can remember only two who failed to impress me as anything but straightforward, ordinary New Zealanders who wanted to get back to work rather than be out of work and on a reduced income. Most regretted their plight intensely and were depressed that they were unable to cope with the ordinary demands of life and work. It is a great pity that the Managing Director's perception of the Corporation's role in this and unfortunately in many other aspects of the Corporation's work had not filtered down to branch level.

**Negative and Perverse Decisions**

Perceptions and theories apart, the development of these attitudes must be regarded as serious, as I saw firm evidence of their being reflected in what can only be described as perverse decision-making.

In some cases staff ignored specialists' reports when making decisions on claims, or were selective in which reports they passed on to decision-makers. In one case Dr Gluckman reported that in his view a particular claimant's condition was essentially emotionally determined and that his original fractures were of very little moment in considering his condition at that time. However, he specifically

stated that this view was expressly subject to the overriding opinion of an orthopaedic surgeon. In fact, an orthopaedic opinion was obtained, six weeks later. It said:

> I would consider it a considerable injustice should (the claimant) be denied continuing support by the ACC.

But within seven days of receiving that report the Corporation advised the claimant that his compensation would be terminated because medical information on the file indicated that he was fit to return to light work and that it was unable to associate his ongoing pain problem with any organic cause directly related to the injuries.

As additional examples of this perverse attitude, further medical reports were often obtained after Dr Gluckman had reported, usually to assess lump sum entitlements. In practically every case Dr Gluckman's report was sent to the subsequent assessor, but often it was the only report which was sent, despite orthopaedic reports having been obtained. In one case in particular where this was done, a neurosurgeon and an orthopaedic surgeon had reported favourably on the claim but Dr Gluckman's subsequent report was unfavourable to the claimant. When the woman was referred for lump sum assessment a new orthopaedic surgeon was chosen but only Dr Gluckman's report was sent. The second orthopaedic surgeon complained that the Corporation had not sent the information it had available to it but no action was taken by the Corporation on his complaint.

When I asked the Corporation for an explanation of this procedure I was told that it was a mistake, but it is very difficult not to draw the conclusion that the process was simply staff being highly selective to the point of perversity.

In one case it was acknowledged by the Corporation that decisions I questioned were made "with scant regard to all the medical information on the file". In another it was acknowledged that no information could be found upon which the challenged comment could have been based.

In another case a Review Officer noted that "the decision to cease ERC payments was made on flimsy evidence". And in yet another case a decision was taken and a lump sum payment made on the basis that an orthopaedic opinion had considered that 6% was appropriate, whereas in fact the orthopaedic surgeon had said that the claimant's residual disability did not exceed 10% - a very different matter.

In yet another case clerical staff persisted with the view that the claimant's on-going disability was not a result of the accident, despite contrary views expressed by an independent specialist, the Corporation's own Medical Officer and the Corporation's Rehabilitation Co-ordinator. That decision, taken by a member of the clerical staff, was subsequently upset on review but at considerable cost to the claimant; not only in terms of money but also in terms of the trouble the initial decision "caused to the claimant - a person under some real financial disability - the anxiety, and the time lost to everyone including the Corporation, before the disabilities could be attended to and the claimant put on the road to some recovery.

The approach taken by the Corporation in making negative decisions and then allowing claimants to take review or appeal action to correct them is simply not appropriate to the scheme. Decisions may well be difficult, but there was surprisingly little attempt to seek legal advice, and very little attempt to have medical reports medically analysed after they had been received and before decisions were taken. Corporation staff seemed content, almost as a matter of course, to rely on the review procedure to correct the effects of its negative attitude. In my view the Corporation is bound to try its utmost to get it right the first time, and to take every care in doing so, and for this purpose to use the simple expedient of seeking, and taking note of, the appropriate legal and medical advice before making decisions.

The repeated occurrence of negative decisions and comments in what is really a confined sampling of the Corporation's work leads me to the conclusion that the confrontational attitudes complained of were indeed typical of the Corporation's operations, at least in the Auckland area. Until very recently subsequent dealings with the Corporation lead me to the view that these attitudes were not confined to Auckland and still persisted. This has to be serious and it must be attended to as a matter of some urgency. The Corporation must develop an expertise in dealing with cases of trauma to ensure that claimants are given a measure of security and assurance at the early stage of the claims process, if only because the persistence of financial fears and anxiety derogates from the healing process.

**Discontinuing Compensation Payments**

There seemed to be an unhealthy readiness, almost an eagerness, by officers of the Corporation at this time to discontinue compensation payments especially if documentation was not received on time. In some cases I saw, the non-receipt by claims handlers of certificates or other information was no fault of the claimant. Sometimes it was the Corporation's fault; the papers had been misplaced within the Corporation's records. No reminder was sent to the claimant before payments were discontinued, nor was an explanation sought. Action was taken without any inquiry being made. That was simply unjust, but more particularly there seemed to be a general lack of appreciation that any discontinuance of payments, even for a week, could have drastic consequences on a claimant's ability to face up to the financial demands of everyday life.

In one case a claimant was two weeks late in getting his certificate to the Corporation but when it was received the branch office did not action it for a further two weeks. This caused considerable inconvenience to the claimant but no apology or acknowledgement was forthcoming from the Corporation. This action damaged relationships with the claimant to the point where adversarial attitudes between him and the Corporation became totally entrenched at huge cost to both parties.

Another example of this apparent eagerness to discount the effect of a claimant's disability, and to start from a basis that long term

claimants are all malingerers, was seen in an assessment made in a memorandum by a Corporation Officer where it was said:-.

> A portion of the injured person's problems appears to be personal discipline, time keeping, attitude to work, etc.

An examination of the files revealed that there was in fact no evidence to substantiate this comment, as was subsequently acknowledged by the Corporation, except an old report from a rehabilitation centre that the claimant had not attended "since last Wednesday" with no explanation. But the opinion recorded in this memorandum proved to be completely damaging to subsequent assessments of this man's claim, to the extent that contrary opinions expressed by a neurosurgeon and an orthopaedic surgeon were simply not accepted. This error was corrected on review but only after much damage had been done.

This arrogance needs to be addressed. There must be recognition of a claimant's problems. Some leeway must be given to human frailty. When mistakes are made and a payment is cancelled inappropriately or precipitately, an apology and an offer of assistance must be made immediately. These were noticeably absent from the files I reviewed.

## The Operations of Insurance Companies Handling Similar Claims

In order to gain an insight into how other organisations operate in this area, I conferred with two major insurance companies. I discussed with senior executives the way in which they handle claims of a similar nature to those handled by the Corporation, particularly

claims relating to disability insurance. Their systems present a stark contrast to what I saw of the Corporation's processes. Team work, discussion, and consultation with other claims handlers and with medico-legal advisers were at the very heart of their procedures.

Both companies emphasised that in handling these types of claim their claims officers were dealing with "a complex product". For this reason all of the claims concerning this type of policy are centralised, in both cases in Wellington. There they are handled by experienced senior officers who have all had significant experience based training in other departments of the companies before they are involved in claims assessments in this field. These officers, in both companies, all have particular experience and some expertise in medical terminology. Most have undertaken courses on general claims assessment skills and are in addition graduates of the "Understanding Medical Terminology" course conducted by the Wellington Polytechnic School of Nursing. Many have nursing backgrounds. All are experienced in handling other claims before they progress to handling this type of claim.

In one office the Claims Supervisor has had five years' experience in this department with a previous five years in the Claims Department. His decisions are subject to the authority of the Department's Manager. The Chief Underwriter, whose advice and assistance is sought on a day-to-day basis is a senior manager in the company with 40 years' experience in the insurance industry and fifteen years' underwriting experience.

In the other company the Head of Disability Services is an officer with *30* years experience. He had previously headed the New Business Department of the life insurance branch of the company and before that had been a Life Underwriting Officer. He has qualified in the Medical Terminology Course at Wellington Polytechnic and is an Associate of the Insurance Institute, qualified in new business and in claims administration, in the selection of insurance risk and in the mathematical basis of life insurance.

When a claim is lodged each company sets about gathering the medical information it requires. The claimant's doctor is generally used initially but whenever medical information is sought about a claimant a full explanation of the company's requirements is given to the doctor concerned. The terms of the policy and its cover are outlined, as well as the details of the claim, and specifically what information is sought by the company and why. A pre-stamped envelope addressed to a particular named person within the company is enclosed with each request to ensure that the reply bypasses the company's normal mail opening process and is treated as confidential to the member of staff directly involved. All information obtained in the course of dealing with these claims is restricted to this particular section of the company and is kept on files completely separate from all other records which the company has concerning that particular claimant.

In one company the decision as to whether or not a claim is covered by the policy and how long payments will continue is made in consultation with other Claims Officers. That decision is always cross checked and then authorised by a more senior Claims Officer

through a process which often involves the advice or assistance of the Chief Underwriter, the company's Medical Adviser and/or its-Legal Adviser.

Within the other company all claims are considered by a committee comprising at least one senior underwriter and a physician and then by the Head of Disability Services and a senior underwriting officer. On some occasions claims may be sent to the head office of the company in Australia for the advice of that office's Underwriting Committee, which is chaired by the company's Chief Medical Officer who is an eminent practising physician. Claims dealt with in this way include those involving long term illnesses or disabilities, contentious matters, and all claims where suspected malingering or non-disclosure is involved.

No claim is rejected or terminated without referral to the Underwriting Committee and without legal input. A decision not to pay is never made by one person alone. These decisions are made only after thorough and sensitive consideration.

Medical reports are obtained regularly, usually on a monthly basis, especially where follow-up information is required for long term disabilities, and particularly for back-related injury or where there are psychological problems. Claimants are actively encouraged to go back to their own general practitioner on a regular basis for treatment and for reassessment.

Where specialist opinion is required the letter of instruction to the specialist is signed by or sent with the express approval of the

Chief Medical Officer for New Zealand. It is never authorised by a member of the clerical staff. The reply is addressed to the company's Chief Medical Officer and is opened by him personally or by one of three specified people who work directly with him.

The information which the company obtains, whether it be from the claimant's general practitioner or from a specialist employed by the company remains the property of the company. On occasions the company may refer information or advice given by a specialist back to a claimant's general practitioner with the suggestion that the claimant consult with that general practitioner, but this action is only taken with the guidance of the company's medical adviser.

Both companies have consultant physicians who attend at their offices daily. They advise on the complex medical matters which these companies say are involved in this type of work. There is a heavy and regular medical input.

Where malingering is suspected private investigators are often used or personal visits are made, usually to deliver a cheque or a claim form.

Each company says that it never declines cover nor terminates it unless it is absolutely sure of its grounds. The standard required to reject or to terminate is very high. Generally speaking the company requires that it be sure, and it requires that decision makers are able to explain its reasons cogently before cover is cancelled.

In clear cut cases of disability, payment of a claim may be approved for an extended period of say three to six months. Checks on the validity of each claim are normally made each month by obtaining a fresh claim form and seeking fresh evidence of health or disability. This may involve a home visit.

**Medical Support**

In my interim report of 7 August 1991 I aired my concerns about the lack of medical involvement in the Corporation's claims handling process and I have in the preceding section of this report detailed those concerns. I now confirm each of them.

Since that interim report, and as a preparation for the new Accident Rehabilitation and Compensation Insurance Act of 1992, the medical advisory service of the Corporation has been strengthened by the appointment of a Medical Adviser to each of the Corporation's seven district offices. These advisers are now based in Auckland, Takapuna, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

At the time of the events which sparked off my inquiry the Corporation did have medical advisers who provided specialist advice to those District Offices. However, the new appointments were to provide the Corporation with medical advisers who were to be identified as working for the Corporation, and who were to take a more integrated and proactive approach to the medical business of the Corporation. They were to provide medical advice to the district management team and to assist the District Manager in fulfilling his

or her responsibilities to claimants within the whole of that district. They were to liaise with Corporation staff in district and branch offices covering claims and rehabilitation and were also to provide regular contact with medical specialists and general practitioners.

