

“Trust me I’m a doctor”

Trust, responsibility and compensation in health care

- lessons from both sides of the Tasman

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TRUST IN HEALTH CARE

Trust is a key element in the doctor patient relationship and in the effective operation of the health care system. At a systemic level, trust allows the system to operate more efficiently – for example, if consumers have confidence in the system which determines if someone is sufficiently skilled to have a right of practice in a hospital, then the consumer can assume that if the doctor is practicing at that hospital, then he or she will be safe to use. The consumer will not have to go on an individual hunt for information.

Trust relates to accountability in such an example through the consumer knowing that a hospital looks critically and from a learning perspective at treatment outcomes, that it has systems in place which can identify “problem areas”, and if someone has a record of unexpectedly poor outcomes or there are unsafe systems in place, that the organisation will act to address the problem.

Trust in an institution also relates to the security of staff. If an organisation is always looking for someone to “take the fall” or failing to acknowledge when an adverse event occurs, rather than looking at its own systems to see how it could be prevented from happening in the future, then staff will be reluctant to discuss things which can go wrong and will not feel supported to identify potential problems. Both the Bristol case and the Australian King Edward memorial hospital inquiries showed these were characteristics of these facilities, but there are many more examples of these in both Australian and New Zealand health care systems.

Trust is required for a patient to communicate honestly with a doctor. If a patient does not trust a doctor, then they may not tell the doctor relevant information or may choose to tell the doctor only what they think is relevant. For example, if a patient that a doctor has a

closed mind to the use of herbal medicines, they may well not disclose that they are also using these, because they do not want to be ridiculed.

THE CHARACTERISTICS OF TRUSTWORTHINESS

Well-founded trust can also serve as an “emotional bank account” for when the doctor and the patient disagree or there is an adverse outcome. In this context at an individual level, trustworthiness requires honesty, openness, good communication and mutual respect. It requires people to be able to admit mistakes and problems and to look to better ways of avoiding them in the future. It is a relationship based concept, that requires a shared ethical framework, where the well-being of the consumer is the known and mutually desired goal.

Similar characteristics are required for organisational and systemic trustworthiness in health. This is where leadership and the constancy and support of these individual characteristics across the organisation is very important. At a systemic level, a trustworthy system is likely to be characterised by equivalent organisational features, both within its own internal dealings and its dealings with consumers.

- The organisation tells the truth and deals honestly with consumers and staff – even if that is not in its best short term interests.
- The organisation’s processes are open and transparent.
- There is good communication within the organisation and between consumers and the organisation
- Consumers, carers and professionals are all treated with respect.
- All people in the organisation are all expected to have the interests of consumers as their paramount concern and the organisation supports them in this.

[Robert Cusack example]

TRUST AS A TENET OF FAITH AND ITS FALL FROM GRACE

Originally, the trust of consumers in the quality and safety of health care was simply based on an article of faith – there were ethical obligations on doctors from the very early periods, as reflected in the Hippocratic Oath from almost 2,500 years ago. Doctors were required to “First, do no harm”. While the availability of health care, its knowledge and skills have varied over time, this principle has underpinned organised medicine essentially since its beginnings.

The history of medical practice over the centuries does not seem to provide strong evidence that this ethic was put into practice by individual practitioners and the health system. Yet many patients still believed that “doing no harm” underpinned many of the heroic and sometimes misguided efforts of medicine to deliver health. This is perhaps testament to the deep human desire to trust health care providers. These are people and services that health care consumers use when they are most vulnerable, and most in need of assistance. The perception and the reality is that the consumer’s life is literally “in their hands”. For health care consumers to allow this to occur requires a very high degree of trust or desperation or a combination of both.

