A balanced opinion? Considering the role of the external clinical advisor in ACC processes

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ABSTRACT

The role of the external clinical advisor is critical to the adjudication of complex claims in the processes of the Accident Compensation Corporation (ACC). This is particularly true of claims for treatment injury that occur during birth, which are often very complicated. In most cases external clinical advisors are non-treating doctors, whose opinion strongly guides the hand of ACC. This viewpoint considers the impact of the role of the external clinical advisor by using extracts from an external clinical advisor’s report to show how a power imbalance can be enacted in ACC decision making processes. Also considered are the way that the normal checks and balances in the system, particularly those provided by the Health & Disability Commissioner, are bypassed in most cases. Finally, a recommendation is made to potential external clinical advisors to precisely follow the standards set by the Medical Council in all cases when writing reports for ACC.

The role of the external clinical advisor (ECA) is critical to the adjudication of complex claims in the processes of the Accident Compensation Corporation (ACC). This is particularly true of claims for ‘treatment injury’ that occur during birth. In broad terms, to establish a claim for ‘treatment injury,’ the claimant must establish that s/he has suffered personal injury caused by the seeking or receiving of treatment (defined broadly), where that injury is not a necessary part, or ordinary consequence of the treatment, taking into account all of the circumstances, including the claimant’s underlying clinical condition and the state of clinical knowledge at the time of the treatment. ‘Personal injury’ includes physical injuries, but excludes ‘personal injury caused wholly or substantially by a gradual process, disease or infection’. This reflects the fundamental distinction at the base of the scheme since its inception between accidental injury, which is generally covered, and disease/illness, which, apart from some exceptions, is not; a distinction which reflects pragmatic cost realities, but which most would agree is responsible for a fundamental inequity.

Because ACC is a cause-based system, the Corporation is charged with establishing the cause of an injury in order to determine whether a claim falls within its legislative mandate. Birth, of course, is a very complicated process. Although it is ostensibly ‘natural’, medicine has been successfully ‘intervening’ in this process for hundreds of documented years, and doubtless many more before that. We have used the single quotation marks above on purpose, to draw attention to a dichotomy between nature and medicine that is often used in birth injury cases for a precise reason—to decide that a personal injury is ‘covered’ by the scheme, ACC must conclude that first, the injury was caused by the treatment or caused by the failure to provide treatment in a timely manner, or importantly for the example we use here, the failure to obtain informed consent regarding the treatment and second, that it was “not a necessary part or ordinary consequence of [the] treatment.”
The motivation for this viewpoint article comes from personal experience; the son of the first author (Author 1) suffered a brain injury during his birth in 2010. His name is Ben, and he is a splendid boy. Fortunately, Ben was spared the often-tragic worst consequences of birth injury. He was born in a tertiary-level hospital in Aotearoa, with a top class NICU facility just down the hall and has grown from those beginnings into a genuine treasure. He has a voracious appetite for Minecraft literature and a cheeky sense of humour. But he also has needs that are special. For instance, he has mild ataxic cerebral palsy, which means he cannot easily join a sports team or walk up and down stairs, and although he can read above his years, he cannot yet spell without the assistance of voice recognition technology. He also has a tic disorder which is worse or better depending on stress, and a selection of other learning and emotional disabilities not seen in most children his age.

It is difficult to pin down how many children, like Ben, suffer brain injuries during their birth, although we do know that up to 360 babies per year are diagnosed with neonatal encephalopathy.\(^7\) It is more difficult to work out how many of these babies end up with ACC cover, because ACC does not keep specific data on birth injury cases. Our best guess following several Official Information Act requests is around 45 per year, approximately 12.5\% of diagnosed cases. The rest receive no cover from ACC and generally face challenges in gaining access to services, because the systems they have to access (health; disability; welfare; education) are not well ‘joined-up’ and funding has not kept pace with costs.\(^8\)