While it is no part of my brief to assess the functioning of these appointments, and I have not done so, it appears to me that these new appointments can provide only a partial answer to the problems I refer to throughout this report.

The role of the Corporation is essentially that of a huge medical insurer. The change of the Corporation's name in 1992 (to the Accident Rehabilitation and Compensation Insurance Corporation) was a recognition of that fact, but the responsibility to empower itself to act as such cannot be taken lightly or dealt with cosmetically. I see a need for major input into the Corporation's functioning by medically trained and experienced people "at the coal face"; this input needs to occur daily and in branch offices. These people need to be accountable to decision makers at branch level and to management at a higher level. There needs to be a genuine medical input into most claims rather than a minority. It may be that some of those requirements could be provided in larger offices by people from, say, the nursing profession, but if that is so, their work must then be under the supervision and control of properly qualified and currently experienced medical practitioners, just as it would be in any hospital or medical centre.

I see a need for additional medical input over and above that introduced in 1992 if the Corporation is in any way to fulfil the needs which were the cause of constant concern to me in practically every aspect of this inquiry and which are now detailed in this report.

If the Corporation's new system of Case Management is to function as it should many of the deficiencies I refer to in this report will require attention so that the medical, vocational, rehabilitational, physical and social needs of each claimant are in fact identified and met. The medical input required to achieve these goals is vast. I note for instance that the first stage of the Case Management process is to determine the level of assessment required. As I point out in the next section of this report, there must be a heavy medical input into this process, both at the beginning and at the end. Similarly, direct medical input is necessary to monitor the quality and quantity of services provided by the Corporation and to review their effectiveness and appropriateness.

After scrutinising the requirements of the Corporation's effective functioning I find it difficult to see that the appropriate and adequate medical input can be provided from district offices.

## PROCEDURES FOR OBTAINING SPECIALIST MEDICAL REPORTS

### Overview

In many of the cases I reviewed the Corporation's practice of referring claimants for specialist assessment and report was bewildering. It was bewildering not only to the claimants but also to me. In most of these cases the disabling factor was long terra or chronic pain. Most of the claimants had been sent to three separate orthopaedic specialists over a prolonged period, and in addition many had been referred to a neurologist and a rheumatologist. Referral to four, five or six. separate specialists was not uncommon; some had been referred to ten separate specialists and two of the claimants I interviewed had been referred to seventeen separate specialists for assessment or treatment.

They were unable to explain why they had been sent to separate specialists; why for instance to three different orthopaedic surgeons. In most cases they were simply not told why these multiple referrals were necessary. Most thought it was just a part of the system and they went because they were told that they would not get paid if they didn't. Many claimants inquired why they were being referred to yet another specialist but they consistently told me that no explanation was given. They said that the normal response to their query was simply, "If you don't go, you don't get paid", so they submissively and compliantly fell in with the system to remove any impression that they were at all resistant.

Claimants were simply notified that an appointment had been made by receiving in the mail, form FCL6, "Advice of Appointment for Medical Examination", without any prior warning or consultation. This form named the doctor with whom the appointment had been made, the address of that doctor and the date and time of the appointment. In most cases, but not all, the claimants were not told of the doctor's area of expertise or the reason for the referral.

This practice contrasted with that of at least one Review Officer who told the claimants why an assessment was being sought and informed them of the qualifications or expertise of the specialist to whom they were being referred. I could see nothing to indicate that this practice put the Corporation at any disadvantage whatsoever, but it did ensure that the claimant knew exactly what was going on; they were informed.

**Perception of Bias**

In the absence of any other explanation by the Corporation these multiple referrals were seen by claimants as an endeavour to obtain a report that was favourable to the Corporation, rather than to them. In particular it was suggested by a large number of claimants that the real reason they were referred to Dr Gluckman was because he was perceived by the Corporation to be consistently biased towards it or to be consistently "anti claimant".

Two of the women I interviewed had previously been private patients of Dr Gluckman, and commented on his treatment of them under the different circumstances. One said:

> There was a dramatic difference in the way I was treated as a private patient of Dr Gluckman and on referral from the ACC.

This woman was so concerned that when she was referred to the doctor for the second time she taped the interview.

The second woman said;

> I had seen Dr Gluckman previously. When I went along for ACC he was different from the previous times I had seen him. Why didn't he put me on the table the first time like he did this time - raising my legs, getting, me off the table, sitting me down, pulling me up again? He must have known when you have a bad back that jumping up and down off tables, seating yourself and that sort of thing is painful. The other psychiatrist never touched me when I told him where the pain was. This was very different from the previous appointment I had with him. The first three times I saw Dr Gluckman as a private patient he didn't examine or touch me at all. I went to see him because I thought he was a nerve disorder specialist.

In an attempt to further evaluate the assertion of perceived bias, I reviewed the files of 46 claimants who had been referred to Dr Gluckman. I found that in only three of those 46 cases (6.5%) were the Corporation's subsequent decisions favourable to the applicant; in 43 cases (93.5%) the Corporation[f] s decision was unfavourable to the claimant.

When I analysed these cases further I found that 28 of the adverse decisions (65%) were taken to review or subsequently to appeal. Of those 28 cases, 17 (60%) were successful on review or on appeal. Many claimants who were unsuccessful on review did not accept the result of that process, but they were exhausted and frustrated and lacked

either the funds, the willingness or the ability to face up to the task of pursuing the matter to appeal.

These results are of real concern. They tend to substantiate the somewhat cynical perception of bias taken by claimants.

I should also record that there was a general perception by those who had been through the review process that Review officers were far from independent. They appeared as employees of the Corporation with the primary task of upholding the Corporation's decisions. That perception was also difficult to refute on the basis of my inquiries. However, this situation has now been remedied with an entirely new system of independent review and appeal so I pursue it no further.

**Diagnosis of Disability**

One of the overriding impressions I gained from my inquiries is that the Corporation went to extraordinary lengths to obtain a specific formal diagnosis of a claimant's disability. They kept referring claimants to specialists again and again, without displaying any real knowledge of what they were seeking, until they found a medical specialist who would actually pinpoint and name the cause of the injury or disability. Until such a specific diagnosis was obtained, they continued to decline the claim, despite the fact that a specific diagnosis in the case of chronic pain is often difficult.

**The Corporation's Policy**

The Corporation maintains that the legislation imposes on it an obligation to ensure that compensation and rehabilitation are provided only for those claimants who have, and continue to have, cover under the statute for their original injury or condition; in addition, once a claimant establishes an initial entitlement to cover, the Corporation is required to ensure that its cover continues only while the effects of the personal injury from that particular accident remain. It is obliged, it says, to be assured that any continuing injury or disability continues as "personal injury by accident" before it can continue its cover. It explains that on some occasions it gives cover for a limited period only, to acknowledge the short term effects of a particular personal injury by accident, at the same time indicating that acceptance of cover may not continue.

The Corporation has asked doctors to examine claimants and to provide it with reports to help it make decisions about the validity of claims. In particular it has sought medical reports and opinions to decide whether under the 1982 legislation:

(a) the claimant's condition has been consistent with "personal injury by accident";

(b) the claimant's incapacity met the specific criteria of an "occupational disease"; or

(c) the injury was consistent with being classified as a "medical misadventure".

In addition, the Corporation sought medical opinions to determine whether a claimant had recovered sufficiently from an injury to allow a return to work or whether further compensation, treatment or

rehabilitation was necessary. It says that in seeking such reports it expected the examining medical practitioner not merely to give an opinion but also to provide the reasons for that opinion, which may well have to be presented to the Accident Compensation Appeal Authority or in a court of law. It emphasises that in this way the medical opinions it sought were different from its requests for information from a claimant's general practitioner or from a hospital doctor about treatment given to a claimant.

The Corporation asserts that it must obtain a diagnosis of an injury or an incapacity in order to support its decisions to provide cover only when personal injury is sustained as a result of the original accident. It asserts that the test of "personal injury by accident" is a legal, rather than a medical matter.

In general this policy is probably sustainable but I have real doubts whether it supports the need for a system of continuing referrals until a specific diagnosis is obtained. Rather it seems to me that a doctor should be asked quite simply whether in his or her view the disability, be it continuing or short term, is an effect of the accident, taking into account the standard of proof required in these cases and the elements of the definition of "personal injury by accident" contained in the Act. Doctors should of course always be required to substantiate the opinion they give with appropriate reasons.

**The Corporation's Practice**

In practice there were two main categories of case where the Corporation obtained medical opinions under the 1982 Act. The first, and by far the largest in terms of volume, was in assessing lump sum compensation for permanent impairment and loss of bodily functions under section 78 of the Act. This involved a relatively simple and straightforward procedure for which the Corporation had developed a prompt and skilled service. An assessment was obtained of the degree of the claimant's permanent impairment in terms of the first schedule to the Act or as a percentage of the whole person. This was then quantified in money terms against a maximum payable, using the Corporation's knowledge gained through repetitive experience and practice in this area. The file was then able to be closed in relatively short order and with a minimum of personal contact with the claimant. It was all done by correspondence "on the papers".

The second category was where the Corporation sought opinion and advice in order to determine whether a claimant's longer term condition or disability could continue to be regarded as "personal injury by accident". These cases were much more difficult. They often required a much fuller investigation, with continuing or repeated contact with the claimant. The knowledge of a medical specialist was sought in an endeavour to establish whether a pre-existing condition, rather than the accident, might be the cause of the continuing injury; whether the injured person's incapacity was still a result of the injuries received in the particular accident,

or whether the person's condition had been brought about by some cause which was excluded from the statutory criteria for cover.

It is acknowledged that these involved the consideration of complex matters. They entailed difficult questions of both law and medicine, and required judgments to be made on the basis of skilled medical observations against a background of difficult legal definitions and concepts. They included the whole question of chronic back pain which was the problem in the majority of the cases I examined.

It is clear to me that most of these cases were initially referred to Dr Gluckman for a psychiatric report in an endeavour to determine whether or not the claimant's chronic back pain was genuine, or whether the claimant was malingering, and latterly whether it could be said that there was a functional overlay (symptoms or disability for which no anatomical or psychiological cause can be identified) for which the Corporation was not answerable or responsible. But there is no doubt in my mind that in the latter stages referrals were made by the Corporation out of a sense of frustration at having these clients "on the books" for such a long time.

I deal with that matter more fully at a later stage, but before I do that it seems important to analyse a little more precisely the task of the Corporation in terms of its statute.

**Personal Injury by Accident**

This phrase was defined in the 1982 Act as "including"

> (i) The physical and mental consequences of any such injury or of the accident:
>
> (ii) Medical, surgical, dental, or first aid misadventure:
>
> (iii) Incapacity resulting from an occupational disease or industrial deafness to the extent that cover extends in respect of the disease or industrial deafness under sections 28 and 29 of this Act:
>
> (iv) Actual bodily harm (including pregnancy and mental or nervous shock) arising by any act or omission of any other person which is within the description of any of the offences specified in sections 128, 132, and 201 of the Crimes Act 1961, irrespective of whether or not any person is charged with the offence and notwithstanding that the offender was legally incapable of forming a criminal intent:

But except as provided above it specifically did not include -

> (i) Damage to the body or mind caused by a cardio-vascular.or cerebro-vascular episode unless the episode is the result of effort, strain, or stress that is abnormal, excessive, or unusual for the person suffering it, and the effort, strain, or stress arises out of and in the course of the employment of that person.
>
> (ii) Damage to the body or mind caused exclusively by disease, infection or the ageing process.

The emphasis in repeating these definitions has been added by me, but it must be said that these definitions were binding on both the Corporation and its claimants. Decisions on whether cover could or should be provided were able to be made only in accordance with these definitions. The phrase "personal injury by accident" could not be interpreted subjectively. In making decisions on cover there was a requirement on claims processors to continue to query whether the injury or the disability did or did not come within the definitions set out in the Act.