The last several decades have brought stark examples where the trust of consumers in the ethics of doctors has been severely challenged in quite public ways. There have been numbers of cases in Australia and overseas where public scrutiny has revealed a system with the same human failings, and in some cases, corruptions, as other professions. For example, the NSW Royal Commission into the Chelmsford Hospital in the 1980s showed a system where doctors continued to practice so-called “deep sleep therapy” experimentally with patients, despite high levels of mortality and morbidity. Other examples included the cervical cancer scandal in New Zealand, where a doctor had run a long term experiment on women without seeking their consent to observe the impact of treating or not treating cervical cancer (with the approval of the hospital’s ethics committee), which resulted in the deaths of a number of women¹.

In addition to these clear examples of illegal and unethical conduct, there has been a growing number of investigations which simply reveal poorly managed systems, rather than culpable individuals. This includes the recent UK Bristol Infirmary Inquiry into paediatric cardiac surgery and the King Edward Memorial Inquiry into obstetric services in Western Australia.

To some extent, it could be argued that these are exceptional cases, and the unquestioning trust originally vested in health care by consumers should not be undermined because of a few aberrant examples of poor quality care or unethical practitioners. However, along with these examples has come the results of a number of studies of adverse events in health care. Adverse events are defined in the research as an unintended injury to a patient resulting in disability, death or extra time in hospital caused by health care management not underlying disease.

PATIENTS SAFETY AND THE IMPACT OF ERROR ON TRUST

US studies in this area were first conducted in the 1980s in California and New York. In Australia, the Professional Indemnity Review commissioned the Quality in Australian Health care Study using similar methodology in 1993. This study was designed as a retrospective record review of 15,000 patient records across 30 hospitals in two States of Australia, with the sample stratified so that the numbers could be generalised across all acute hospitals in Australia. They did not include adverse events in psychiatric in-patient facilities or in primary health care, unless the person ended up in hospital. The results were published in 1995 and these showed that around 16.6% of hospital admissions involved or resulted from an adverse event where harm occurred to a patient. To illustrate the impact of this, these figures equate to:

- 470,000 hospital admissions that involved an adverse event
- 240,000 of these were considered "strongly preventable"
- 18,000 adverse events resulted in death
- 50,000 resulted in some degree of permanent disability
- 3.3 million bed days were attributable to these adverse events.

Internationally, studies have consistently shown that around 10% of admissions involve a preventable adverse event which leads to either disability, death or prolongation of hospital stay. The size and cost in both human and financial terms is very high. In its landmark study *To Err Is Human*, the US Institute of Medicine said:

When extrapolated to the over 33.6 million admissions to US hospitals in 1997, the results of the study in Colorado and Utah imply that at least 44,000 Americans die each year as a result of medical errors.³ The results of the New York Study suggest the number may be as high as 98,000.⁴ Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the 8th leading cause of death.⁵ More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).⁶

Total national costs (lost income, lost household production, disability and health care costs) of preventable adverse events (medical errors resulting in injury) are estimated to be between \$17 billion and \$29 billion, of which health care costs represent over one-half.⁷

In terms of lives lost, patient safety is as important an issue as worker safety. Every year, over 6,000 Americans die from workplace injuries.⁸ Medication errors alone, occurring either in or out of the hospital, are estimated to account for over 7,000 deaths annually.⁹

In Australia, the Australian Patient Safety Foundation (APSF) in its report *Iatrogenic Injury in Australia* said:

“There are substantial risks off-setting the great benefits of health care. Simply being an inpatient in an Australian acute-care hospital is forty times more dangerous, per hour than being in traffic and only ten times safer than leaping out of an aircraft equipped with a parachute.”