Both Ben and his mother have a rare form of skeletal dysplasia (Léri-Weill dyschondrosteosis), an inherited genetic disorder. Relatively little is known regarding the possible impact of Léri-Weill dyschondrosteosis (LWD) on a pregnancy, and as such it has become a significant part of Ben’s claim for ACC cover. Typically, LWD is described as a mesomelic dwarfishm, meaning that it usually affects the limbs, particularly the lower ones, though it can also have a range of other effects across the musculoskeletal structure.\(^9\)–\(^13\) It is typically diagnosed by the obvious physical signs; many (but not all) people with LWD have short stature, and bilateral Madelung deformities. However, LWD is a syndrome in the sense that it describes a group of people who have a variety of deletions in or near the SHOX region of the X chromosome. It has a wide phenotypic variation because it also has a wide genotypic variation.\(^14\)–\(^16\) The state of the literature on LWD is arguably still at a preliminary stage; it is only recently that advanced genetic testing was able to show the precise genetic changes that are passed on in certain familial lines, and as such the parers for diagnosis are not clear.\(^17\)

The pregnancy included genetic counselling prior to conception, and multiple consultations with specialists during pregnancy (including an obstetrician and a maternal-fetal medicine specialist), though this was primarily concerned with the likelihood of Ben inheriting LWD. However, during an obstetrics referral (at 28 weeks) a doctor made a point of noting that Ben’s mother was very short, and that this was linked to a higher chance of requiring a caesarean section delivery. However, no recommendation was made, and a record of the discussion was not included in the clinical notes. No further discussion of LWD and its implications for delivery occurred during the pregnancy. In the maternal-fetal consultation Ben was observed on ultrasound. His limbs were measured and the risks and merits of amniocentesis to test genetically for LWD were discussed and declined based on the risks. Importantly there was no discussion of maternal LWD and possible complications of birth.

In New Zealand, maternity care is provided by an LMC, typically a registered midwife. There are a range of circumstances where care is recommended to be transferred to an obstetrician. These are detailed in a Ministry of Health document: Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines).\(^18\) The only mention in this document of genetic conditions is a section in Table 2 that identifies conditions and their associated referral category. All genetic conditions, aside from Marfan’s, are covered in the entry 1032 “Any known genetic condition significant in pregnancy” p. 22, which carries the referral category ‘transfer’, meaning that the agreed protocol is for the care to be transferred to a specialist, in consultation with the mother.
In Ben’s case, care was not transferred to a specialist, nor was it recommended. This has become one of the issues that has been subject to scrutiny by the ECAs who have provided opinions on Ben’s case with regard to informed consent regarding delivery options, specifically failure to recommend and/or offer delivery by caesarean section.19

ACC almost always seek external clinical advice from a doctor or other registered health professional when determining cover and causation in birth injury cases. They have a system for doing this, including publishing a guide for providing ‘objective clinical advice’ for health practitioners (most recently updated in May 2018)20 and a schedule of fees. It is also well documented that they end up using a relatively small pool of advisors and sometimes get into a relationship that is unhelpful, where one advisor is heavily relied on, sometimes writing hundreds of clinical opinions per year.21–22 In 2016, Miriam Dean QC published a comprehensive report which examined a range of ACC issues, including access to medical experts. We do not have the scope to cover the entirety of these here but for those interested, part six of Dean’s report22 is essential reading. Although ACC undertook to address the matters regarding expert opinion raised in the Dean report, those closely following the changes suggested by Dean remain unconvinced,23 with the core power imbalance remaining essentially intact. This creates a profound problem: doctors providing expert advice to ACC are in an extremely powerful position. In relation to birth injuries, this position can fundamentally change the life course of a brain-injured baby and their family. It is an unenviable position, and not well compensated given the opportunity costs; hence the reluctance of many doctors to participate.