The definition is framed in what has been called "inclusive/exclusive terms" but the Court of Appeal in Green v Matheson [1989] 3NZLR 564 described it quite simply. At page 571 of that judgment the Court said:

> ...one should begin by noting that the definition in the Act of "personal injury by accident" is in the non-exhaustive form, so that the natural and ordinary meaning of the phrase is left to apply and what is specified is additional or for greater certainty. .. in the context of an act dealing with compensation for personal injuries, it is obvious that "personal injury by accident" refers to a mishap causing harm to the person.

It is noted that the definition specifically included the physical and mental consequences of the injury or accident no matter what claims handlers or specialists subjectively thought ought to be the case. Mental consequences of the injury or accident were covered by the scheme just as conclusively as physical consequences. In general it was only damage to the body or mind which was caused exclusively by disease, infection or the ageing process which was excluded.

Furthermore, it had long been held in the High Court and in the Accident Compensation Appeal jurisdiction that the Corporation was bound to accept its claimants as it found them. A claimant who was particularly susceptible to injury because of an underlying disease, or a predisposition to injury, was entitled to compensation or cover for the actual injury he or she had sustained, even though a "normal" person might not have suffered such ill effects or ill effects to such an extent as the claimant. If the claimant in fact suffered pain or other debilitating disabilities that were very real to them as a result of their injury or accident, then they were entitled to

cover, even though that pain or those disabilities could perhaps quite readily have been overcome earlier by another claimant.

This principle applied even if an underlying condition was merely activated or aggravated by the accident. It was not a question of determining whether the claimant's loss of earning capacity was due partly to the injury or accident and partly to an underlying disease or pre-disposition or condition. Provided that the loss of capacity was due in some extent to the injury or the accident, then the claimant was entitled to the full cover set out in the Act. Indeed, it was only if it could be shown that the damage was exclusively caused by disease, infection or the ageing process that cover could be denied.

Furthermore, the Corporation was required to heed the principle of law which demands that, while there is a need to establish a causal connection between the accident and the injury or the effect of the injury, it is not necessary to establish that the accident was the sole cause of the incapacity. As long as there was a causal connection between accident and injury then the obligation to provide cover had in fact been established.

I continually found a reluctance or an inability to accept these propositions. In many cases - as I shall illustrate - there seemed to be a dogged perversity in refusing to accept these long established criteria. This reluctance or perversity was consistent in the decision-making process and in formulating medical opinion, and it was allowed to continue. I find that difficult to defend.

**The Standard of Proof**

If medical practitioners were to be asked to give their opinion about whether a particular injury or disability was "personal injury by accident" then they should have been properly informed about the appropriate standard of proof which was required in this jurisdiction. It was simply one of persuasion.

Chief Justice Davison described it in Jones v Accident Compensation Commission [1981] NZACR 105. He said:-

> The Commission and the Hearing Officer except in special castes where the Act requires proof ... are not concerned with concepts of burden of proof or proof on the balance of probabilities as such are normally related to civil cases.
>
> What is done is to inquire whether the applicant for compensation has rights under the Act. If after considering all available evidence the Commission or the Hearing Officer, as the case may be, is brought to the belief that he has, then the applicant is entitled to compensation. I think that what is required under the Accident Compensation Act is best expressed by Dixon J in Brinquinshaw v Brinquinshaw (1938) 60 CLR 336, 361:
>
> > 'The tribunal must feel an actual persuasion of its occurrence or existence ... it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal.'

This standard is a particularly low one but there was a general reluctance by claims assessors, if they knew of it, to accept or apply it, and this showed in the referral process. Consistently, a higher standard of proof was being required by claims handlers and by the medical specialists to whom claimants were referred.

**What The Medical Specialist Should Know**

I am firmly of the view that before any medical practitioner could report effectively to the Corporation he or she must have had a good working knowledge of the requirements of "personal injury by accident". Without this he or she had no proper basis upon which to formulate an opinion which would facilitate the Corporation's decision-making; the specialist would have been talking of "chalk" while the statute and the claimant's entitlement would be anticipating "cheese" in classic *Alice in Wonderland* style.

But this is what was happening in many of the cases I reviewed, especially where the mental effects of injury or accident were involved. In one case the Corporation's medical officer said:

> "I agree ACC has now no responsibility for the injured person's ongoing back problems as the pain is mainly psychosomatic in origin. However I agree that the injured person should be 'let down gently' and a further ongoing counselling, preferably through the GP, should be encouraged."

In other cases the instruction was given to ask if the incapacity was "solely" related to accident. But it is clear that it was not essential for a claimant to establish that the accident was the sole cause of the injury. As long as there was a. cause or connection between the injury and the accident, entitlement to cover should have been established. The questions asked were quite contrary to that proposition.

Many of Dr Gluckman's reports reflected this erroneous approach with consequent effects on the claimants' entitlement.

I appreciate that the newer 1992 Act provides a different and more positive definition of personal injury and of accident. However, the position which prevailed over the period of my investigation is generally as I have set out, but it was not applied in that way.

The information provided for medical practitioners on the back of form FLC 9, "Request for Medical Report", may well have been appropriate for lump sum settlements under sections 78 and 79 of the Act, but it was woefully inadequate as a guide to medical practitioners being asked to assess whether a chronic disability came within the definition of personal injury by accident.

**The Availability of Specialist Reports to Claimants**

Many of the claimants I interviewed told of intense difficulties in obtaining copies of their files - or of any part of those files - or of any specialist reports that had been written about them. In many cases the staff's attitude was totally intransigent, and it was maintained until threats to invoke the Official Information Act or something similar were used. In one case I saw, the Corporation's own Medical Officer asked that a copy of a report be sent to the claimant's general practitioner but this was simply never done. It was, however, noticeable as I read through files that this attitude was not taken with solicitors, who it seems were given information and copies of reports about their clients without question.

In the latter stages of the period under review this attitude towards claimants who sought information or copies of reports changed, and they were able to obtain the information they required with relative ease. I am now told that the Corporation does generally make available to claimants or their general practitioners reports which it obtains from specialists. I have no doubt that the Corporation is correct in adopting that policy.

In my view the matter should not end there, however. When claimants did obtain copies of their reports they frequently expressed disbelief at what had been said of them in psychiatric reports prepared about them. Often they were appalled.

Many of these claimed inaccuracies could be said to be irrelevant or unimportant to the major consideration or to the., conclusion of the report. But when the report was seen many months after the event, and usually after an adverse decision, the perception was that the report was hopelessly biased and that the claimant had been treated unfairly.

If a claim is to be rejected it is important that it be done on the basis of an opinion which is firmly founded on a proper appreciation of correct facts. If the facts upon which medical opinion is based are faulty or inaccurate and the claim is rejected, it is natural that there will be a perception that the opinion is flawed or biased. It matters not whether the particular fact is considered to be important to the diagnosis or opinion. If the fact in question is irrelevant, it ought not be there, but if facts have been recorded

and recorded inaccurately, then the patient has every right to consider that the consequential opinion or diagnosis is also faulty. In any case the perception of a flawed opinion remains.

As a matter of "natural justice" the patient or claimant should be shown a copy of the report, especially if it is to be the basis of an adverse decision. In this way the claimant is at least aware of the facts upon which the medical opinion is given and if necessary can be accorded the opportunity to challenge or correct them.

If the medical reports were as a matter of course made available to claimants as soon as they were received and they were asked to comment, any atmosphere of distrust would be dissipated immediately and any errors could be corrected.

Often mistakes occurred because the level and quality of communication between the claimant and the doctor was less than desirable. Most claimants had no idea of what was to be required of them before coming to the examination and interview. They were simply not briefed and I deal with that matter later.

Some specialist reporters dictate at least the factual or historical part of the report in the presence of the claimant so that the patient knows there and then precisely what is being said and may contest or correct it at the time. That practice is to be commended.

In any case there would seem to be an obligation on the Corporation to send a copy of the specialist report to the claimant as soon as it has been received, particularly if a decision is to be made to reject the claim.

**The Ethical Position**

While this appears to be common sense, medical ethics also seem to confirm this advice. Clause 7 of the Code of Ethics of the New Zealand Medical Association requires that patients have a right to know the nature of any illness from which they are known to suffer, its probable cause, and the available treatments, together with their likely benefits and risks. In May 1991 the Medical Council expressed the view that the examining doctor should be careful not to incorporate material into a report which a claimant might not wish to have disclosed, but noted that such information should be excluded only if it was not material to the claim.

I am told that the Corporation's policy requires that copies of all medical reports are sent to the claimant's own doctor. I approve of that policy but note that I saw many instances of it not being carried out.

I am told that it must now be clearly noted on the file who the report is sent to, by whom and on what date. It seems logical that this system should be computerised so that this requirement comes up to be actioned every time a report is received and entered into the Corporation's system, with the system locking until the procedure has been followed.

**Referral for Examination**

As I have previously reported, in almost every case I reviewed no explanation had been given as to why the claimant was being referred to a psychiatrist. Most did not know that they were going to a psychiatrist until they arrived at Dr Gluckman's premises. They had been given only his name and address. Some had looked in the telephone book to find out who they were going to, or rather what was to be the purpose of their visit, but most just went.

Almost all were embarrassed and bewildered when they discovered that their referral was to a psychiatrist. They thought that their business with the Corporation was because of persistent pain in their back or in their shoulder or in their wrist. They had no idea why they were being referred to Dr Gluckman and when they found out most of them objected strongly. Claimants were incensed at the possibility of it being thought that they were "not right in the head", or "crazy", "a nut case", or "mad".

Many of those who knew where they were going were ashamed and angry that they were being required to undergo a psychiatric examination

and they often did so without the knowledge and support of friends or close relatives. They felt a deep underlying resentment at the possibility of it being thought that they were malingering. They were resentful and far from co-operative.

All of this was further complicated by the fact that Dr Gluckman was also a specialist physician by qualification and registration, so that once the claimant had become used to the idea that they were being examined by a psychiatrist, they were then asked to undergo a physical examination, and to remove articles of clothing. In some cases this examination involved embarrassing thoroughness, claimants often being asked detailed - sometimes what they regarded as offensively detailed - questions about their psychosexual history. The experience was for most of them totally bewildering and confusing to say the least. Their attitudes as described to me are confirmed in the doctor's reports. There are so many examples of this that Corporation Officers ought to have picked up and acted on the message.

Most of these people regarded themselves as long term clients of the Corporation. They considered that they deserved to be treated as such, and they all thought that their referral to Dr Gluckman more than any other referrals should have been explained personally, on a face to face basis, by a senior officer of the Corporation. A simple explanation would have allayed their apprehension and their fear. It may also have clarified whether a psychiatric or a physical examination was being sought by the Corporation and it may have prepared them for what they subsequently saw as a long ordeal.

None were briefed on where they were going or what would be required of them and consequently they were not prepared for what was ahead. They went simply because they had been told to go, in the belief that this was part of the system - or because they knew that unless they went and did what they were told their claim would not be dealt with. A briefing would probably have made them co-operative rather than antagonistic; as it was, the lack of any briefing exacerbated their perception that the Corporation's procedures and its staff were confrontational and adversarial and that they disbelieved everything they said.

None of the claimants knew that they would be involved in a three or four-hour examination; they were simply not prepared for such a long involvement. They were entitled to have been warned.

They should also have been told that they were going to be required to provide a full personal history. Because they were not told many of them were labelled. They were described as "bad historians", or as having "provided conflicting details", or as "somewhat contradictory about the time factors", or "somewhat vague about dates". In some cases even more condemning comments were, made but as I read these criticisms of how various claimants were unable to provide a comprehensive history I could not help but think that I would have done no better in the circumstances, and that I would deeply resent this subsequent labelling. In the context of it being considered that I might be a malingerer or making things up I would easily have cried that it was simply unfair.