It is probably little wonder then that the implicit faith of consumers in the health system to deliver health to them as individuals has been sorely tested. While some have argued this is reflected in the greater propensity for patients to sue for unsatisfactory outcomes², the number of patients who do sue is still very small and completely dwarfed by the numbers of people who suffer harm in health care. Indeed, the public hysteria promoted by bodies such as the Australian Medical Association about a cost crisis in litigation needs always to be viewed in the context of the enormous financial and human costs associated with preventable adverse events in health care. Professor Bill Runciman of the Australian Patient Safety Foundation made the following estimates of some of these:

- \$6 million/day in direct medical costs
- \$1 million/day in litigation, compensation
- Twice these amounts in indirect costs
- Personal costs to patients, relatives, carers
- Person costs to health providers
- Costs to society

Professor Runciman and the Institute of Medicine both identified the loss of trust in health care systems and alienation of health care professionals as some of the societal costs. This is at a time when the knowledge and skill bases of health care professionals and systems are probably at an historic all-time high and the chances of delivering better health outcomes in many cases is better now than ever before. At the same time, it is the least likely time in

history that health care consumers will base their trust in health care upon a simple statement about the ethics of the medical profession.

It is not the existence of error which undermines the trust of consumers, but the lack of individual and systemic acknowledgment of their existence, the failure of the system and individuals to apologise when harm is caused and the systemic failure to act to prevent these occurring. It can be aggravated by the imposition of a charge for remedying the error or for even discussing its occurrence.

HOW TRUST IS UNDERMINED WITH THE BEST INTENTIONS

Doctors to a large extent are no longer placed upon an automatic pedestal because of their professional status – enough of their fellows have been shown to have feet of clay for many people to be sceptical and to require proof that trust can be given appropriately. There have been enough examples where health care is provided that is either not necessary, not useful or potentially harmful because of financial reasons or because of professional laziness or jealousies to acknowledge that the scepticism of consumers may in some cases be well-founded.

There are recurring examples of these – often in areas where the science is not strong but consumers' fears and insecurities are strongest. When I was relaxing on my honeymoon, I was reading the New Zealand newspaper examination of the practices of the so-called "Men's Sexual Health Clinics". Reading both their practices and about the context for that advice I was left with the sense that many are acting as the new version of snake-oil salesmen. Pills to enhance an erection were being provided to young men who were nervous about their first sexual encounter and to address "premature ejaculation". The evidence provided with the drugs did not present information about the utility of the drug for anyone under 40 and yet they were prescribing it for men as young as 16. The drugs are too new to have had long term follow-ups in these groups. Many consumers look at these stories and see greedy drug companies and unethical doctors playing on the insecurities of men and boys, with little regard to long term physical, mental or emotional health.

A similar story occurs in Australia with women and weight loss drugs. Advertising campaigns, which float at the edge of direct-to-consumer advertising – illegal in Australia – promise "Lose weight, Gain life – see your doctor". They use a sad looking large woman who is holding off from dancing, presumably because of her weight. Given a major side effect of the drug is faecal incontinence, I wonder if she isn't dancing because she is already

taking the drug and trying to hold her cheeks together. I have raised this with some doctors who widely prescribe and promote the drug and who have said that this is its clinical efficacy. Consumers are "educated" about the fat in food by the degree of faecal incontinence they experience! So much for food-labelling and the enquiring consumer!

Anyway, if you then look at the various studies used to support the hype, all are constructed around placebo and drug groups, both of whom have to follow a 1200 calorie diet for 6 months, followed by a 1,000 calorie diet thereafter. Both groups are required to exercise. For those of you who have been around for a while, this could look like a regular weight loss regime, but this isn't mentioned in the advertising. Consumers then have to fork out around \$120 per month and at the end of twelve months, the average additional weight for the drug group is around 3-4kg! In the studies I have looked at a significant proportion of participants were also lost to follow-up (up to 40% in one study), so there is questionable science even in the claims as modest as this. And to keep it off, you need to take the drug (and something to counteract the loss of fat-soluble vitamins which is another side-effect of the drug) and/or maintain your lifestyle changes. I wonder how many doctors who recommend using this drug have looked beyond the drug company's colourful promotional material to provide a full picture of what such a drug will deliver and what it will cost? It is little wonder that consumers look at this kind of thing and ask "Why should we trust the health care system?".