It is precisely because of this power imbalance that we sought to write this viewpoint. In general, doctors hold significant power over their patients, and this is particularly true in colonised countries like Aotearoa New Zealand.24 But there are significant checks and balances on this power; health practitioners are subject to a range of legislation, most notable in terms of performance are the Health and Disability Commissioner Act 1994 and the Health Practitioners Competence Assurance Act (HPCAA) 2003, the first of which provides for legislated rights of consumers and correlative provider duties and a complaints process, though significant issues with the HDC complaints process have been raised recently,25 and the second established a process by which a registered health practitioner can be held to account in terms of competence. Also relevant is the role of the Medical Council of New Zealand, which stipulates standards according to which doctors should practise. This includes the standards of practice expected of doctors employed as non-treating external clinical advisors writing third party reports, including for ACC.26

However, there is a serious difficulty with proper enforcement of the very appropriate standards in the Council’s Statement. The checks and balances normally at play within the profession are bypassed. The Health and Disability Commissioner does not have jurisdiction over complaints relating to the conduct of a non-treating doctor, where s/he performs no medical assessment of a patient, but the assessment is based solely on information in the patient’s file. Despite the Medical Council being the statutory regulator of such non-treating doctors, it advises patients to direct their complaints directly to the third party. And it refers complaints to the HDC, who itself refers the complaint to the third party (in our case ACC), who has no incentive whatsoever to question the professional standard of reports and recommendations in its favour, being at best compromised.

In Ben’s case, ACC contracted an external clinical advisor who had already written two opinions for ACC on the case, regarding other areas of concern, to provide an opinion. This doctor is registered in New Zealand with a vocational scope of practice in obstetrics and gynaecology and is regularly called on by ACC—in 2018 providing opinion on almost 100 cases. ACC asked:

‘Is there any evidence to support that during the antenatal and perinatal period the Obstetric Service did not obtain informed consent for the vaginal birth they assisted with?’

In the claim decision letter, under the heading ‘Antenatal’, ACC made the following comments, and relied on these to decline Ben’s claim:
“[The ECA] noted that there is an expectation that pregnant women would labour and attempt vaginal delivery. Obstetric intervention can be indicated in some situations, which [The ECA] outlined.

[The ECA] noted [Ben’s mother] had a reasonably rare condition (Dwarfism), which caused her to be referred to a Materno-Feto-Medical subspecialist for consultation during the pregnancy. [The ECA] concluded that this condition, in [Ben’s mother’s] case, did not affect her pelvis or make vaginal delivery a risk to her or the baby. [Ben’s mother’s] short stature would not be expected to cause fetal growth restriction, preterm birth (the child was born postdates), or fetal intolerance of labour....”

This is the relevant section from the ECA opinion quoted by ACC:

“[Ben’s mother] has a reasonably rare condition called [sic] which has a number of reproductive implications. This is why she was appropriately referred to a Materno-Feto Medicine sub-specialist for a consultation during her pregnancy. Leri Weill dwarfi sm is an inherited condition and [Ben] has the same form of dwarfi sm as his mother. It is possible that [Ben’s mother] has other affected family members. It is also possible that [Ben’s mother] knows more knows more [sic] people with this condition and knows more about her condition than any of the health care professionals she met during her pregnancy.

In terms of considering actual risk in the pregnancy and at the time of delivery the following observations are relevant;

A. The effect of her dwarfism on her pelvic dimensions.

[Ben’s mother] has a type of dwarfism which usually causes abnormal shortening of the lower arms and legs. As far as I can tell from my reading the bony pelvis is not affected in this type of Dwarfism. I do not believe this condition per se carries a contra-indication to an attempt at vaginal delivery. There was no recommendation from the MFM specialist that [Ben’s mother] should have an elective caesarean section.”

No references were included with the ECA report; though there is research available looking at skeletal dysplasia and birth outcomes.27

To conclude, we want to reflect on the duty of care that our current system requires of doctors writing third-party reports. There is minimal oversight and almost no legitimate vehicle for contest regarding these opinions. There are at least two concerns regarding the ECA opinion above, notably the speculative suggestion that Ben’s mother ‘knows more’ than the obstetrics professionals about LWD and the lack of any references provided for the conclusion that LWD is not relevant in pregnancy. However, as we have explained, no adequate complaints process exists for a claimant to contest an ECA opinion. Thus, we argue that doctors writing third-party reports must apply a level of professional rigour commensurate with the vulnerability of the patient and the importance of the ECA’s opinion to the outcome of their claim, and the likely heavy reliance that the third party will place on their opinion, with no incentive to contest a recommendation which accords with its financial interests. ACC’s own Guide instructs experts to give opinions only on matters within their own expertise and to decline appointment if not suitably qualified. Experts have a duty to be independent and not to act as hired guns: The Medical Council’s Statement warns doctors that they must not allow the financial interests of either the patient or the third party to influence their assessment, opinion or recommendations. It requires a doctor’s professional opinion and recommendations to be “accurate, objective, and based on all the available evidence”; the doctor to be suitably qualified; that the non-treating doctor adhere to the professional standard of care set in the Code of Rights; that the doctor’s report be restricted to medical issues, and be accurate, objective and not based on speculative, insufficient or flawed evidence.