The Corporation owes a clear duty to its claimants to seek and to obtain the truth relating to any situation which affects their claim. It should therefore aim to secure the co-operation of claimants and to work with them rather than against them. An adequate briefing or explanation would ensure not only that their consent was genuine and informed but that the claimant was ready for what would be required and in a co-operative frame of mind.

There seems little or no reason why claimants should not receive a copy of the Corporation's instructions to the specialist to whom they are being referred. This would ensure that all parties knew what was required; there would be no hidden agendas or suspicions and both doctors and claimants would know what was required of them. Claimants could prepare themselves and make appropriate arrangements.

## Overall Impressions

I have the clear impression that insufficient regard has been had to the legal and medical requirements of "personal injury by accident" as defined in this particular legislation, and that claimants were being required to prove their claim conclusively before they were provided with cover under the Act. Many claims were decided on the inclination of a senior client officer or a branch manager with little or insufficient medico-legal knowledge of what was involved or of the requirements of the Act.

Consequently many of the referrals to medical specialists were unnecessary, ill-defined and inappropriate. That was particularly so

for the majority of referrals which were made to Dr Gluckman, where loose, inappropriate referrals resulted in loose and irrelevant reporting.

In general, when claimants were referred by the Corporation for medical examination and report in difficult cases, they were ignorant of where they were going, why they were going and what was to be required of them. In many cases this may well have invalidated the patient's consent.

Referrals for medical examination should only be made by people with appropriate medical knowledge and experience. The resulting reports should come back to these people to be analysed and then filed in a fashion which clearly indicates respect for the confidentiality of the material received.

Claimants should be informed, preferably in personal discussion, with information confirmed in a subsequent letter

(a) that a report, assessment or opinion from a particular type of specialist is sought;

(b) the reason why such a report is being sought;

(c) who the Corporation suggests as an approriate specialist;

(d) that the claimant may nominate an alternative specialist if the one suggested by the Corporation is in any way unacceptable; and

(e) that the claimant will be required to consent to the specialist reporting to the Corporation and to the Corporation's supplying that specialist with such medical information as it already holds.

**Current Procedures for Psychiatric Referrals**

The Corporation has informed me that it now has new procedures which are required to be followed when it contemplates referral of a claimant to a psychiatrist. I am told that the initial decision of whether or not a claimant is to be referred for psychiatric examination must now be made by a Medical Officer who is required to state and record specifically why a psychiatric opinion is necessary. The claimant is then contacted and the purpose of the referral is explained. If the claimant is already consulting a psychiatrist then the report is sought from that person. If not, the claimant is offered the opportunity of choosing the specialist; the intention is that the referral be made to a specialist of the claimant's choosing.

I am assured that psychiatric assessments are not now sought without the reasons for the need for that assessment being set out in writing by a medical officer, and that the consent of the claimant and their own doctor is obtained.

I am told further that the Corporation actively promotes the involvement of the claimant and their medical manager in any medical assessments required by the Corporation and that the appointment of the Corporation's District Medical Advisers has ensured that this approach is maintained through branches.

I approve of these processes but I confirm and re-emphasise that in my view all referrals should be fairly and squarely under the control of a medically qualified and experienced officer, someone with

appropriate medical or nursing experience. That person should be accountable for obtaining the subsequent report directly and for the custody of that report.

**Referral for Treatment**

The issue of communicating with the claimant's general practitioner is even more important where a referral is being made for treatment. In some of the cases I reviewed the Corporation made a referral for treatment without reference to the claimant's own doctor. In one case the examining psychiatrist recommended that the claimant would benefit from eight psychotherapy sessions with him. This recommendation was referred to the Corporation's District Medical Officer who noted on the file that he was apprehensive about the ethics involved in such a referral; the claimant was at that time consulting another psychiatrist independent of the examination required by the Corporation. Despite this caution the senior client officer authorised and directed the treatment recommended.

When questioned on this the Corporation acknowledged that treatment of the claimant should not have been managed by that officer or by the Corporation's Medical Officer.

I am told that the Corporation's current policy is for the specialist's report in such cases to be referred to the claimant's

own doctor and for any treatment to be undertaken under that person's control rather than at the referral of any officer or agent of the Corporation. This is totally in conformity with the practice of the two insurance companies I interviewed. I sincerely hope this practice is followed assiduously.

## THE APPROPRIATENESS OF REFERRALS

### The Corporation's Policy

When the question of the appropriateness of referrals, contained in my terms of reference, was put to the Corporation I was told that it obtains reports from registered medical specialists with qualifications in the specialist area in which the report is required. That is, I was told, reports on orthopaedic injuries are obtained from orthopaedic specialists, and on psychiatric issues, from a psychiatrist.

But that disarmingly simple response from the Corporation begs the question and illustrates one of the major problems which it faces under its present structure. The question which I suggest is being begged is essentially - when is an injury an orthopaedic matter and when is it a psychiatric matter? In some instances the answer is simple or even obvious, but in other cases it is by no means clear cut, or simple. To illustrate:

In one case I saw, an orthopaedic specialist had suggested that there might be some psychogenic component to the claimant's injury. A referral was made to a psychiatrist but, I am advised, in this case a psychological assessment may well have been as or more appropriate, at least in the first instance.

In another case the referral to Dr Gluckman was made by the Rehabilitation Co-ordinator and the Senior Client Officer despite the Branch Medical Officer having minuted the file five days earlier that

he did not consider that a psychiatric referral was necessary. Nevertheless the referral was made. It resulted in a decision adverse to the claim. It had to be taken to review to be corrected.

In another case the claimant's general practitioner asked for a psychometric assessment. The matter was referred to a Rehabilitation Officer who recommended without advice being obtained from the Corporation's medical adviser, that the claimant be referred to Dr Gluckman. In my view the Corporation's medical adviser should have been asked who should undertake the psychometric assessment. It was inappropriate to leave that question to a Rehabilitation Officer.

In yet another case a neurologist had suggested that a claimant who was suffering from chronic back pain might be suffering from some underlying psychological problems. It was thought that some psychogenic element may have been prolonging her incapacity. The woman was referred to Dr Gluckman. The possibility of a psychological assessment was not canvassed. It would probably have been more appropriate in the circumstances. A psychological element in the treatment of chronic pain is well recognised and many pain clinics have a psychologist as a member of their team.

These and other cases led me to at least the possibility that many of the psychiatric referrals I reviewed were inappropriate.

**The Selection of Appropriate Medical Specialists**

But these matters apart, I was told, on further inquiry, that in selecting specialists for "difficult" cases there are a number of factors which are taken into consideration, including:

(a) the special expertise of the specialist and his or her seniority;

(b) whether the specialist has an understanding of the Corporation and its assessment methods - it was noted that education was often required;

(c) the ability of the specialist to report clearly and in an unbiased way;

(d) the availability of the specialist and his or her ability to report without undue delay; and

(e) the specialist's fee-charging structure.

I am told that selection is on an anecdotal basis and that some doctors rule themselves out of contention by their past performances, either by providing inadequate reports, through their lack of understanding of what the Corporation requires, or simply because they are unduly slow in reporting. Others charge inappropriate or unacceptable fees. As a matter of principle I have no problem in accepting any of these criteria.

But I am also told by the Corporation that doctors tend to protect their own clients in preference to supporting the Corporation's attempts at rehabilitation or to cease ' compensation payments, and that for these reasons the Corporation seldom seeks an assessment

from the client's regular medical adviser or specialist. Whether or not this is an accurate statement about the medical profession, it may be appropriate for any one of a number of reasons for the Corporation to seek an opinion independent of the claimant. In doing so, however, the Corporation must ensure that the opinion it obtains is in fact independent, not only of the claimant but also of the Corporation, and equally importantly, that it is seen to be so.

Furthermore, the process of choosing the appropriate specialist even according to the criteria stated still requires an intimate knowledge of what speciality is actually involved in a particular case, and of the Corporation's legal requirements as opposed to the subjective requirements of its management or staff. The examination and the report must be relevant to the legal and medical principles which must guide the Corporation in its decision-making processes, and all extraneous and irrelevant material must be disregarded. I am not at all convinced that the Corporation's procedures allow this to happen.

**Why Referrals Were Made to Dr Gluckman**

But coming to the specific cases involved in this inquiry, when I asked a very highly placed officer of the Corporation why referrals were made to Dr Gluckman so frequently, I was told that it was in an attempt to obtain what the staff saw as "natural justice". It was said that there was a clear perception among staff that claims of prolonged incapacity after a relatively trivial accident were due to:

(a) psycho-social problems which far outweighed the trivial nature of the injury;

(b) alcohol and substance abuse;

(c) an unsatisfactory job and poor working relationships;

(d) psychiatric illness or other medical condition;

(e) the claimant nearing the end of a working life and having no desire to return to work

or a combination of any of these causes.

Corporation staff, I was told, had become fed up with clients who were seen to be "ripping off the system". These people were therefore referred to a specialist who I was told, was unafraid of examining factors aside from the injury. I was told quite clearly that this was where Dr Gluckman's usefulness lay, as he was a qualified physician, and a psychiatrist, and he had been used over a number of years as the Corporation's "hit man".

I was also told that an increasingly liberal interpretation of the meaning of "personal injury by accident" and "medical misadventure" by Review Officers and Appeal Court judges had also had an effect on staff over the years and that this had influenced their choice of a specialist for referral. I was told that an adversarial situation often developed between the client and the Corporation, and that "when Laurie Gluckman was used as the hit man everybody was ripping us off - they were all alcoholics - or something was wrong. It was a nasty situation."

It was said that the Corporation was in a real bind with most of these people; that it didn't know where to go; that rehabilitation was so poor that staff got stuck with claimants for five or six years and that very few of the medical profession were prepared to stick their necks out and say these things. Theirs was a desperation attempt to try to do something about these clients who were "on our books" for so long.

These were totally inappropriate reasons for referral and in no way conformed to accepted principles of law.

**Referrals for Chronic Pain**

But even if the referrals were made in an attempt to search for possible psychological factors as a cause of the debilitating pain and other symptoms which claimants described it was in my view in general misguided. There may have been some point in referring a claimant to a psychiatrist to evaluate the psychological impact of the injuries involved and to contrast the claimant's then functioning abilities with those before the accident, but I saw little or no evidence that this was what was being sought. Indeed, against the very clear explanation given by the officer I have referred to, and bearing in mind the volume of referrals made in the first half of 1987, I am sure that these factors were not in the mind of any Corporation officer who referred claimants to Dr Gluckman.

But it appears that most of the cases that were referred to Dr Gluckman involved chronic low back pain or musculo-skeletal pain

where there were no objective physical signs of what was causing that pain. Examinations had indicated that there was nothing pathologically serious amiss, but the person was still in extreme and disabling pain. Soft tissue pain is, I understand, notoriously difficult to treat and its cause difficult to find, but it can drive people to depression and sometimes towards suicide, but those are the results of the pain rather than its cause.

There may have been no functional explanation for the pain but that did not necessarily mean that the complaint was a deception or an invention. The plain fact was that the pain existed, and that it existed as a malfunction of the body as a result of an injury, even though there may have been no observable changes to that body.

It seems clear to me that the first few cases which were referred to Dr Gluckman were "successful" in that his examinations and reports were able to give a basis to the Corporation's officers to decline continuing compensation payments. This success in turn bred success, and the news appeared to have travelled rapidly among Corporation officers in Auckland, with consistent results. In my view there was a total lack of appropriate legal and medical knowledge and practice on the part of the Corporation's officers, born out of a lack of training or expertise in dealing with complicated, difficult or long term cases.