Doctors can also undermine trust through the best of motives. For example, doctors may provide limited information to a patient about potential risks, because "Otherwise they will be too afraid to have the procedure". To a doctor, this may sound altruistic and sensible, a useful short cut to the "right decision". However, by not actually providing all the necessary information to the consumer and working through the issues that the person raises, the doctor's unilateral decision undermines the principle of personal autonomy and if things turn out badly in Australia, may well land the doctor in court.

The breakdown of communication which characterises much litigation in our country often has its genesis in shortcuts in risk disclosure or the failure to tell a consumer what risks are involved. If a consumer decides to go ahead knowing all the risks, and without feeling "railroaded", then it is unlikely that they will take action if a known risks eventuates – they are much more likely to see it as "the luck of the draw". If the consumer decides on all the evidence that they don't want to proceed with the treatment, then that can also be a valid choice, not failure on the part of the doctor. The consumer does however need to

understand the likely consequences of doing nothing, just as they need to understand the likely consequences of intervening.

Another situation where consumers are left with reduced trust in the system is when something goes wrong. In Australia, the threat of litigation is often given as the reason for the walls of silence that go up around the event, but I think that this also occurs in New Zealand, where your legal system for compensation is very different. Often the patient and/or family are unable to find out what happened to them and why. UK studies show that this “closing down” provides a big incentive to litigate or complain. However, perhaps more insidiously, it perpetuates an atmosphere of distrust – about the system “looking after its own. To a consumer or family member, it appears that the original trust which they placed in the hospital and doctor to look after their best interests when they were vulnerable has been breached – the system protects itself, rather than the consumer being treated.

SYSTEMIC BLINDNESS ABOUT THE UBIQUITY OF ERROR

However, for those inside, the health care system does not look after its own either. As anyone who makes a mistake in health care knows, it can be a devastating event professionally and personally. For a long time, the culture of health care has been to deny the existence of error. A series of important articles³ in the early 1990’s looked at the culture of health care and its approach to error. The Professional Indemnity Review summarised the conclusions of these studies in the following manner:

[Leape argues that] a doctor’s training and medical culture leads him or her to expect “to function without errors” and to “view an error as a failure of character”. This, in turn leads to need to deny the existence of error at a very fundamental level, because the admission of an error is no longer simply a recognition of every doctor’s essential humanity and the reality of health care. Another author has discussed the negative impact of perfectionism and the vision of absolute control in a doctor’s capacity to deal with mistakes. “These processes that motivate the physician to maintain excellent standards of practice do not incorporate the notion of fallibility, in contrast to the premises of the science of medicine, which are founded on probability and error”.

Rather, admission of an error becomes “a confession of having a flawed character. Having erred is seen as the antithesis of the very self-perception that a doctor has developed over years of training and enculturation.” Where the error results in

significant patient harm, there is an additional burden. It can trigger emotions such as shame, guilt, depression and anxiety, as well as professional self-doubt. It may lead to psychological defence responses, such as denial, anger or blaming of someone else, even the patient. It can lead to an internal conflict where the doctor knows they are a hardworking, altruistic care giver, and yet they also know they made an error, which resulted in patient harm.⁴

The failure as a systemic level to recognise the existence of error and to actively work to create safer systems often mean that where there are serious problems, nothing is done until too late. I first noticed this when I started the work of the Professional Indemnity Review in 1991. I had come from a workers' compensation background, where it was widely recognised that workplaces were dangerous places, that workers and others made mistakes, that people got tired and that a safe workplace didn't just happen. I was staggered that patient safety in the health system was not seen in this way at all. There was no data at that point on the incidence of harm. When I suggested setting up the Quality in Australian Health Care Study, the representatives of the Australian Medical Association on my committee stated that the research was not necessary for two reasons – the first was that there were no mistakes in health care, or if there were, we should not find out about them, because that would undermine public confidence in health care. That REALLY worried me!!