Doctors also have a professional responsibility to ensure that they are properly informed in their instructions of the relevant, applicable legal principles, so that they can address their opinions and recommendations to the proper legal tests. For example, the Court of Appeal has authoritatively interpreted the words “a failure to provide treatment or to provide treatment in a timely manner” for the purposes of “treatment” in cover for treatment injury. It decided that, while these words necessarily incorporate a departure from a normative standard of care, that standard is not the...
civil standard of reasonable care and skill; no finding of negligence is required. Rather, the Court accepted the ‘experienced specialist’ standard advocated in research by the second author, which requires proof that the injury would likely have been avoided if an experienced specialist in the field would have acted differently at the time, thereby avoiding the injury.28 And, even though negligence sets a higher standard of proof than that under ACC, in a recent landmark decision, the UK Supreme Court stated that the negligence standard requires a practitioner to take reasonable care to ensure that a patient is aware of the ‘material’ risks of injury that are inherent in proposed treatment and of the reasonable alternative or variant treatments. It defined a ‘material’ risk as: “whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk or alternative option, or the doctor is or should be aware that the particular patient would be likely to attach significance to it”.29 Additionally, given the cardinal importance of causation in determining treatment injury claims, ECAs need to be aware that the legal, not scientific, test for causation applies, what that test is, and notably that New Zealand’s leading decision on causation in ACC treatment injury recognises that, because causation can be an insuperable barrier for claimants, it is sometimes appropriate for ACC (guided by responsible, independent and professional ECAs) to draw an inference of causation between treatment and injury, ie, ACC or a judge may decide that causation is probable, even though “positive or scientific proof of causation has not been adduced” and “medical science is only prepared to say that there is a possible connection”.30

The purpose of this viewpoint is to remind the profession of the importance of the work of an ACC external clinical advisor. The advisor’s report is often determinative of the outcome of an ACC case, but, short of the claimant obtaining additional advice contesting it, is largely unassailable within the process. This disjunction can too easily result in advice falling below proper professional standards and perverse outcomes. Our recommendation is that any ECA writing a report for a third party such as ACC, consider that their words and reasoning may one day find themselves under the close scrutiny of a court as part of the appeal process, and ask themselves whether they will then feel comfortable defending it. Only by precisely following the standards set by the Medical Council in all cases will they be justified in doing so.

Competing interests:
Dr Dickson reports that his son suffered a brain injury in 2010 during his birth. There is an ongoing ACC claim related to this injury that has generated a number of external clinical advisor reports. This experience is what inspired the idea for the viewpoint and is explained in the article.

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2. See Accident Compensation Act 2001, section 32(1).


19. Failure to provide information to enable the person to make an informed decision on whether to accept treatment constitutes “treatment” for the purposes of cover for treatment injury, see section 33(1) (e); mothers are entitled to be informed of the alternative delivery options that a reasonable pregnant woman would expect to be advised of in her medical circumstances, see Right 6 of the Code of Rights & Montgomery v Lanarkshire Health Authority [2015] 2 WLR 768 (UK SC)


23. Broughton C. ACC tells minister justice issues have been fixed, but advocates not so confident. Stuff.co.nz, 2019; Feb 26 [Available from: http://www.stuff.co.nz/national/health/110789966/acc-tells-minister-justice-issues-have-been-fixed-but-advocates-not-so-confident]


29. Montgomery v Lanarkshire Health Authority [2015] 2 WLR 768 (UK SC), para 87.