Decisions on referral appeared to have been made at a relatively low level of management and on an ad hoc basis with little legal or medical understanding, input, or supervision. Staff at branch ievel were required to deal with these difficult cases on the same basis as

they dealt with simple, clear-cut cases involving readily noticeable and identifiable injuries. At that level, however, they lacked the experience and knowledge to deal with these cases effectively and in accordance with the requirements of the statute.

The files I saw were quite remarkable for the abundance of cryptic comments made in memoranda between officers. They showed the prejudices, bias, and frustrations which I have previously described, but they also showed a lack of appreciation of the medical and legal issues involved. The continuing quest for a diagnosis or a labelling of the incapacity was clearly being sought so that the claim could be dealt with along the lines familiar to claims handlers involved with easily identifiable injuries, to allow payment to be made and the file to be closed. But the handling of these claims for long term pain-induced disabilities required different skills, training and knowledge. They required a continuity of dealing with these matters so that a basic knowledge of the terminology and an understanding of the medical and legal issues involved could be learned and applied.

They also required meshing in with the rehabilitative aspects of the Corporation's work if the long term effects of an accident, were to be alleviated or removed, and they demanded a reasonably detailed knowledge of the usual or likely physical and mental consequences of trauma or accident and of those elements of bodily damage which can be caused by disease, infection and the degenerative or ageing process.

It is, I think, fair to say that in the area of compensation or damages for personal injury, one of the most troubling and least

understood aspects of all chronic conditions is pain, especially that which manifests itself in the back, shoulders and arras. This is the area which involved the claimants I interviewed, an area which has been troubling medical and legal experts for many years. It was in my view quite unfair of the Corporation to ask untrained and inexperienced staff to make decisions in these areas.

There may well have been a need to identify and clarify a claimant's disability so that it could be isolated from other disabilities which were specifically exempted from "personal injury by accident" as defined in the Act. But in that case the doctor should have been told specifically what other information was being sought; for example whether the disability could be said to be an incapacity which was due exclusively to the ageing process.

Overall I am firmly of the view that the process of selecting the appropriate medical speciality for a referral in these cases was inappropriately placed; i.e. it should be the function, of people who have at least some medical or nursing background and understanding; preferably it should have been carried out by or under the supervision of a qualified and experienced medical practitioner or nurse as it was far from an easy or routine matter.

**Dealing with Pain**

Pain is a problem which inevitably - to the patients who have that problem - seems to get referred to a variety of specialists so that care becomes fragmented and difficult to co-ordinate. The cases I have referred to are a graphic illustration of this proposition.

There was a tendency to think about pain in a very fragmented way -in terms of which part of the body was sore - and each specialist would deal with the pain in 'their' part of the body only.

It was anaesthetists who first began to identify that there was something about dealing with pain which meant that a much more holistic and multi-disciplinary approach was needed, and that the proper treatment of pain would necessarily involve the concerted and co-ordinated efforts of a variety of different medical specialists (dentists, rheumatologists, psychiatrists, orthopaedic surgeons,-neurologists and neurosurgeons), and also of nursing staff, physiotherapists, occupational therapists, social workers and psychologists. From this realisation Pain Clinics emerged. They try to collect the efforts of all or some of these divergent services into one place, so that as far as possible the specialists involved in any particular case can together co-ordinate a management and treatment programme.

Referrals to Pain Clinics come either from general practitioners or from specialists, with the basic requirements of an X-ray, a clinical examination and some blood tests so that clinicians will know they are not dealing with rheumatoid arthritis, spondylitis or a condition that a particular speciality may deal with alone. Certain pathologies have to be ruled out, such as cancers, infections and fractures.

Some patients may then have adjustments made to their medication (some people need to withdraw from pain killers and tranquillisers and be introduced to medications that might be more helpful) ; some may undergo nerve blocking techniques which range from finding a nerve that may be trapped in scar tissue or some similar problem, to injecting around or into a particular pain site, or alternatively some further investigation may be required.

One of the major causes of back pain ' is problems with the facet joints, the small joints at the back of the wings of the vertebrae which meet on either side all the way up and down the spine. These are highly innervated and very sensitive so that only by injecting local anaesthetic around those joints can a pain problem be improved. Epidurals involve going deeper into the spinal canal, but outside the coverings of the cord itself, so that the fluid spreads and affects the nerve roots and the nerves coming from the spinal cord. Occasionally spinal injections will be used, where the needle goes into the spinal sac and into the spinal fluid.

It is generally recognised that chronic pain is a physical problem rather than a mental one and the days are gone when people with back pain were put to bed for weeks on end. Rather the person is stopped from getting into bed. Efforts are made quite forcibly to get them walking and doing exercises.

Pain Clinics have moved progressively away from "hands on" manipulative-type physiotherapy in the treatment of chronic back pain

as there seems to be good evidence that this is not the best way to handle this pain. The preferred approach is to educate people in stretching and muscle strengthening exercises and to get them fit and on to exercise programmes.

Pain Clinics have over the years developed a quite highly structured pain management programme running on a group basis with exercise and education, teaching people about their pain and of the specific techniques of relaxation, meditation, self-hypnosis and visualisation in the hope that each patient will come to something that will work for them. The aim of this approach is so that when people leave the programme they will:

(a) be fitter and more active and be able to do more;

(b) understand their problem better; that there is a limit to what the professions- can do for them, and that a large part of coping with their problems is up to them; and

(c) have some ideas about psychological strategies such as relaxation techniques which will help them.

It is acknowledged that there may not be a cure, or that not everyone can be cured, but they also get a large number of people back to work. The sooner treatment is started, the sooner patients can return to work, but if they have become too chronic then treatment is not a great deal of use to them.

Some patients have concomitant psychiatric illness, mostly depression or anxiety, which may need management with medication. There is some evidence to suggest that people who develop chronic pain may have a

background which may make them prone to develop that pain; that they are pain-prone personalities.

There is a lot of evidence which suggests that most of the psychiatric and psychological difficulties of people with chronic pain are a consequence of the pain itself. However, some people do consider that pre-existing psychiatric morbidity must indicate that the person's pain is not solely due to an accident.

A large number of people suffer psychiatric problems because they are frustrated. But if they can be got back into the workforce and leading a normal life then often this psychological pain will disappear.

**psychogenic Pain**

It is perhaps appropriate to mention at this stage that there was, and may still be, some debate among medical professionals about "psychogenic pain" and "conversion disorder" and that there were differing schools of thought on these topics.

As I understand it Dr Gluckman was a follower of Freudian writings about hysteria which developed the theme that emotional conflict arising from past traumatic events, or from current unacceptable wishes, could be converted into physical symptoms and that this could be associated with psychogenic pain, a term used to denote pain produced by emotional factors. This early literature had emphasised childhood punishments, guilt, and sexual difficulties in patients who suffered with chronic pain. More recently psychogenic pain had been linked with depression, and some psychiatrists regarded psychogenic pain or the "pain-prone disorder" as a variant of depressive illness. It was suggested that some people may have been particularly vulnerable to chronic pain because of their early childhood experiences and their personality style, and in particular it was suggested that people with chronic pain when compared with people with acute pain showed a neurotic profile.

Evidence of an adherence to these theories came through strongly in Dr Gluckman's reports and an understanding of these theories may in some way help to explain the doctor's actions in what most of the claimants saw as an irrelevant and completely unhealthy preoccupation with a detailed analysis and reporting of their sexual practices and

history, to their frustration and often to their total disgust. In his examinations and reports the doctor certainly focused on eliciting from claimants a detailed family and personal history and required a very detailed psychosexual history from them.

On the basis of the widely accepted proposition that the Corporation is bound to accept its claimants as it finds them, it is very difficult to see the relevance of these matters. The existence or otherwise of a predisposition to pain or a neurosis is in most cases irrelevant, whatever the theory; someone with a basic knowledge of the law relating to these matters should have informed the doctor accordingly, and required him to disregard these matters when he considered the Corporation's claims. If this had been done I wonder if in fact referrals would have been made and if they were made what would have been the results in terms of the claim.

**Monitoring of Performances**

The Corporation has no formal system of monitoring the performance of its medical consultants. Quite simply it should have. It is, as I have already said, a very large medical insurer. As such it ought to rely heavily on medical opinion and advice. I have already indicated that I consider the . amount of that advice is inadequate but that apart, whatever advice is obtained must, in terms of quality, be the best that is available, both at the decision making phase and on review or appeal. Any failure to obtain appropriate competent medical advice is simply missing the point of the Corporation's operation and function.

But medical knowledge is not constant or stagnant. It is in a state of continual growth. The competent medical adviser or specialist is consistently learning and gaining further knowledge through experience. No one person or institution claims to have knowledge in its totality. Diagnosis is often a matter of divergent opinions such that it is only at the post mortem stage that an exact diagnosis can be made. Research and ever improving technology is consistently revealing hitherto unknown facts and adding to the accumulated knowledge of the medical profession, and as lay patients become more exposed to universal education in so many ways the demands for higher standards required of professionals generally, become more exacting. Consultation, discussion and supervision seem to be at the very heart of good medical practice and opinion today, and there appears to be a growing emphasis on review of performance by ones professional peers, before mistakes are made.

Against this background, and with the accumulated knowledge obtained in this inquiry, it seems clear to me that the Corporation is obliged to put in place an efficient system to monitor the performance of first, its own medical officers, and secondly that of its external medical advisers. It owes that duty of care to its claimants. Such a system should in the first place rely upon internal monitoring of the Corporation's own medical staff by professionals within its own heirachical structure and secondly by utilising a system of regular peer review available and offered by the various specialty Colleges within the medical profession on an ad hoc or regular basis.

## CONFIDENTIALITY AND CONSENT

### The Professional Obligation to Keep Secret

There is a duty on all professional people, including doctors, to keep their clients' or their patients' affairs secret; they must not disclose them without proper cause. For doctors this obligation is governed by the medical profession's code of ethics as well as by common law and by statute.

In this country the Code of Ethics of the New Zealand Medical Association requires doctors to keep in confidence information, derived from a patient or from a colleague regarding that patient and to divulge it only with the permission of the patient., except where the law clearly requires otherwise.

Confidentiality is a fundamental duty which is at the very heart of a professional relationship. It is a duty which continues after that professional relationship has ceased through the patient's change of doctor or the death of the patient. It is quite distinct from the immunity which certain medical professionals have from disclosing in the course of court proceedings information about communications which they have received from patients.

It is important, particularly against the background of this inquiry, to emphasise that the protection of information which passes from patients to their doctors is founded on the necessity to establish a bond of trust so that the patient may feel confident to confide freely in the doctor and to divulge vital information which they

might otherwise be inclined to withhold. It is to enable frank disclosure by a patient in an environment of trust protected by the assurance that information about the patient will be treated delicately and sensitively and will not be disclosed without the patient's consent, unless some other overriding good requires this.

The obligation on the doctor to keep information secret extends to information beyond that which the patient communicates to the doctor. It includes observations and diagnoses which the doctor may make about the patient.

Within this general requirement for confidentiality it has been said that the position of the patient of a psychiatrist who "confides more utterly than anyone else in the world" is even more special.

The information obtained by a doctor in the course of a consultation is the property of the patient. It is therefore the right of the patient to determine who should receive that information, and it cannot normally be passed on to others without the patient's consent. This requirement to keep secret may be waived by the patient, or the patient may consent to its disclosure - or the doctor may in certain exceptional circumstances be required by law to disclose the information.

The consent of a patient to disclose confidential information may be express, or it may be implied, but the quality or integrity of that consent, express or implied, must be "informed". The obligation on doctors to refuse to divulge patient information if there is any

doubt whatever whether the patient has consented, extends to the quality of that consent. The consent must be informed.

In Pallin v DSW [1983] NZLR 266 Justice Somers talked of this at page 277 when he said:-

> The ability to consent to a disclosure by a medical practitioner depends in the abstract upon the ability of the patient to understand what is involved

and the Medical Council of New Zealand has, in a statement issued to the profession in June 1990, said:-

> Medical consent means a voluntary, uncoerced decision made by a legally competent or autonomous person on the basis of adequate information and discussion.