There was also a culture which saw pushing on the past the point of exhaustion as heroic and which, as best I could see, ran its rosters as if sleep was an optional extra for doctors and to a lesser extent nurses. I heard doctors argue for continuation of this practice on the basis that "Well, in my day, I had to do it! You have to be able to conquer fatigue if you are going to make it." When I mentioned interstate transport drivers and limits on their wakefulness, I was looked on as an outsider, who really just didn't understand. Recent research in Australia by people such as Drew Dawson has shown the negative patient safety impacts of exhaustion on doctors and nurses. The health system is starting to act slowly to address these issues.

Thankfully, there has also been a growing recognition of the systemic nature of many adverse events in health care. This analysis began with the work of James Reason, which showed the inter-relationship between cultural factors, system factors, barriers and individual human error in producing bad outcomes in complex systems. Incident monitoring and root cause analysis are some of the growing suite of tools being used to look at the underlying causes of harm in health care. It is increasingly being recognised that most harm doesn't

come from “bad apples” but from badly designed systems. There is also a recognition that errors occur all the time, even among those who are the most expert. There is, at least at a symbolic level, a desire to move away from a culture of individual blame to one where there is systemic accountability for preventing adverse events happening in the future. There is also a growing recognition that patients and consumers need to be told about the risks of health care before they receive it and that they should be told the truth if an adverse event occurs.

THE AUSTRALIAN LITIGATION CRISIS

In Australia, this cultural transition has been occurring in the context of a so-called “litigation crisis”, which has seen the failure of one medical defence organisation and calls for significant reforms to the tort system. While the scope of the increase in litigation over the past 10 years has been much more modest than the increase in the costs of MDO subscriptions, it would appear that the fear of litigation among doctors has grown exponentially, as has that of institutions.

The focus of the Australian system of negligence litigation is to a large extent individually “blame” based and framed in the language of fault and moral culpability, even though it shares some of the same underlying “purposes” as the New Zealand no-fault scheme. While the Australian system also includes a strong component of individual blame through its fault base, it shares the same role as essentially a formalised way of compensating losses suffered by someone harmed in health care.

While the New Zealand no-fault compensation system “disconnects” fault and compensation to some extent (though arguable not completely), there have been other systems, namely the criminal justice and disciplinary systems which have been used with the apparently same aim of “accountability”. The New Zealand disciplinary system has also come to be used as a supplement to what is seen as an inadequacy in the non-fault scheme, where care has been considered to be sub-standard.

CONFLICTING MESSAGES

The messages of the compensation arrangements and other legal systems relating to health care adverse events are in many ways at odds with some of these broader cultural changes that are occurring in health care. Even in New Zealand, with its no-fault compensation arrangements, there remains elements both in that system and in the broader criminal and disciplinary processes which can be broadly categorised as “blame” focussed. These

tensions sometimes act to thwart desirable reforms, as participants in the system are pulled in conflicting directions.

For example, the issue of “open disclosure” has brought these competing values into stark contrast. Telling a consumer when something goes wrong is a prerequisite for a trust-based, “learning” health care system. In the development of the national standard relating to open disclosure, much conflict has arisen between telling a consumer and the fear that telling someone of an error will result in litigation. The “old” way often meant that unless a consumer or family member asked and kept asking, there was no admission that an error had occurred. For insurers and defence lawyers this was seen as one way of reducing the incidence of litigation, even though the evidence about “hiding the truth” shows that it probably served to anger more consumers and itself, give rise to litigation.

Messages from insurers are often mixed – reporting an incident may well result in an increased premium, even though it is what the system is trying to encourage. Sometimes doctors will not want to tell someone about a problem unless there are adverse consequences – a nicked bowel which is detected and remedied under the same anaesthetic is one example.