**The Corporation's Statute**

Section 99(3) of the Accident Compensation Act 1982 said

> The Corporation may allow any such claim upon the statement or statutory declaration of the claimant alone, or may, if it thinks fit, call for such other evidence or information as it may require from the claimant or any other person before allowing any such claims.

This section placed a requirement on a claimant to supply information, or evidence or to consent to the supply of information or evidence to the Corporation, or alternatively to abandon their claim or allow it to be rejected. It required the claimant to provide information, but it did not of itself enable or authorise a doctor to do so, without the claimant's consent. If information is obtained or held by a doctor then the patient or claimant must consent to the information being provided to the Corporation by the doctor as the patient's

agent, but the doctor may do so only after the patient has shown that he or she understands what is involved.

The highlighting of the requirements of informed consent since the passing of the 1982 Act is reflected in the provisions of the Accident Rehabilitation and Compensation Insurance Act 1992. Section 64(1)(c) of that Act is much more specific than section 99(3) of its predecessor. It requires every person who claims for, or is in receipt of, a rehabilitation compensation grant or allowance, when reasonably required to do so by the Corporation, to authorise the Corporation to obtain medical and other records which are or may be relevant to the claim, and to:-

(a) undergo examination at the expense of the Corporation by an appropriate method,

(b) undergo assessment of impairment, disability or handicap at the expense of the Corporation, and

(c) undergo assessment of present and likely future capabilities for the purposes of rehabilitation at the expense of the Corporation.

The emphasis in the new Act is on the claimant having to provide an authority for the Corporation to obtain the information, rather than the claimant having to provide it, and for the claimant to undergo any examination which might be necessary.

**Information Obtained from a patient's Doctor**

Normally the Corporation seeks routine information from the claimant's own doctor. This clearly requires the specific approval and consent of the patient. It is also necessary for the doctor to be assured that the patient's consent is informed; that the patient understands what is involved and knows exactly what information will be supplied in response to the Corporation's request, and the ramifications if the doctor provides the information sought. This is particularly important if the doctor has information which is or may be contrary to the interests of the patient in his or her claim on the Corporation, or where the supply of that information may in any way endanger or prejudice the doctor/patient relationship. In these circumstances it is necessary for the doctor to explain to the patient that he or she may decline to allow the doctor to conform to the Corporation's request to supply the information, and that the doctor will decline unless specific approval or authority is given by the patient.

The emphasis must be on the patient being fully informed of what is involved in the request being made of the doctor and of understanding what may be involved if that information is supplied.

If the patient elects not to consent to the supply of some of the information held by the doctor then the doctor, must not supply misleading or incomplete information which might lead to an "incorrect" decision being made. It might not be appropriate for the doctor to supply information about the patient in these

circumstances. If the doctor does supply incomplete information then, that fact should be made clear; that the information is partial only and that the doctor has other information which he or she is unable to disclose. It is the patients information and it is the patient who must decide whether or how much information is to be disclosed.

**Information Obtained at the Corporation's Request**

Some say that because treatment is the essential ingredient of the doctor/patient relationship there may not be the same obligations of confidentiality where a request for examination and report, not involving treatment, is made by a third party such as the Corporation. I have severe doubts about the efficacy of that distinction. It seems to me that if a referral is made by a third party to a doctor who is not the patient' s doctor then the doctor/patient relationship is established on the patient's presenting themselves to the receiving doctor. By the fact of their attendance there is an implied consent by the patient. But there is still the same necessity for the doctor to ensure that the patient's consent is informed before disclosing information to the instructing third party.

There is no doubt that in these circumstances the doctor has a contractual responsibility to the third party, in this case to the Corporation. It has contracted with the doctor for the supply of his or her services and for the outcome of the examination which is the doctor's report. But this responsibility to the Corporation is based on the prior necessity of the patient actually attending on the

doctor and on their establishing a relationship of doctor and patient. Otherwise there can be no examination and no report. The relationship created is one of professional and client. It requires the doctor to behave in a proper professional and ethical manner towards the patient.

The Medical Board of Victoria has recently (December 1993) put it this way

> "A medico-legal examination is a professional service which, despite the inherent difficulties, requires the same standards of behaviour and care as the traditional medical consultation. The practitioner should make his/her role clear at -the start of the consultation, should observe the normal courtesies and respect for a patient's privacy and inform the patient of the nature of the examination. This is particularly so if the practitioner detects apprehension or if a test may produce pain
>
> The Board expects the practitioner, as the experienced professional person, to promote a co-operative attitude and to be sensitive to the circumstances of the process. This will facilitate a satisfactory medical history and physical examination and the opinion expressed will therefore be enhanced."

As the Medical Board of Victoria has said - the doctor should make his or her role clear at the start of the consultation. That in my view involves two matters. First that the patient knows that the doctor will be reporting to the third party, and secondly that the patient knows what the doctor will be reporting about. Without the patient's specific consent or authority for these matters there can be no examination or report. It is that requirement which makes necessary the doctor's explanation of his or her role, but it also entails the patient knowing exactly what the doctor is to do; the patient being fully or appropriately briefed before they are asked to consent.

In practice the patient is asked to sign a form consenting to the release of the information to the Corporation. The very requirement-that such a form be signed seems to acknowledge the need for the consent of the patient, but I question how such consent can be said to be informed if the patient does not know what is involved.

In the cases I reviewed I have severe doubts that the patient in any way consented to the disclosure to the Corporation of the very intimate and personal details of their private lives that were contained in the majority of the reports I saw, and most claimants objected violently when they saw what had been reported.

**Patients Consent**

It was the Corporation's normal practice when it sought information from doctors about claimants to have the claimant sign a form which

it called C.12. That form purports to:-

> authorise any medical practitioner whom I have previously consulted or whom I am attending, to supply the Accident Compensation Corporation or its duly authorised agent with a full report on any aspect of my health which the Corporation considers may have a bearing upon the condition for which I am making a claim with the Accident Compensation Corporation, and to make x-rays available.

It was intended to cover all reports which the Corporation may request about the claimant in an omnibus consent for the whole time taken to process the claim. I am not convinced that this form achieved that purpose with the required quality of consent. The claimant would have little or no idea of what would be involved at the time he or she commenced the claim. Certainly the claimants I

interviewed had no understanding that they would be involved with a psychiatrist when they presented with a sore back.

I am also not at all sure that the form authorised the Corporation to pass that confidential information on to any other party, including any doctor from whom, it sought a second opinion. The authority was for the medical practitioner to supply information to the Corporation. It was not an authority for the Corporation to pass that information on to another party for whatever reason, unless the consent of the claimant was obtained.

In fact I found very little evidence of this form having been used although I am assured that it was signed on each occasion when a claim was made. I certainly found no evidence of this or any other form being used on each occasion a request for patient information was made and I found no evidence of the claimant being informed or given an understanding of what would be involved when they were referred to Dr Gluckman. In particular there was no understanding whether the referral was to a psychiatrist for a psychiatric report or to a physician for a physical and medical report, or both. There was in fact total confusion in the minds of most claimants - first about the referral for a psychiatric report and secondly for a physical examination when they were asked to remove their clothing.

**The Corporation's Procedures**

The information which the Corporation gains through the reports it receives from doctors may well belong to it but there can be no doubt that the Corporation must respect the confidentiality of that material in the same manner as a doctor. It must use the information only for the purpose for which it was obtained - to further the processing of the patient's claim - and for no other. This is a heavy responsibility. It was the perception that this obligation was being disregarded which gave the Medical Council cause for concern.

The Corporation contends that its procedures for maintaining the external and internal confidentiality of reports are appropriate. It says that all of its staff are required to sign a Declaration of Secrecy which affirms that disclosure of information can lead to dismissal and that this power to dismiss has been used on those rare occasions when information has been divulged. The Declaration of Secrecy is certainly comprehensive and is stated to be in consideration of employment with and remuneration by the Corporation. It is an undertaking to faithfully and honestly keep secret all the Corporation's confidential information both during the period of service with the Corporation and at all times after that service has ended.

The Corporation also points to the setting up of a Sensitive Claims Unit and procedures which require that all criminal injury claims are handled in one unit in a separate office. It says that any claim relating to sexual abuse or other sensitive issue is now forwarded

directly from the claimant's general practitioner to this unit in special envelopes which are not opened until they reach the unit. Similarly, it says, medical reports required for these claims are forwarded directly to the unit.

As for reports containing intimate details which appear to have no relevance to the claim, the Corporation says that these are simply filed on the claims file; the irrelevant parts are ignored as being of no value. It acknowledges that it would be a useful adjunct to the development of procedures to encourage claims handlers to draw such reports to the attention of the District Medical Advisers. It also points out that such information is now subject to the principles contained in the Privacy Act and that the provisions of that Act have been brought to the attention of staff.

**The Obligation to Maintain Confidentiality**

It may well be that the Corporation' s procedures are effective in removing staff who do not conform to the required standards of confidentiality, but by that time it is too late - the breach has occurred and generally cannot be repaired. If one may be cynical -most of the well known spies of history have signed Declarations of Secrecy. It is also current practice within the public service, but it does not prevent "leaks".

What is required is positive action to ensure that breaches of the secrecy obligation do not occur; that the opportunity or the temptation to pry into the confidential affairs of others - a very

human instinct - is removed or not available. If confidential material is treated in the same way as any other information -available to anyone who has access to the file for any reason - then unauthorised people will read it and thereby acquire the information. Confidentiality is breached even if they retain the information and do not pass it on. The damage is done when the information is acquired- It is compounded if it is passed on. As one claimant said:

> "I didn't want all that to go down on my file. It's not fair. I'm so ashamed when I go to see all the ACC people. I know they've read my file and I hang my head."

The information is secret. It ought to be passed on to no-one who is not directly involved in the purpose for which it was given.

The Corporation is proud of its record on breaches of confidentiality, and says that they are rare. I wonder though, whether it is aware of just how often breaches do occur.

In the course of my inquiry it was clear that there were a surprising number - not major breaches, but nevertheless serious or potentially so. In one case a person from the electoral office of a Member of Parliament phoned to inquire if a claim had been declined. The information was given as a matter of course, over the phone, without further - authority or identity being required. On other occasions information was freely given to spouses, relatives and friends, or rather people who said they were such. Information relating to payments seems to have been regarded as routine and available to anyone who asked.

Medical information about claimants cannot be treated as simply routine, even though the frequency with which it is used by the Corporation's staff may give it a familiarity which tends to detract from its special quality.

The question of confidentiality is one which is taken very seriously by che medical profession- Stringent ethical obligations apply. There is therefore little wonder that the Medical Council expressed its concern over what appeared to be a lack of appreciation of the way in which confidential material was handled within the Corporation.

The obligations to ensure that medical material is kept confidential and is used only for the purpose for which the claimant's consent was given is an obligation which rests primarily with the Corporation; the obligation on staff comes only through their being agents of the Corporation. In these circumstances it is inappropriate for the Corporation to place the onus of keeping secrets entirely on its staff and to rely wholly on their integrity and honesty. It must remove any temptation for its staff to breach the requirements of secrecy. It, the Corporation, must treat the information as secret and by its systems and procedures ensure that this information is not left in places where it may be accessible to people generally, be they staff or otherwise. It must assist staff to keep confidences rather than present them with opportunities to breach that obligation.

The obligation on the Corporation seems to be all the more onerous-when there is within its control material which is irrelevant; to the claim's processing. It can not be conceived that claimants consented-in an informed way to irrelevant detailed information of their psychosexual history being divulged to Corporation staff or anyone else. If information is irrelevant,, if it is not concerned with the processing of the claim, then it must be kept totally secret or destroyed. Material which is or appears to be irrelevant to the claim must, most emphatically, be removed from the claims handling process, particularly if that information appears to be sensitive in any way.

**An Appropriate System**

Where I have drawn the Corporation's attention to cases where claims files retain copies of reports containing intimate details, those reports have been removed and are now held in a sealed envelope in the office of the District Manager. But I wonder whether this is an appropriate place. In any case this seems to be a totally unsatisfactory procedure in the long term.

There is no question that medical practitioners expect the people who receive their reports to work within the same dimensions of confidentiality as exist within their own profession. They regard this as a matter of ethics more than as a matter of medical training.

They expect the people who receive their reports to receive them and deal with them in a way which reflects the confidentiality required of those who obtain the information initially.

Medical specialists expect their reports to be interpreted by at least a medically trained person if not by another specialist. They are used to reporting to people with medical *training*; generally speaking they prepare reports on the assumption that they will be read by people with medical training and knowledge, people who have at least an understanding of medical concepts and terms. They are trained to communicate with other medically trained people and they do so in a way that will be understood by other medically trained people. That is the way they prefer to go about their business.

The Central Ethical Committee of the Medical Association has issued a statement on the topic. It has said:

> Doctors are frequently asked to supply reports on patients to agencies such as insurance companies, the Ministry of Transport and the like - this must always be regarded as confidential information and the written consent of the patient must be supplied before such reports are given. Ideally the report should be released in confidence to a medical practitioner in the employment of the inquiring agency, such as insurance company referees or Ministry of Transport medical officers, and where possible such agencies should be encouraged to appoint medically qualified persons for such purposes. Obviously, in the present situation this is not practical in all cases, and in these circumstances, a report should be released in confidence to no-one with less than senior administrative responsibility within the inquiring agency.

It is generally preferred by the Medical Association that information not be released to any member of the staff requesting it, but that such information should be released to medical practitioners only.

For all of these reasons I recommend that all medical reports should come addressed to and be opened by the Corporation's Medical Officer or by suitably trained staff directly under his or her control. He or she should, as necessary, take from that report sufficient material - and only sufficient material - for a claims officer to work with it, and thereafter the report should be put onto a confidential medical file and be retained under the direct custody and control of the Corporation's Medical Officer. That appears to be the system which works with insurance companies and with the Corporation's own Sensitive Claims Unit. I see no reason why it should not be adopted by the Corporation universally for all medical matters.

## COMPLAINTS

### Overview

Although most of the people I interviewed were to varying degrees angered by their experience with Dr Gluckman, only a few actually complained to the Corporation. This may be a reflection of the high regard which the public has for its medical professionals which results in a reluctance to think that anything a doctor says or does is other than correct or necessary.

But some claimants were more pragmatic. They told me that they wanted to complain but the threatening nature of the background to the referral and to their overall dealings with the Corporation led them to conclude that any complaint they made might prejudice their claim. Despite that some complaints were made, but when I pursued the fate of these there was simply no record of any complaint ever having been made.

I initially thought that the complaints were simply not addressed by the Corporation, but it did acknowledge that complaints were received about Dr Gluckman's examinations which led to his no longer being used as an adviser. The problem was, it is said, it took some time for this to become its practice. I note that there was a sudden fall-off in referrals to Dr Gluckman from the end of July 1987, but many of the complaints I heard of were made long before this. On the

other hand one of the most vehement complaints was made in respect of a woman who was referred twice, as late as February 1989.

There is certainly no evidence of any complaints received by the Corporation being referred to Dr Gluckman.

Some of the complaints were by people saying they did not wish to be examined by Dr Gluckman for one reason or another. Others were made after the event; they complained about what had happened. In one case it was a husband who complained about how his wife had been treated. I interviewed that man. He was certainly *very angry*. I accept that he made a complaint and I believe his complaint would have been in no uncertain terms, but there is simply no record on his wife's file of a complaint ever having been made.

This apparent lack of attention to complaints was not only in respect of Dr Gluckman. Many claimants reported that they complained about the Corporation's attitude but they did not receive any satisfaction nor any report on the result of this complaint.

One claimant wrote to the Corporation complaining about its disclosure of confidential information. It was specifically directed to the actions of a particular named officer. The claimant made it clear that he wished to have nothing further to do with that officer because of the matters he complained of. Not only was the claimant

not told of the result cf his complaint but the person he complained of remained in charge of his file and, as if to rub salt into his wounds, the claimant was told that this person would remain as his claim handler. I would have great difficulty in trying to conceive of a more inflammatory response to a complaint about standards of service. The Corporation now acknowledges that little action was taken over this complaint other than to interview the particular officer. It also acknowledged that the nature of the complaint required that someone in authority should have personally interviewed the claimant and perhaps then arranged a case conference with all parties. It also acknowledges that its response was non-apologetic and that it did not deal with the complaint effectively.

I am left with the very clear view that certainly at that time, complaints were simply not taken seriously by the Corporation. There was no system of recording, investigating and considering complaints, or if there was such a system it was not used. For an organisation which ought to be service orientated, that is lamentable.

**Dealing with Complaints**

The Corporation must institute and operate an effective system of recording, investigating and dealing with complaints. This is essential for any organisation that is service directed or any way involved in the delivery of service. Indeed, it is difficult to see how any organisation can deliver an effective service unless it is willing and able to deal with and learn from complaints it receives

at all levels. As a matter of courtesy the complaints system must include reporting to the client the result of the investigation. Any organisation which does not have an effective system for dealing with complaints will automatically encourage more rather than fewer complaints.

A positive system of dealing with complaints can be a very effective means of monitoring the organisation's objectives, particularly the delivery of its services. It can be used as a means of indicating not only deficiencies in the organisation which ought to be known and remedied, but also as a means of positively monitoring the performance of staff members and of the organisation's systems generally. With this in mind many organisations within service-based industries, particularly those which operate in a competitive environment, positively and actively seek audits of their organisation's performance by making client monitoring systems readily available to clients and even offering incentives for client participation. In these organisations the responses are considered regularly - in some organisations at daily management meetings - and are used as effective tools in team building and for the overall improvement of morale and the consequential delivery of service. Praise is often an outcome of these surveys and the notification of praise among staff is used as an incentive and an example, particularly for those staff members who may not be performing effectively. By using these systems positively rather than negatively better results can be achieved.

There is also in any organisation a need to identify and to deal with, by education or otherwise, those staff members who do not deliver effective service, or systems which are not delivering to the required standard.

All this seems rather basic. It is certainly desirable in any organisation, particularly a large one. Gains in productivity and quality of service can be obtained. In this case the effective operation of a complaints system properly networked may well have obviated many of the matters which by now have caused intense embarrassment to the Corporation. At the same time it could have provided an effective frontline monitoring system for many of the problems which occurred.

## REMEDIAL ACTION

My terms of reference require me to inquire whether the interests of claimants generally or in particular have suffered as a result of any of the matters covered by this inquiry and if so what action (if any) should now be taken by the Corporation to remedy or redress those matters.

## A Disclaimer

It has become clear to me that many of the claimants who were referred to Dr Gluckman have suffered in that their claims were the subject of adverse decisions after the Corporation received his report. These results were not in all cases a direct or necessary consequence of the doctor's actions. In many cases the suffering or detriment which resulted ought not to have been the consequence of Dr Gluckman's examination and report.

Many of the people he examined, and reported on, suffered adverse decisions because the Corporation unjustly took advantage of the doctor's interpretation of the law or wrongly allowed itself to be influenced by that interpretation. In other cases the Corporation allowed the doctor's clinical conclusions to influence its decisions in situations where it should not have done so. It should have applied valid interpretations of the law to those conclusions and acted accordingly.

In linking suffering or detriment to claimants[1] interests with the doctor' s examinations and reports I in no way conclude that the doctor was the cause of that suffering or detriment. Such a conclusion would be well beyond my terms of reference and I specifically decline even to consider the possibility within the framework of this inquiry, especially as I have attempted to exclude any real input from the doctor.

Secondly, and for similar reasons, I exclude from consideration under these headings the emotional and the sometimes physical suffering which many or most of the claimants described to me as having occurred in the course of or as a consequence of their examination by the doctor. This is quite the wrong forum to consider these matters except in so far as they present as anecdotal background to the matters I have been asked to consider.

**Costs of Review or Appeal**

I can however report that a number of the claimants suffered because they were forced to pursue their rights of review or appeal. It cost them to obtain a valid decision in the face of an incorrect decision after the doctor's examination and report. Others suffered detriment because they decided for various reasons not to pursue their rights of review or appeal; they suffered because the decisions they were given did not accord with their rights under the statute.

In the case of the first group, those who pursued their rights and obtained relief, their actions were not without suffering or loss. Because of the delays involved in effecting a correction they all unnecessarily suffered a loss of time, effort, security and peace of mind inherent in any review or appeal process. But these people also suffered a financial loss in not being able to recoup the cost of having to take that step. The most visible of these costs was the fees paid to a third party to assist them in processing their review or appeal. The claimants received a contribution to those costs but that in no way covered the actual cost in which they became involved.

In most cases the contribution received from the Corporation was between $150.00 and $250.00 but the cost to the claimant was many times that amount. In one case a claimant paid an advocate $4,478.25 to correct a decision on review and received a contribution of $175.00. In another case a claimant paid a solicitor $1,210.00 to get her compensation payments reinstated and received a contribution of $250.00, leaving her to face a deficit of $960.00 from her meagre savings. Another woman paid her solicitor $1,219.85 and received a contribution of $250.00. These cases are typical of those I saw. In none of the cases I saw could it be said that the bill rendered by a solicitor was anything but reasonable. They compared more than favourably with the fees charged by "compensation advocates", usually legally trained but non-practising solicitors whose work was confined solely to this jurisdiction. Their fees were always far in excess of those charged by solicitors.

All this raises a point of principle; one that has been argued on many occasions. Should a claimant suffer any financial loss in taking a decision on review where the original decision was wrong; where it was the Corporation which drove the process which resulted in that wrong decision; where the process which' resulted in that wrong decision was driven in a wrong direction and often for the wrong reasons; where the resulting decision was entirely the fault of the Corporation It is often claimed that in these circumstances the Corporation or the party who initiated the error should bear the entire cost of correcting that error.

As a matter of logic it is difficult to fault that line of thinking but it suffices to say that traditionally that view has not found favour with the courts in this jurisdiction or in any other jurisdiction of a similar nature. The defaulting party is generally required only to make a contribution to the successful party's costs, and successful party is always left dissatisfied with the result. The usual comment is - the little man can never win against the big corporation, especially where a monopoly is involved.

Personally I have real sympathy for that view, especially in those cases where compensation payments are involved over a long period of time and where the claimant is of necessity and compulsorily losing 20% of their income in any case, even when they win. But rarely if ever is such a plea successful.

That aside, I am of the view that the Corporation is unduly niggardly in the scale of contribution it makes on review. In the very early stages of its existence the Corporation declined to make any contribution towards a claimant's legal costs. It took the view that the review system was simple, one which did not require the involvement of the legal profession, and it declined to make any contribution to a claimant's legal costs on review. It soon retreated from that position and agreed to make contributions towards legal costs but these were minimal, even parsimonious.

There is a great deal of legal involvement in these matters and if the Corporation is unable to get it right the first time, it ought in the main bear the cost of the consequences. If that was the case it may encourage the Corporation to require claims officers to obtain greater legal input at the stage of initial decision-making instead of proceeding to make perverse or inadequate decisions without legal input.

**Remedies Which Have Been Effected**

I have brought a number of cases to the attention of the Corporation. In the cases of ten claimants, I have been able to obtain for them a greater contribution to their costs but still not enough to cover the expenses in taking the case to review. A number of other cases are still being considered but with the passing of time and inflation the true cost will never be recovered.

In a number of other cases where claimants were for a variety of reasons unwilling to proceed to review or appeal to correct a clear injustice I have been able to obtain some satisfaction for them.