The existence of qualified privilege legislation in most Australian jurisdictions is another example – this legislation is generally intended to promote better quality of care, through protecting the investigation processes of why things occurred from being able to be subpoenaed or otherwise revealed. However, in some cases, it has limited consumer access to any understanding of what is being done to address problems and to “get behind the ramparts”. Getting a balance between the public interests in openness and the need for some protection to ensure participation in the investigation and prevention processes is something we are struggling with at the moment in Australia, particularly so far as the results of root cause analyses are concerned. This debate is likely to continue as root cause analyses identify system breakdowns, which may reduce the identification of individual “negligence”, but increase the likelihood of a finding of institutional negligence. Rather than discomfited clinicians, there will be discomfited administrators.

Even the growing emphasis on “risk management” strategies to reduce the likelihood of litigation brings the tension between these two movements together. Risk management often brings together a range of good practices, including incident monitoring, better proactive complaints handling, better information for consumers where harm occurs, early

non adversarial handling where liability is likely, and consumer participation in organisational decision-making. However, it can also be set out in terms which are not about partnership and openness in the creation of a trustworthy system.

Sometimes the language surrounding risk management sounds very much like Orwellian insurer-speak – for example good case management is spoken of in a way which leaves a consumer feeling that the insurer is describing a process for “handling difficult people with kid gloves to reduce what we have to pay out” rather than a consumer focussed process which is “acknowledging the legitimate concerns of someone who has suffered harm and should be adequately compensated” – probably the same end point but a completely different mindset in both cases. Both can even end up with similar processes, but unless the mind-set is changed, the process change will not result in the development of a trust-based, resilient system.

WHAT CAN THE FUTURE LOOK LIKE

The health care system is at the crossroads at the moment – it is gradually coming out of its own secret darkness and recognising the value in being honest with itself. Doctors and nurses and administrators are looking at how their care can be made safer for consumers and how the falling morale which has accompanied the professional and systemic “fall from grace” can be addressed. Many are actively embracing the concept of “learning from mistakes” within a hostile liability environment. These tensions must be addressed in the design of the whole health care and liability system.

Equally, compensation systems need to respond differently. Both New Zealand and Australia suffer from having social security and health care systems, which are separate” to their compensation arrangements and where consumer and provider entitlements vary. People are generally looking for mechanisms that improve equity between those with similar degrees of disability and ensure appropriate services for a good quality of life. Consumers are also looking for systems which somewhere recognise what has happened to them (usually with an apology), systems and individuals which are accountable for preventing it happening again, and where, if the care results in a permanent disability, that is recognised.

I believe that the key to all these things are to create trustworthy and trusted systems in both medicine and the law – no longer based on a “Trust me I’m a doctor” ethos or perhaps more questionably “Trust me, I’m a lawyer”, but rather on the creation of systems which are overtly values based. The characteristics of such systems will be that:

- Are inherently centred on patient safety and consumer/family health and well-being;
- Have transparent processes of systemic accountability (both for learning and discipline);
- Are based on full consumer participation and involvement in health care (and even the law!!) at all levels;
- Requires open disclosure when something goes wrong; and
- Provides appropriate compensation and assistance in as non-adversarial an environment as possible.

We need systems which are honest with each other – if a root case analysis discloses a likely legal liability for harm, then the system should be proactive in ensuring the harm is compensated. We should not have two time-consuming, costly fact-finding processes. We need early active attention to reduce the consequences of an adverse event – whether by meeting costs as they arise or through prompt access to effective rehabilitation. We need compensation systems which reduce the disabling effects which appear to flow from these systems.