The cost of counselling has been paid to two claimants where payment of this cost had been terminated.

In four cases additional lump sum payments under section 78 were obtained.

Additional compensation payments have been made to four claimants and two received additional rehabilitation assistance where that had been declined in the past.

Two claimants received a refund of the cost of treatment originally declined.

In two cases a comprehensive administrative review of the claimants' cases was undertaken at my request and in one other case the Corporation agreed to accept a late review application where that had been declined in the past.

A few other cases are still being reviewed or are under discussion but apart from those it would appear that most of the "problems" which arose after claimants had been referred, to Dr Gluckman have now been resolved to the reasonable satisfaction of the claimants, but it is appreciated that there is other suffering, largely emotional, which will never be able to be rectified.

## CLAIMANT'S ADVOCATE OR COMPENSATION OMBODSMAN

Against the background of these matters it is appropriate now to consider the need for institutional safeguards within the accident compensation system to protect the rights and interests of claimants. There is in my mind no doubt that there is such a need.

The legislation is far from simple. It is complex. It was complex in 1982 and it has become even more complex since the introduction of the 1992 Act and the myriad of regulations which have been made subsequently to administer what was originally intended to be a simple, comprehensive, 24-hour, no fault protection for everyone who suffered personal injury by accident. That so many cases have been taken, on appeal to the High Court and to the Court of Appeal (after going through review and the system's own appeal jurisdiction) is a clear indication in itself that this is a field where the ordinary average citizen needs assistance.

By far the most common complaint I heard was "Nobody told me anything" or "You never got anything unless you knew what to ask for". I suspect that the system of Case Management, continued publicity, the emergence of effective watch-dog groups, and (sadly) dwindling benefits may well take care of many of these complaints.

But the experience I have had in reviewing so many files in the course of this inquiry and the lack of an effective complaints system

leads me inextricably to the conclusion that claimants need protection. I appreciate that I was reviewing the actions of staff ten years ago in the largest city in New Zealand, but that in my view is little excuse for the injustices which I saw being visited on so many people. Inadequate personalities and lack of training may well be a reason, but it is not in my view an excuse. The Corporation has a monopoly. There is no competition. There is nowhere else to go. The effect of hearing the threat that "you wont get your money" unless you "do as I say", will remain with me for a long time. I only wished that responsible officers of the Corporation could have been with me at that time and *seen* the looks on the faces of ordinary people telling me of being faced with those alternatives in situations of real crises.

In this context it is appropriate to recall that the scheme was originally proposed on the basis of five basic principles

- community responsibility
- comprehensive entitlement
- complete rehabilitation
- real compensation, and
- administrative efficiency

and I recall the large number of concessions made by the Corporation when I brought to its notice the deficiencies in its service or its failure to deal with people in a fair manner.

There is too much room for a perverse decision simply because of an officer's subjective views about a particular claimant and his or her motives in making a claim. There was not only the opportunity but

more particularly the reality of people suffering an injustice because of their lack of knowledge and lack of bargaining power against the power and lack of knowledge of the officer with whom they were dealing.

Whilst Case Management may well remove many of these problems I am of the view that the public is entitled to have the assurance and confidence that a totally independent person can be called upon to review a situation about which they have a complaint.

But apart from these very practical situations it seems to me that the public of New Zealand are entitled to overt protection from administrative deficiencies in return for the statutory removal of something as serious as their common law right to sue in the ordinary courts of the land. Although that system was far from perfect it was nevertheless based on a valued and valuable right. The removal of that right must have a built in guaranteed confidence in its replacement. There must be a confidence that anyone involved in an accident is able to receive a proper decision on their entitlement under the law with a minimum of fuss and cost, but given the present legal and medical niceties and the complexity of the statute and its administration, and the lack of a complaints system, there is little wonder that confidence has eroded. There is a real need to restore that degree of confidence which the scheme demands.

The recognition of the need for consumer protection has taken on a new urgency in so many fields over recent years. We have seen the emergence of the Banking Ombudsman and latterly the Insurance Ombudsman with similar objectives of protecting the rights of the consumer with simple and inexpensive access being provided at the cost of the Corporation.

**REPORTING OF PERCEIVED BREACHES OF PROFESSIONAL OBLIGATIONS**

Both the Medical Practitioners' Disciplinary Committee and the Medical Council report that until the enactment of the 1992 legislation there have been surprisingly few complaints brought to them by the Corporation.

Four matters have been considered by the Medical Council where the Corporation was involved - three where inaccurate certificates were supplied to the Corporation; the fourth was the matter which has given rise to this inquiry - but each of these inquiries was taken on complaints made and pursued by patients.

Complaints to the Medical Practitioners' Disciplinary Committee were made by the Corporation on three occasions but none were allowed to get to the stage of a formal inquiry before the Corporation withdrew them. On two occasions it did so because it said that it considered that its pursuing complaint action was inappropriate to its desire to preserve its relationship with the medical profession generally. On the third occasion the Committee was advised, informally, that the complaint was being withdrawn because of political considerations. Clearly there has been a reluctance for the Corporation to become involved.

Under the 1992 legislation the Corporation is charged with the task of reporting the circumstances of medical misadventure to the

appropriate disciplinary body where it considers that the medical misadventure may be due to negligence or inappropriate action on the part of a registered health professional, but after it has given the health professional a reasonable opportunity to comment. I am told that cases of this nature are now beginning to come through.

It seems to me that this is a procedure which should be adopted in all cases where the Corporation becomes aware of what it considers may be breaches of professional standards or obligations. The Corporation has an obligation to its claimants to ensure that only appropriate procedures are carried out, particularly on referral by the Corporation. It should not allow breaches to run unnoticed. It should complain if professional standards are not met. Its function is merely to report perceived breaches by complaint. It has no obligation to make the inquiry. Indeed it would be inappropriate for it to do so, but it ought as a matter of courtesy give the professional involved the opportunity to comment or explain before making the complaint.

Each of the medical disciplinary bodies have indicated that they are available to investigate and deal with any matters which are of concern to the Corporation as indicating a breach of professional standards or obligations. That is clearly their function.

## CONCLUSIONS & RECOMMENDATIONS

In conclusion, I repeat that I am deeply conscious that the various events which are the basis of this inquiry took place nearly 10 years ago so that there will be a natural inclination to react to its findings by saying that all of the systems and procedures which I have discussed were of that era, and have been overtaken by new and corrected systems, operated by new and more enthusiastic staff.

Whilst I readily acknowledge that there have been changes, some of them major changes, particularly over more recent months, I caution against the general reaction that all is well. Many, if not most of the matters I raise are I believe still current, at least to some degree, or to the extent that there needs to be a conscientious supervision and audit to ensure executives that all these matters have in fact been attended to by the new system of Case Management and by the replacement of old staff. I believe that despite these changes, and they must be applauded, there is still a hangover of old systems and the legacy of old staff within the overall functioning of the Corporation which need attention.

On that basis I make the following recommendations.

1. The Corporation must positively address any inclination toward adversarial attitudes by members of its staff toward claimants. Claimants must be given a measure of security and assurance

particularly at the early stage of the claims process. They must be kept fully informed of the progress of their claim. Any mistakes must be acknowledged and put right immediately.

2. The Corporation must seek and take note of appropriate legal and medical advice before making decisions. It must make every effort to ensure that the right decision is made the first time, and should not rely on the review process to put things right.

3. There should be medical input into most claims. The Corporation's functioning requires a major input from medically trained and experienced people at branch level as well as district level. Direct medical input is also required in monitoring the quality and quantity of services provided by the Corporation/ and to review their effectiveness and appropriateness.

4. Medical practitioners reporting to the Corporation must have a clear working knowledge of the legal requirements of the Corporation's statute.

5. Referrals for medical examination should only be made by people with appropriate medical knowledge and experience. Reports should be addressed to and opened only by the Corporation's

Medical Officer or by suitably trained staff directly under his or her control. Such material as is needed by claims officers should be taken from the report by medical staff. The report should then be placed on a confidential medical file retained under the direct custody and control of the Medical Officer.

6. Claimants should be informed, preferably in person and then in a confirming letter, when specialist medical examination is required, and why. They should be informed of the specialist suggested by the Corporation and given the opportunity to nominate an alternative specialist if the suggested practitioner, is unacceptable to them. They must be informed that their consent is required to the specialist reporting to the Corporation and to the Corporation's supplying the specialist with such medical information as it holds. In all matters of consent the Corporation must ensure on each occasion that claimants are fully informed about what is to happen.

7. Claimants should be given a copy of the Corporation' s instructions to specialists, and a copy of the specialist's subsequent report. They should also have the opportunity to comment on the report and to correct any factual errors or obtain another report if they consider that necessary or appropriate.

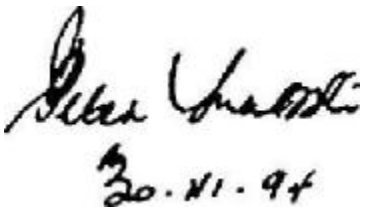
8. The Corporation must ensure that the opinions it obtains from medical practitioners are independent, not only of the claimant but also of the Corporation, and that they are seen to be so.

9. The Corporation must put procedures in place to ensure the confidentiality of information it receives about claimants, and must ensure that any information is used only for the purpose for which it was obtained. Information about claimants muse only be accessible to those directly involved in the purpose for which it is given. It is suggested that appropriate computer technology be used to store and track files, and to ensure that procedures are followed.

10. The Corporation must institute and operate an effective system of recording, investigating and dealing with complaints. This must include a system of reporting promptly to the claimant the result of the investigation.

11. There is a need for a Compensation Ombudsman with functions and powers similar to those of the Banking Ombudsman and the Insurance Ombudsman.

12. The Corporation should report perceived breaches of professional obligations and standards in the same way as it is required to in cases of medical misadventure under the 1992 Act.



**ANNEX:**

**Terms of Reference of the Inquiry**

To inquire into:

1. Whether the Accident Compensation Corporation (ACC) has adequate and appropriate procedures for the selection of properly qualified and independent medical advisers to give it specialist opinions.

1a If not, what procedures should be put in place.

2. Whether the ACC has adequate and appropriate criteria for referring claimants or additional medical advice.

3. Whether the foregoing procedures and criteria, if any, are properly complied with and regularly monitored.

4. Whether there is monitoring of the quality of performance of medical advisers and if so the adequacy of the criteria used (if any).

5. If there is no, or no adequate monitoring of the performance of medical advisers, whether procedures should be considered for monitoring them, and if so, what procedures.

6. Whether the quality of performance of the adviser, Dr Gluckman, was monitored.

7. Whether claimants have complained to the ACC about the consultations and reports of Dr Gluckman

7A. Whether in any event the content of Dr Gluckman's reports to the ACC concerning claimants should have given rise to concern on the part of the ACC or any of its employees as to Dr Gluckman's ability or fitness as a medical adviser.

8. Whether action was or should have been taken by the ACC in response to any such complaints and/or in response to any such reports.

8A. If any such action should have been taken, the reasons, and where the responsibility lies, for the failure to take such action.

8B. Whether the interests of Claimants generally, or any particular Claimants, have suffered as a result of any of the matters covered by this inquiry and if so, what actions (if any) should now be taken by the Corporation to remedy or redress those matters.

9. Whether the ACC has appropriate procedures for maintaining both the internal and the external' confidentiality of reports containing private information.

10. The responsibilities of the ACC on receiving reports with intimate details which appear to have no relevance to the claim being considered.

11. What action should be taken by the ACC when such irrelevant information is received.

12. On what occasion and on what evidence should the ACC report to the Medical Practitioners[1] Disciplinary Committee or the Medical Council perceived breaches of professional obligations by medical practitioners.

13. Whether there is a need for institutional safeguards within the ACC system to protect the rights and interests of claimants, such as a Claimants' Ombudsman or a Claimants' Advocate.