When I started this work, I believed we needed legislative and cultural change before we could move down this track. My last several years in Australia have often left me with very little hope at the Federal health policy level that this will ever occur. However, I and many others have been working away at how we can bring about many of these changes, without waiting for such a wholesale transformation. These changes have included:

- Significant efforts and money going towards on patient safety both at the State/Territory and Commonwealth level, and more importantly at the institutional level;
- Increasing consumer involvement in quality improvement committees and processes and in broader decision-making levels in health care;
- Changing the coal-face and statutory complaints systems as well as court processes to reduce inappropriate adversarial treatment of people harmed in health care;
- Consumers and doctors working together to lobby for systemic change e.g. in the area of long term care costs;
- Early interventions in some States and Territories to avoid unnecessary litigation in the public systems, especially in South Australia and the Northern Territory, which have impacted positively on legal costs and delays.

Most of the successful efforts I have been involved in have required a gradual building of trust between players, extreme honesty about what is and is not working, open and critical ongoing appraisal of what further needs to be done. I feel that in many ways we are making big steps down the path together, but as a consumer now on many of these journeys, I find it hard and tiring and sometimes an enormous voluntary effort. I feel discouraged and think things will never REALLY change. A new health professional will attend and say something which makes me and many of my committee colleagues cringe and I will feel that the job is impossibly large doing it brick by brick. I then swear that this will be the last 7AM meeting I will go to "fit in" with everyone's schedules.

And then there is a breakthrough! We get some data back which shows a dramatic improvement in consumer outcomes and reduced costs! We have a senior manager or clinician talking honestly about the frequency of adverse events and discussing how to address these with us as consumer partners. We have the Royal Australian College of Physicians determining that their experiences of consumer participation in their work have been so positive that they will require it in all their work.

From both sides of the Tasman, we bring lessons to the remaining problems. I feel we also need to recognise that much of what we have done and are doing here in these areas is leading edge. We have sat with a cultural cringe in many of these debates, and yet when I look at the intellectual rigour and dynamism that we people on either side of the Tasman have addressed these issues, I believe that there is much for us to be proud of. The work of the Professional Indemnity Review preceded the work of the Institute of Medicine. Incident monitoring had its roots in our countries. The Quality in Australian Health Care Study has been an international landmark study. We are international leaders in the area of consumer participation in quality activities. In New Zealand, you have a long experience now with the positive and negative components of no-fault compensation.

Problems, issues and complex quandaries remain, but I think we have much to offer the debate from these experiences and we need to be looking at opportunities to influence change in these areas. I have spoken about trust as a key element of where we must go to address the remaining problems. It involves recognising the importance of values and relationship in health care, not just the "bottom line". Creating trust requires individual and collective integrity – staying in there and working it out, even when it is difficult; learning to listen harder than we speak; putting yourself in the shoes of the other person; developing

structures and processes that support such a dialogue. In one sense it is creating a system which embodies the meaning and the hard work of the verb “to love” in its full ethical and spiritual sense. Perhaps that’s why I felt that it was not inappropriate for me to address you this evening while I am on my honeymoon. I would like to achieve these in my life with Clyde and, with the help and commitment of many others, in our health care system and our broader communities of influence.

¹ Committee of Enquiry into Allegations Concerning Treatment of Cervical Cancer at the National Women’s Hospital and into Other Related Matters. *The Report of the Committee of Enquiry into Allegations Concerning Treatment of Cervical Cancer at the National Women’s Hospital and into Other Related Matters*. Government Printing Office July 1988 Auckland: 38 (Cervical cancer inquiry report).

² It is likely that the reasons for this are much more complex and relate to continuing poor and often disrespectful communication practices by some doctors, as much as their quality of care. The long term increase in litigation against doctors, which rose rapidly from a very low base in the 1960’s over the next 30 years, reflects a broader societal shift to question professionals and to question the results of services provided by them as you might any other provider of a service, such as a builder or car mechanic.

³ See e.g. Leape L. Error in medicine. 1994 *JAMA* 272(23): 1851-1857; Christensen J, Levinson W, Dunn P. The heart of darkness: the impact of perceived mistakes on physicians. 1992 *Journal of General Internal Medicine* 7(July/August): 424-431 at 430.

⁴ Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995. AGPS Canberra, Chapter 5, pages [check]